2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures

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

12/13/13

PQRS Introduction

The measure specifications contained in this manual are intended for individual eligible professionals reporting via claims or registry and group practices reporting via registry for the 2014 Physician Quality Reporting System (PQRS).

- Measure specifications for measures groups reporting are included in a separate manual, "2014 Physician Quality Reporting System Measures Groups Specifications Manual," which can be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

- Group practices electing to participate in the PQRS group practice reporting option (GPRO). reporting PQRS via GPRO Web-Interface may access the GPRO Web Interface Narrative Specifications at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/GPRO_Web_Interface.html

- Meaningful Use measure specifications can access electronic clinical quality measures (eCQMs) at: http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/ClinicalQualityMeasures.html

- Information regarding CG-CAHPS may be found at: http://acocahps.cms.gov/Content/Default.aspx#aboutSurvey
  Please note that this link is directed to the Accredited Care Organization webpage. There will be a separate PQRS CAHPS webpage available in spring 2014.

Each measure is assigned a unique number. Measure numbers for 2014 PQRS represents a continuation in numbering from the 2013 measures. For 2014 PQRS measures that are continuing forward in the 2014 PQRS, measure specifications have been updated. In addition to the measure specifications manual, please refer to the "2014 Physician Quality Reporting System Implementation Guide" for additional information essential in assisting eligible professionals' understanding and submission of measures. This document can be accessed at: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html.

Those who report satisfactorily for the 2014 program year *may* avoid the 2016 payment adjustment. Additional information on how to avoid future PQRS payment adjustments can be found through supporting documentation available on the CMS website: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/.

Eligible Professionals

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

Frequency and Performance Timeframes

The measure instructions limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Each individual eligible professional or group practices participating in 2014 PQRS should report according to the frequency and timeframe listed within each measure specification.

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

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. The denominator population may be defined by demographic information, certain International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis (01/01/2014-9/30/2014), International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis (10/01/2014-12/31/2014), Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted by individual eligible professionals as part of a claim for covered services under the PFS for claims-based reporting. This same criteria is also applied for individual eligible professsionals and group practices who chose to report via a registry although this data is not necessarily submitted via a claim.

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

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

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

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

For eligible professionals reporting individually, PQRS measures, including patient-level measure(s), may be reported for the same patient by multiple eligible professionals practicing under the same Tax Identification Number (TIN). If a patient sees multiple providers during the reporting period, that patient can be counted for each individual NPI reporting if the patient encounter(s) meet denominator inclusion. The following is an example of two provider NPIs (National Provider Identifiers), billing under the same TIN who are intending to report PQRS Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy. Provider A sees a patient on February 2, 2014 and prescribes an aspirin and reports the appropriate quality-data code (QDC) for measure #6. Provider B sees the same patient at an encounter on July 16, 2014 and verifies that the patient has been prescribed and is currently taking an aspirin. Provider B must also report the appropriate QDCs for the patient at the July encounter to receive credit for reporting measure #6.

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

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

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

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

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

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

This symbol (asterisk) represents the Measure Developer (as noted in the Symbol and Copyright Information section following the 2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry). The NQF number is also listed.

Sample 2014 PQRS Measure Specification

Official measure title.

*Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

2014 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

Each individual measure specification identifies the available reporting option(s).

DESCRIPTION:
This segment includes a high-level description of the measure.

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

INSTRUCTIONS:
Details when the measure should be reported and who should report.

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

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

Measure #19 can be reported via claims and registry.

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

To ensure satisfactory reporting, submit all measure-specific coding for the beneficiary on the claim(s) representing the eligible encounter. If criteria are met, claims may be reconnected based on TIN/NPI/Beneficiary/Date of Service.

Measure Reporting via Registry:
Review patient demographics, DX, and encounter codes to determine if the patient meets denominator criteria.

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient [illegible] who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

Review other PQRS measures for which the patient meets denominator inclusion.

Enter the correct combination of codes on the claim.

Denominator statement describes the population evaluated by the performance measure.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Diagnosis for diabetic retinopathy (ICD-10-CM) [for use 10/01/2014-1
E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.
E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.3

Patient population that may be counted as eligible to meet a measure's inclusion requirements.

Identified by ICD-9-CM/ICD-10-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc), and place of service (if applicable).

ICD-10-CM codes are included in the 2014 *PQRS Measure Specifications* for use 10/01/2014 – 12/31/2014. ICD-9-CM codes should be utilized 1/1/2014 – 9/30/2014.

E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359

AND

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

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

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

Measures may or may not contain definitions.

Definition:

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

Findings – Includes level of severity of retinopathy AND the presence or absence of macular edema

Measure #19 is an example of a complex measure. Review carefully to submit the quality-data codes (QDCs) that meet the quality action being reported.

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Macular or Fundus Exam Findings Communicated

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

Section 1: Satisfactory Reporting and Performance.

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

AND

Examples of QDCs.

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

OR

Dilated Macular or Fundus Exam Findings not Communicated for Medical R

II code & one quality-data code [5010F-1P & G8397] are required on the claim fo numerator option)

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

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

Section 2: Satisfactory Reporting and Excluded from Performance.

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

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

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

AND

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

OR

Measure #19 has two performance exclusion sections.

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

OR

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

AND

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

Section 3: Satisfactory Reporting and Performance Not

A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.

Questions or comments regarding how the measure is constructed or suggestions for changes to a measure should be submitted to the measure's developer/owner.

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

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

Summary of clinical recommendations based on best practices.

List of 2014 PQRS Individual Measure Specifications for Claims and Registry Reporting			
Measure Number	Measure Title	Reporting Options	Page
1	Diabetes: Hemoglobin A1c Poor Control	C, R	20
2	Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL)	C, R	23
5	Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	R	25
6	Coronary Artery Disease (CAD): Antiplatelet Therapy	C, R	30
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy - Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)	R	32
8	Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	R	37
9	Anti-depressant Medication Management	R	41
12	Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation	C, R	45
14	Age-Related Macular Degeneration (AMD): Dilated Macular Examination	C, R	47
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	C, R	49
19	Diabetic Retinopathy: Communication with the Physician Managing On going Diabetes Care	C, R	51
20	Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician	C, R	54
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	C, R	60
22	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	C, R	65
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	C, R	70
24	Osteoporosis: Communication with the Physician Managing On-going Care Post- Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	C, R	77
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	C, R	83
30	Perioperative Care: Timing of Prophylactic Antibiotic – Administering Physician	C, R	85
31	Stroke and Stroke Rehabilitation: Venous Thromboembolism (VTE) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage	C, R	88
32	Stroke and Stroke Rehabilitation: Discharged on Anithrombotic Therapy	C, R	90
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge	R	93
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	C, R	95
36	Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered	C, R	98
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	C, R	100
40	Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older	C, R	103
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	C, R	110
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery	C, R	113

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Measure Number	Measure Title	Reporting Options	Page
	(IMA) in Patients with Isolated CABG Surgery		
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery	C, R	115
45	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures)	C, R	118
46	Medication Reconciliation	C, R	121
47	Advance Care Plan	C, R	124
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	C, R	127
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older	C, R	129
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	C, R	131
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	C, R	133
52	Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy	C, R	135
53	Asthma: Pharmacologic Therapy for Persistent Asthma – Ambulatory Care Setting	R	138
54	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain	C, R	140
55	Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope	C, R	142
56	Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Vital Signs	C, R	144
59	Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Empiric Antibiotic	C, R	148
64	Asthma: Assessment of Asthma Control – Ambulatory Care Setting	R	153
65	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	R	156
66	Appropriate Testing for Children with Pharyngitis	R	159
67	Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	C, R	162
68	Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	C, R	165
69	Hematology: Multiple Myeloma: Treatment with Bisphosphonates	C, R	168
70	Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	C, R	170
71	Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer	C, R	172
72	Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients	C, R	176
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol	C, R	179
81	Adult Kidney Disease: Hemodialysis Adequacy: Solute	R	181
82	Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute	R	183
83	Hepatitis C: Confirmation of Hepatitis C Viremia	R	185
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment	R	187

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85	Hepatitis C: HCV Genotype Testing Prior to Treatment	R	189
87	Hepatitis C: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks After Initiation of Treatment	R	191
91	Acute Otitis Externa (AOE): Topical Therapy	C, R	193
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	C, R	195
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	C, R	197
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade	C, R	200
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	C, R	203
104	Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients	C, R	206
106	Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity	C, R	209
107	Adult Major Depressive Disorder (MDD): Suicide Risk Assessment	C, R	214
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD)Therapy	C, R	217
109	Osteoarthritis (OA): Function and Pain Assessment	C, R	220
110	Preventive Care and Screening: Influenza Immunization	C, R	222
111	Pneumonia Vaccination Status for Older Adults	C, R	224
112	Breast Cancer Screening	C, R	226
113	Colorectal Cancer Screening	C, R	228
116	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	R	231
117	Diabetes: Eye Exam	C, R	234
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)	R	237
119	Diabetes: Medical Attention for Nephropathy	C, R	241
121	Adult Kidney Disease: Laboratory Testing (Lipid Profile)	C, R	244
122	Adult Kidney Disease: Blood Pressure Management	C, R	246
123	Adult Kidney Disease: Patients on Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL	C, R	250
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy - Neurological Evaluation	R	253
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	R	256
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	C, R	258
130	Documentation of Current Medications in the Medical Record	C, R	262
131	Pain Assessment and Follow-Up	C, R	266
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	C, R	270
137	Melanoma: Continuity of Care – Recall System	R	274

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138	Melanoma: Coordination of Care	R	276
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement	C, R	280
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care	C, R	283
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications	C, R	286
143	Oncology: Medical and Radiation – Pain Intensity Quantified	R	288
144	Oncology: Medical and Radiation – Plan of Care for Pain	R	293
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	C, R	298
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening	C, R	300
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy	C, R	302
154	Falls: Risk Assessment	C, R	305
155	Falls: Plan of Care	C, R	309
156	Oncology: Radiation Dose Limits to Normal Tissues	C, R	312
157	Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection	C, R	314
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage Performed	R	316
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis	R	318
163	Diabetes: Foot Exam	C, R	322
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation	R	324
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate	R	326
166	Coronary Artery Bypass Graft (CABG): Stroke	R	328
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure	R	330
168	Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration	R	332
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge	R	334
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge	R	336
171	Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge	R	338
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula	C, R	340
173	Preventive Care and Screening: Unhealthy Alcohol Use -- Screening	R	342
176	Rheumatoid Arthritis (RA): Tuberculosis Screening	R	344
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity	R	347
178	Rheumatoid Arthritis (RA): Functional Status Assessment	R	349
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis	R	352
180	Rheumatoid Arthritis (RA): Glucocorticoid Management	R	355
181	Elder Maltreatment Screen and Follow-Up Plan	C, R	358
182	Functional Outcome Assessment	C, R	362
183	Hepatitis C: Hepatitis A Vaccination in Patients with Hepatitis C Virus	R	366

List of 2014 PQRS Individual Measure Specifications for Claims and Registry Reporting			
Measure Number	Measure Title	Reporting Options	Page
	(HCV)		
185	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use	C, R	368
187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy	R	371
191	Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery	R	373
192	Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures	R	382
193	Perioperative Temperature Management	C, R	389
194	Oncology: Cancer Stage Documented	C, R	393
195	Radiology: Stenosis Measurement in Carotid Imaging Reports	C, R	397
197	Coronary Artery Disease (CAD): Lipid Control	R	400
198	Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment	R	403
204	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic	C, R	405
205	HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis	R	408
217	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments	R	410
218	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments	R	413
219	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments	R	416
220	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments	R	419
221	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments	R	422
222	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments	R	425
223	Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments	R	428
224	Melanoma: Overutilization of Imaging Studies in Melanoma	R	432
225	Radiology: Reminder System for Mammograms	C, R	435
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	C, R	437
228	Heart Failure (HF): Left Ventricular Function (LVF) Testing	R	440
231	Asthma: Tobacco Use: Screening - Ambulatory Care Setting	C, R	443
232	Asthma: Tobacco Use: Intervention - Ambulatory Care Setting	C, R	445
233	Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection	R	448
234	Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)	R	450
236	Controlling High Blood Pressure	C, R	452
241	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C	C, R	455

List of 2014 PQRS Individual Measure Specifications for Claims and Registry Reporting			
Measure Number	Measure Title	Reporting Options	Page
	Control (<100 mg/dL)		
242	Coronary Artery Disease (CAD): Symptom Management	R	458
243	Cardiac Rehabilitation Patient Referral from an Outpatient Setting	R	461
245	Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)	C, R	465
246	Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)	C, R	468
247	Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence	C, R	471
248	Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence	C, R	473
249	Barrett's Esophagus	C, R	476
250	Radical Prostatectomy Pathology Reporting	C, R	478
251	Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients	C, R	481
254	Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain	C, R	483
255	Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure	C, R	486
257	Statin Therapy at Discharge after Lower Extremity Bypass (LEB)	R	488
258	Rate of Open Repair of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)	R	491
259	Rate of Endovascular Aortic Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day #2)	R	493
260	Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)	R	495
261	Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness	C,R	497
262	Image Confirmation of Successful Excision of Image-Localized Breast Lesion	C, R	500
263	Preoperative Diagnosis of Breast Cancer	C, R	502
264	Sentinel Lymph Node Biopsy for Invasive Breast Cancer	R	504
265	Biopsy Follow-Up	R	506
266	Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)	C, R	509
267	Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome	C, R	511
268	Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy	C, R	513
303	Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery	R	515
304	Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery	R	519
317	Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented	C, R	522
320	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal	C, R	526

List of 2014 PQRS Individual Measure Specifications for Claims and Registry Reporting			
Measure Number	Measure Title	Reporting Options	Page
	Colonoscopy in Average Risk Patients		
322	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients	R	528
323	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)	R	530
324	Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients	R	532
325	Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions	R	534
326	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	C, R	538
327	Pediatric Kidney Disease: Adequacy of Volume Management	C, R	541
328	Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL	C, R	543
329	Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis	R	545
330	Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days	R	547
331	Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)	R	550
332	Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis	R	552
333	Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)	R	554
334	Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)	R	557
335	Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks	R	560
336	Maternity Care: Post-Partum Follow-Up and Care Coordination	R	562
337	Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier	R	565
338	HIV Viral Load Suppression	R	567
339	Prescription of HIV Antiretroviral Therapy	R	569
342	Pain Brought Under Control Within 48 Hours	R	571
343	Screening Colonoscopy Adenoma Detection Rate	R	573
344	Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)	R	575
345	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)	R	577
346	Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA)	R	579
347	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital	R	581
348	HRS-3 Implantable Cardioverter-Defibrillator (ICD) Complications Rate	R	583
349	Optimal Vascular Care Composite	R	587
358	Patient-centered Surgical Risk Assessment and Communication	R	593

List of Retired Physician Quality Reporting Measure Specifications

Measure #	Measure Title	Retirement Effective Date
3	Diabetes Mellitus: High Blood Pressure Control	January 1, 2014
4	Screening for Future Fall Risk	January 1, 2009
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	January 1, 2013
11	Stroke and Stroke Rehabilitation: Carotid Imaging Reports	January 1, 2010
13	Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended	January 1, 2008
15	Cataracts: Assessment of Visual Functional Status	January 1, 2008
16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation	January 1, 2008
17	Cataracts: Pre-Surgical Dilated Fundus Evaluation	January 1, 2008
25	Melanoma: Patient Medical History	January 1, 2008
26	Melanoma: Complete Physical Skin Examination	January 1, 2008
27	Melanoma: Counseling on Self-Examination	January 1, 2008
29	Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)	January 1, 2008
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered	January 1, 2010
37	Dialysis Dose in End Stage Renal Disease (ESRD) Patients	January 1, 2008
38	Hematocrit Level in End Stage Renal Disease (ESRD) Patients	January 1, 2008
42	Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise	January 1, 2008
57	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation	January 1, 2013
58	Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status	January 1, 2013
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 Physician Quality Reporting 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
79	End Stage Renal Disease (ESRD): Influenza Immunization in Patients with ESRD	January 1, 2012
80	End Stage Renal Disease (ESRD): Plan of Care for ESRD Patients with Anemia	January 1, 2009
86	Hepatitis C: Antiviral Treatment Prescribed	January 1, 2014
88	Hepatitis C: Hepatitis A and B Vaccination in Patients with HCV	January 1, 2009
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption	January 1, 2014
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy	January 1, 2014
92	Acute Otitis Externa (AOE): Pain Assessment	January 1, 2013
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	January 1, 2012
95	Otitis Media with Effusion (OME): Hearing Testing	January 1, 2010
96	Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use	January 1, 2009
97	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	January 1, 2009
98	Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use	January 1, 2009
101	Appropriate Initial Evaluation of Patients with Prostate Cancer	January 1, 2009
103	Prostate Cancer: Review of Treatment Options in Patients with Clinically Localized Prostate Cancer	January 1, 2009
105	Prostate Cancer: Three Dimensional (3D) Radiotherapy	January 1, 2013
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use	January 1, 2011
115	Preventive Care and Screening: Advising Smokers and Tobacco Users to Quit	January 1, 2011
120	Chronic Kidney Disease (CKD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy	January 1, 2009
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)	January 1, 2013
125	Health Information Technology (HIT): Adoption/Use of Medication Electronic Prescribing (e-Rx) *Refer to new Electronic Prescribing (e-Rx) incentive program*	January 1, 2009
129	Universal Influenza Vaccine Screening and Counseling	January 1, 2009

List of Retired Physician Quality Reporting Measure Specifications

Measure #	Measure Title	Retirement Effective Date
132	Patient Co-Development of Treatment Plan/Plan of Care	January 1, 2009
133	Screening for Cognitive Impairment	January 1, 2009
135	Chronic Kidney Disease (CKD): Influenza Immunization	January 1, 2012
136	Melanoma: Follow-Up Aspects of Care	January 1, 2011
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement	January 1, 2011
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD	January 1, 2010
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula	January 1, 2012
158	Carotid Endarterectomy: Use of Patch During Conventional Carotid Endarterectomy	January 1, 2013
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy	January 1, 2014
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy	January 1, 2014
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis	January 1, 2011
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization	January 1, 2012
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV	January 1, 2014
186	Chronic Wound Care: Use of Compression System in Patients with Venous Ulcers	January 1, 2013
188	Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear	January 1, 2014
189	Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear Within the Previous 90 Days	January 1, 2013
190	Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss	January 1, 2013
196	Coronary Artery Disease (CAD): Symptom and Activity Assessment	January 1, 2013
199	Heart Failure: Patient Education	January 1, 2012
200	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation (AF)	January 1, 2012
201	Ischemic Vascular Disease (IVD): Blood Pressure Management	January 1, 2014
202	Ischemic Vascular Disease (IVD): Complete Lipid Profile	January 1, 2012
203	Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control	January 1, 2012
206	HIV/AIDS: Screening for High Risk Sexual Behaviors	January 1, 2013
207	HIV/AIDS: Screening for Injection Drug Use	January 1, 2013

List of Retired Physician Quality Reporting Measure Specifications

Measure #	Measure Title	Retirement Effective Date
208	HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis	January 1, 2014
209	Functional Communication Measure – Spoken Language Comprehension	January 1, 2014
210	Functional Communication Measure – Attention	January 1, 2014
211	Functional Communication Measure – Memory	January 1, 2014
212	Functional Communication Measure – Motor Speech	January 1, 2014
213	Functional Communication Measure – Reading	January 1, 2014
214	Functional Communication Measure – Spoken Language Expression	January 1, 2014
215	Functional Communication Measure – Writing	January 1, 2014
216	Functional Communication Measure – Swallowing	January 1, 2014
235	Hypertension (HTN): Plan of Care	January 1, 2013
244	Hypertension: Blood Pressure Management	January 1, 2014
252	Anticoagulation for Acute Pulmonary Embolus Patients	January 1, 2014
253	Pregnancy Test for Female Abdominal Pain Patients	January 1, 2013
256	Surveillance after Endovascular Abdominal Aortic Aneurysm Repair (EVAR)	January 1, 2014
321	Participation by a Hospital, Physician or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality	January 1, 2014

♦ Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,

E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

AND

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211,99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0270, G0271, G0402, G0438, G0439

NUMERATOR:

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

Numerator Instructions:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Hemoglobin A1c Level > 9.0%

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

OR

Hemoglobin A1c not Performed, Reason not Otherwise Specified

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

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

OR

Most Recent Hemoglobin A1c Level ≤ 9.0%

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

OR

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

RATIONALE:

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

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

CLINICAL RECOMMENDATION STATEMENTS:

American Geriatrics Society (Brown et al. 2003):

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

American Diabetes Association (2009):

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

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

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

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

♦ Measure #2 (NQF 0064): Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period

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

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

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

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

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

DENOMINATOR:
Patients 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,

E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

AND

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0270, G0271, G0402, G0438, G0439

NUMERATOR:

Patients whose most recent LDL-C test is < 100 mg/ dL during the measurement period

NUMERATOR NOTE: For performance, the patient is not numerator compliant if the result for the most recent LDL-C test during the measurement period is >= 100 mg/dL, or is missing, or if an LDL-C test was not performed during the measurement period.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent LDL-C Level < 100 mg/dL

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

OR

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

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

OR

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

OR

LDL-C Level not Performed, Reason not Otherwise Specified

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

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

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life ending or life-altering complications, including poor cholesterol, specifically lipoprotein (LDL). Clinical guidelines recommend lifestyle modifications that include reducing intake of saturated fat, trans fat and cholesterol; weight loss; and increased physical activity (American Diabetes Association, 2009). Statin therapy is suggested for eligible patients whose levels are consistently and significantly higher (American Diabetes Association, 2009).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2009): In most adult patients, measure fasting lipid profile at least annually. In adults with low-risk lipid values (LDL cholesterol < 100 mg/dl, HDL cholesterol > 50 mg/dl, and triglycerides < 150 mg/dl), lipid assessments may be repeated every 2 years.

American Association of Clinical Endocrinologists (2007): Aggressive management of dyslipidemia in patients with diabetes mellitus is critical; treat patients to achieve the following goal: LDL-C < 100 mg/dL (< 70 mg/dL is recommended for patients with diabetes mellitus and coronary artery disease).

➧ Measure #5 (NQF 0081): Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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

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

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

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

There are two reporting criteria for this measure:

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

OR

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

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

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

DENOMINATOR NOTE: LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction. The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely

depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients.

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

Denominator Criteria (Eligible Cases) 1:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter(s) during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: 3021F

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

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

Numerator Options
Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed or currently being taken (4010F)

OR

Documentation of medical reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia, allergy, intolerance, other medical reasons) (4010F *with* 1P)
OR
Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, patient declined, other patient reasons) (4010F *with* 2P)
OR
Documentation of system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, other system reasons) (4010F *with* 3P)

OR

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

OR

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

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

DENOMINATOR NOTE: LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction. The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients.

Denominator Criteria (Eligible Cases) 2:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter during reporting period (CPT): 99238, 99239
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: 3021F

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

Definitions:
Prescribed – Inpatient setting: May include prescription given to the patient for ACE inhibitor or ARB therapy at discharge OR ACE inhibitor or ARB therapy to be continued after discharge as documented in the discharge medication list.

Numerator Options:
Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed or currently being taken (4010F)

OR

Documentation of medical reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia, allergy, intolerance, other medical reasons) (4010F with 1P)
OR
Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, patient declined, other patient reasons) (4010F with 2P)
OR
Documentation of system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (eg, other system reasons) (4010F with 3P)

OR

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

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

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

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

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

Drug	Initial Daily Dose(s)	Maximum Doses(s)
ACE Inhibitors		
Captopril	6.25 mg 3 times	50 mg 3 times
Enalapril	2.5 mg twice	10 to 20 mg twice
Fosinopril	5 to 10 mg once	40 mg once
Lisinopril	2.5 to 5 mg once	20 to 40 mg once
Perindopril	2 mg once	8 to 16 mg once
Quinapril	5 mg twice	20 mg twice
Ramipril	1.25 to 2.5 mg once	10 mg once
Trandolapril	1 mg once	4 mg once
Angiotensin Receptor Blockers		
Candesartan	4 to 8 mg once	32 mg once
Losartan**	25 to 50 mg once	50 to 100 mg once
Valsartan	20 to 40 mg twice	160 mg twice

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

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

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

For the hospitalized patient:
In patients with reduced ejection fraction experiencing a symptomatic exacerbation of [heart failure] requiring hospitalization during chronic maintenance treatment with oral therapies known to improve outcomes, particularly ACE inhibitors or ARBs and beta-blocker therapy, it is recommended that these therapies be continued in most

patients in the absence of hemodynamic instability or contraindications. (Class I, Level of Evidence: C) (ACCF/AHA, 2009)

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

➧ Measure #6 (NQF 0067): Coronary Artery Disease (CAD): Antiplatelet Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND

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

NUMERATOR:
Patients who were prescribed aspirin or clopidogrel

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Aspirin or Clopidogrel Prescribed
CPT II 4086F: Aspirin or clopidogrel prescribed

OR

Aspirin or Clopidogrel not Prescribed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to Category II code 4086F to report documented circumstances that appropriately exclude patients from the denominator.
4086F *with* 1P: Documentation of medical reason(s) for not prescribing aspirin or clopidogrel (eg, allergy, intolerance, receiving other thienopyridine therapy, receiving warfarin therapy, bleeding coagulation disorders, other medical reasons)
4086F *with* 2P: Documentation of patient reason(s) for not prescribing aspirin or clopidogrel (eg, patient declined, other patient reasons)
4086F *with* 3P: Documentation of system reason(s) for not prescribing aspirin or clopidogrel (eg, lack of drug availability, other reasons attributable to the health care system)

OR

Aspirin or Clopidogrel was not Prescribed, Reason not Otherwise Specified
Append a modifier (8P) to CPT Category II code 4086F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4086F *with* 8P: Aspirin or clopidogrel was not prescribed, reason not otherwise specified

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

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.
Aspirin should be started at 75 to 162 mg per day and continued indefinitely in all patients unless contraindicated. (Class I Recommendation, Level A Evidence) (ACC/AHA, 2007)

Clopidogrel when aspirin is absolutely contraindicated. (Class IIa Recommendation; Level of Evidence B) (ACC/AHA, 2002)

➧ Measure #7 (NQF 0070): Coronary Artery Disease (CAD): Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

This measure will be calculated with 2 performance rates:

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

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

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

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

There are two reporting criteria for this measure:

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

OR

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

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

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 18 years and older with a diagnosis of coronary artery disease or history of cardiac surgery seen within a 12 month period who also have a current or prior LVEF < 40%

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

OR

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

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

Denominator Criteria (Eligible Cases) 1:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.790, I25.791, I25.760, I25.761, I25.768, I25.769, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

OR

History of cardiac surgery (CPT): 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943
AND
Patient encounter(s) during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits
AND
Left ventricular ejection fraction (LVEF) < 40%: G8694

NUMERATOR (REPORTING CRITERIA 1):
Patients who were prescribed beta-blocker therapy

Definitions:
Prescribed – May include prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list.
Beta-blocker Therapy – For patients with prior LVEF < 40%, beta-blocker therapy includes the following: bisoprolol, carvedilol, or sustained release metoprolol succinate.

Numerator Options:
Beta-blocker therapy prescribed or currently being taken (G9189)

OR

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

OR

Beta-blocker therapy not prescribed, reason not given (G9188)

OR

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

DENOMINATOR (REPORTING CRITERIA 2):

All patients aged 18 years and older with a diagnosis of coronary artery disease or history of cardiac surgery seen within a 12 month period who also have prior MI

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

OR

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

**Inclusion for this reporting criteria requires the presence of a prior MI diagnosis AND at least two denominator eligible visits during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.*

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

Denominator Criteria (Eligible Cases) 2:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00*, 410.01*, 410.02*, 410.10*, 410.11*, 410.12*, 410.20*, 410.21*, 410.22*, 410.30*, 410.31*, 410.32*, 410.40*, 410.41*, 410.42*, 410.50*, 410.51*, 410.52*, 410.60*, 410.61*, 410.62*, 410.70*, 410.71*, 410.72*, 410.80*, 410.81*, 410.82*, 410.90*, 410.91*, 410.92*, 411.0, 411.1, 411.81, 411.89, 412*, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01*, I21.02*, I21.09*, I21.11*, I21.19*, I21.21*, I21.29*, I21.3*, I21.4*, I22.0*, I22.1*, I22.2*, I22.8*, I22.9*, I24.0, I24.1*, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2*, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.790, I25.791, I25.760, I25.761, I25.768, I25.769, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

OR

History of cardiac surgery (CPT): 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92980, 92981, 92982, 92984, 92995, 92996

AND

Diagnosis for myocardial infarction – includes patient that had a prior myocardial infarction at any time (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412

Diagnosis for myocardial infarction– includes patient that had a prior myocardial infarction at any time (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.1, I25.2

AND

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

AND

Two Denominator Eligible Visits

NUMERATOR (REPORTING CRITERIA 2):

Patients who were prescribed beta-blocker therapy

Definitions:

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

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

Numerator Options:

Beta-blocker therapy prescribed or currently being taken (4008F)

OR

Documentation of medical reason(s) for not prescribing beta-blocker therapy (eg, allergy, intolerance, other medical reasons) (4008F *with* 1P)

OR

Documentation of patient reason(s) for not prescribing beta-blocker therapy (eg, patient declined, other patient reasons) (4008F *with* 2P)

OR

Documentation of system reason(s) for not prescribing beta-blocker therapy (eg, other reasons attributable to the health care system) (4008F *with* 3P)

OR

Beta-blocker therapy not prescribed, reason not otherwise specified (4008F *with* 8P)

RATIONALE:

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

A patient with a diagnosis of coronary artery disease seen within a 12 month period and LVEF < 40% should be taking either bisoprolol, carvedilol, or sustained release metoprolol succinate. While all beta-blockers appear to be of equal efficacy in patients with chronic stable coronary artery disease, these three medications have specifically shown to reduce mortality in patients with reduced LVEF.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

➧ Measure #8 (NQF 0083): Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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

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

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

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

There are two reporting criteria for this measure:

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

OR

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

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

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

DENOMINATOR NOTE: LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular

systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients.

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

Denominator Criteria (Eligible Cases) 1:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter(s) during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: G8923

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

Definitions:
Prescribed – Outpatient Setting - May include prescription given to the patient for beta-blocker therapy at one or more visits in the measurement period OR patient already taking beta-blocker therapy as documented in current medication list.
Beta-blocker Therapy - For patients with prior LVEF < 40%, beta-blocker therapy should include bisoprolol, carvedilol, or sustained release metoprolol succinate.

Numerator Options:
Beta-blocker therapy prescribed (G8450)

OR

Beta-Blocker Therapy for LVEF < 40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons, or other reasons attributable to the healthcare system) (G8451)

OR

Beta-blocker therapy not prescribed (G8452)

OR

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

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

DENOMINATOR NOTE: LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients.

Denominator Criteria (Eligible Cases) 2:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter during reporting period (CPT): 99238*, 99239*
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: 3021F

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

Definitions:
Prescribed – Inpatient Setting: May include prescription given to the patient for beta-blocker therapy at discharge OR beta-blocker therapy to be continued after discharge as documented in the discharge medication list.
Beta-blocker Therapy — For patients with prior LVEF < 40%, beta-blocker therapy should include bisoprolol, carvedilol, or sustained release metoprolol succinate.

Numerator Options:
Beta-blocker therapy prescribed (G8450)
OR
Beta-Blocker Therapy for LVEF < 40% not prescribed for reasons documented by the clinician (e.g., low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, allergy, intolerance, other medical reasons, patient declined, other patient reasons, other reasons attributable to the healthcare system) (G8451)
OR
Beta-blocker therapy not prescribed (G8452)

RATIONALE:
Beta-blockers are recommended for all patients with stable heart failure and left ventricular systolic dysfunction, unless contraindicated. Treatment should be initiated as soon as a patient is diagnosed with left ventricular systolic dysfunction and does not have low blood pressure, fluid overload, or recent treatment with an intravenous positive inotropic agent. Beta-blockers have been shown to lessen the symptoms of heart failure, improve the clinical status of patients, reduce future clinical deterioration, and decrease the risk of mortality and the combined risk of mortality and hospitalization.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

For the hospitalized patient:

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

♦ Measure #9 (NQF 0105): Anti-depressant Medication Management

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported.

- *Effective Acute Phase Treatment*: Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks)
- *Effective Continuation Phase Treatment*: Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)

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

This measure will be calculated with 2 performance rates:

1) Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks)
   AND
2) Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months)

Note: This measure is to ensure that a patient was treated with antidepressant medication and continued on this medication for 12 weeks and 6 months. This measure has a performance period of 12 months from the date of an denominator eligible encounter to determine the episode of MDD.

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

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

There are two reporting criteria for this measure:

1) Effective Acute Phase Treatment- Patients who remained on their antidepressant medications for at least 84 days (12 weeks) of the 114-day period following the Index Prescription Start Date for an antidepressant dispensed during the reporting period

   AND

2) Effective Continuation Phase Treatment- Patients who remained on their antidepressant medications for at least 180 days (6 months) of the 231-day period following the Index Prescription Start Date for an antidepressant dispensed during the reporting period

REPORTING CRITERIA 1: Patients who remained on their antidepressant medication for at least 84 days (12 weeks) of the 114-day period

DENOMINATOR (REPORTING CRITERIA 1):

Patients 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, who had a visit during the reporting period

DENOMINATOR NOTE: To be eligible for the denominator of this measure, there must be a 105-day negative medication history (a period during which the patient was not taking any antidepressant medication) prior to the first antidepressant dispensing event during the reporting period (Index Prescription Start Date). As long as there are no treatment days (calendar days covered by at least one prescription for an antidepressant medication) present during this time period, the patient is eligible for denominator inclusion.

Definition:
Index Prescription Start Date - The earliest prescription dispensing event for an antidepressant medication during the measurement period.

Denominator Criteria (Eligible Cases) 1:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for MDD (ICD-10-CM) [for use 10/01/2014-12/31/2014REFERENCE ONLY/Not Reportable]: F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.8, F33.9, F34.1
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90849, 90853, 99078, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR (REPORTING CRITERIA 1): *Effective Acute Phase Treatment*
Patients who received antidepressant medication for at least 84 days (12 weeks) of continuous treatment during the 114-day period following the Index Prescription Start Date

Numerator Instructions: Report G8126: 1) For all patients with a diagnosis of major depression who were prescribed at least 84 days (12 weeks) of continuous treatment with antidepressant medication during the 114-day period, OR 2) At the completion of a 12-week course of antidepressant medication.

Numerator Options:
Patient with a diagnosis of major depression documented as being treated with antidepressant medication during the entire 84 day (12 week) acute treatment phase (G8126)

OR

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 (G8128)

OR

Patient with a diagnosis of major depression not documented as being treated with antidepressant medication during the entire 84 day (12 week) acute treatment phase (G8127)

AND

REPORTING CRITERIA 2: Patients who have received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day period

DENOMINATOR (REPORTING CRITERIA 2):
Patients 18 years of age and older with a diagnosis of major depression and were treated with antidepressant medication, who had a visit during the reporting period

Definition:

Index Prescription Start Date - The earliest prescription dispensing event for an antidepressant medication during the measurement period.

Denominator Criteria (Eligible Cases) 2:
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for MDD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F32.0, F32.1, F32.2, F32.3, F32.4, F32.9, F33.0, F33.1, F33.2, F33.3, F33.40, F33.41, F33.8, F33.9, F34.1
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90849, 90853, 99078, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR (REPORTING CRITERIA 2): *Effective Continuation Phase Treatment*
Patients who received antidepressant medications for at least 180 days (6 months) of continuous treatment during the 231-day period following the Index Prescription Start Date

Numerator Instructions: 1) Report G9194 for all patients with a diagnosis of major depression who were prescribed at least 180 days (6 months) of continuous treatment with antidepressant medication during the 231-day period, OR 2) At the completion of a 6-month course of antidepressant medication.

Numerator Options:
Patient with a diagnosis of major depression documented as being treated with antidepressant medication during the entire 180 day (6 month) continuation treatment phase (G9194)

OR

Clinician documented that patient with a diagnosis of major depression was not an eligible candidate for antidepressant medication treatment or patient did not have a diagnosis of major depression (G9193)

OR

Patient with a diagnosis of major depression not documented as being treated with antidepressant medication during the entire 180 day (6 months) continuation treatment phase (G9195)

RATIONALE:
Depression affects nearly 15 million adults in the U.S. (National Alliance on Mental Illness, 2009) and is estimated to affect nearly a quarter of adults in their lifetime (Burcusa and Iacono, 2007). Symptoms of depression include appetite and sleep disturbances, anxiety, irritability and decreased concentration (Charbonneau et al., 2005). The American Psychiatric Association recommends use of antidepressant medication and behavioral therapies, such as psychotherapy, to treat depression (American Psychiatric Association, 2010).

For the past 50 years, antidepressant medication has proven to be effective especially for patients with more severe symptoms (Fournier et al., 2010). Among patients who initiate antidepressant treatment, one in three discontinues treatment within one month, before the effect of medication can be assessed, and nearly one in two discontinues treatment within three months (Simon, 2002).

Due to increased risky behaviors for chronic disease (e.g., physical inactivity, smoking, excessive drinking and insufficient sleep), evidence has shown that depressive disorders are strongly related to the occurrence of many chronic diseases including diabetes, cancer, cardiovascular disease and asthma (Centers for Disease Control and Prevention, 2011).

Aligning depression quality improvement with methods used in managing other chronic illnesses has been an important step in depression care. Depression management systems have demonstrated improved short- and long-

term outcomes of depression severity and persistence, employment retention, functional status and patient satisfaction (Katon et al., 2002; Rost et al., 2001).

CLINICAL RECOMMENDATION STATEMENTS:

American Psychiatric Association (APA 2010):

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.

Acute Phase: An antidepressant medication is recommended as an initial treatment choice for patients with mild to moderate major depressive disorder [I: Recommended with substantial clinical confidence] and definitely should be provided for those with severe major depressive disorder unless electroconvulsive therapy (ECT) is planned [I: Recommended with substantial clinical confidence]. For most patients, a selective serotonin reuptake inhibitor (SSRI), serotonin norepinephrine reuptake inhibitor (SNRI), mirtazapine, or bupropion is optimal [I: Recommended with substantial clinical confidence]. In general, the use of nonselective monoamine oxidase inhibitors (MAOIs) (e.g., phenelzine, tranylcypromine, isocarboxazid) should be restricted to patients who do not respond to other treatments [I: Recommended with substantial clinical confidence], given the necessity for dietary restrictions with these medications and the potential for deleterious drug-drug interactions.

During the acute phase of treatment, patients should be carefully and systematically monitored on a regular basis to assess their response to pharmacotherapy, identify the emergence of side effects (e.g., gastrointestinal symptoms, sedation, insomnia, activation, changes in weight, and cardiovascular, neurological, anticholinergic, or sexual side effects), and assess patient safety [I: Recommended with substantial clinical confidence]. If antidepressant side effects do occur, an initial strategy is to lower the dose of the antidepressant or to change to an antidepressant that is not associated with that side effect [I: Recommended with substantial clinical confidence].

Continuation Phase: During the continuation phase of treatment, the patient should be carefully monitored for signs of possible relapse [I: Recommended with substantial clinical confidence]. Systematic assessment of symptoms, side effects, adherence, and functional status is essential [I: Recommended with substantial clinical confidence], and may be facilitated through the use of clinician- and/or patient-administered rating scales [II: Recommended with moderate clinical confidence]. To reduce the risk of relapse, patients who have been treated successfully with antidepressant medications in the acute phase should continue treatment with these agents for 4–9 months [I: Recommended with substantial clinical confidence]. In general, the dose used in the acute phase should be used in the continuation phase [II: Recommended with moderate clinical confidence]. To prevent a relapse of depression in the continuation phase, depression-focused psychotherapy is recommended [I: Recommended with substantial clinical confidence], with the best evidence available for cognitive-behavioral therapy.

Maintenance Phase: During the maintenance phase, an antidepressant medication that produced symptom remission during the acute phase and maintained remission during the continuation phase should be continued at a full therapeutic dose [II: Recommended with moderate clinical confidence].

*Measure #12 (NQF 0086): Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for primary open-angle glaucoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 365.10, 365.11, 365.12, 365.15
> Diagnosis for primary open-angle glaucoma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.151, H40.152, H40.153, H40.159
> AND
> Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Optic Nerve Head Evaluation Performed

CPT II 2027F: Optic nerve head evaluation performed

OR

Optic Nerve Head Evaluation not Performed for Medical Reasons

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

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

OR

Optic Nerve Head Evaluation not Performed, Reason not Otherwise Specified

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

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

Ophthalmic Evaluation

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

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

(AAO, 2010)

*Measure #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 50 years on date of encounter
> AND
> Diagnosis for age-related macular degeneration (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.50, 362.51, 362.52
> Diagnosis for age-related macular degeneration (ICD-10-CM) [for use 10/01/2014-12/31/2014]: H35.30, H35.31, H35.32
> AND
> Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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

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

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

OR

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

OR

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

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

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

*Measure #18 (NQF 0088): Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Diagnosis for diabetic retinopathy (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

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

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

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

OR

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

OR

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

RATIONALE:
Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data 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:
Because 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 (extensive retinal hemorrhages/microaneurysms, venous beading, and IRMA)
- Vitreous or preretinal hemorrhage
  (A:III) (AAO, 2008)

*Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for diabetic retinopathy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
> Diagnosis for diabetic retinopathy (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
> AND

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

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dilated Macular or Fundus Exam Findings Communicated
(One CPT II code & one quality-data code [5010F & G8397] are required on the claim form to submit this numerator option)
CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons or Patient Reasons
(One CPT II code & one quality-data code [5010F-xP & G8397] are required on the claim form to submit this numerator option)
Append a modifier (1P or 2P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.
5010F *with* 1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes
5010F *with* 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

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

OR

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

* Measure #20 (NQF 0270): Perioperative Care: Timing of Prophylactic Parenteral Antibiotic – Ordering Physician

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

SURGICAL PROCEDURE	CPT CODE
Integumentary	15732, 15734, 15736, 15738, 15830, 15832, 15833,

SURGICAL PROCEDURE	CPT CODE
	15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380
Le Fort Fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular Fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22586, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31400, 31420
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Spleen and Lymph Nodes	38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880

SURGICAL PROCEDURE	CPT CODE
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700
Rectum	45000, 45020, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45395, 45397, 45400, 45402, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Liver	47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47350, 47360
Biliary	47400, 47420, 47425, 47460, 47480, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
Pancreas	48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum, & Omentum	27080, 27158, 27202, 27280, 27282, 49000, 49002, 49010, 49020, 49040, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic Surgery	57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear Implants	69930
Neurological Surgery	22524, 22551, 22554, 22558, 22600, 22612, 22630, 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, 33365, 33366, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422,

SURGICAL PROCEDURE	CPT CODE
	33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
Cardiothoracic (Pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
Genitourinary Surgery	50020, 50234, 50236, 50548, 50727, 50728, 50760, 50770, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50947, 50948, 50951, 50953, 50955, 50957, 50961, 50970, 50972, 50974, 50976, 50980, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51800, 51820, 51900, 51920, 51925, 51960, 52007, 52204, 52214, 52224, 52234, 52235, 52240, 52250, 52260, 52265, 52281, 52300, 52301, 52310, 52315, 52325, 52327, 52330, 52332, 52341, 52342, 52343, 52344, 52345, 52346, 52352, 52354, 52400, 52402, 52450, 52601, 52630, 52640, 52647, 52648, 52649, 53445, 53850, 53852, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 54700, 55705, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866
General Thoracic Surgery	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 33361, 33362, 33363, 33364, 34051, 35021, 35216, 35246, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
Mediastinum and Diaphragm	39501, 39540, 39541, 39545, 39560, 39561
Bariatric	43770, 43771, 43772, 43773, 43774, 43775, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888
Meckel's Diverticulum and Appendix	44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970
General Surgery	23470, 23472, 23473, 23474, 23616, 24363, 24370, 24371, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281,

SURGICAL PROCEDURE	CPT CODE
	60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Table 1A: The antimicrobial drugs listed below are considered prophylactic parenteral antibiotics for the purposes of this measure. G8632 should be reported when antibiotics from this table were not ordered.

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

Documentation of Order for Prophylactic Parenteral Antibiotic (written order, verbal order, or standing order/protocol)
G8629: Documentation of order for prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)
OR
Documentation that Prophylactic Parenteral Antibiotic *has* been Given within One Hour Prior to the Surgical Incision (or start of procedure when no incision is required)
G8630: Documentation that administration of prophylactic parenteral antibiotics was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered

OR

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

OR

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

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

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

CLINICAL RECOMMENDATION STATEMENTS:
Overall, administration of the first dose of antimicrobial beginning within 60 minutes before surgical incision is recommended. Administration of vancomycin and fluoroquinolones should begin within 120 minutes before surgical incision because of the prolonged infusion times required for these drugs. (ASHP, 2013)

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, 2004)11

*Measure #21 (NQF 0268): Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

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

SURGICAL PROCEDURE	CPT CODE
	19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380
Spine	22325, 22586, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Vascular	27880, 27881, 27882, 27884, 27886, 27888, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34800, 34802, 34803, 34804, 34805, 34812, 34820, 34825, 34830, 34831, 34832, 34833, 34834, 34900, 35011, 35013, 35081, 35082, 35091, 35092, 35102, 35103, 35131, 35141, 35142, 35151, 35152, 35206, 35266, 35301, 35363, 35371, 35372, 35460, 35512, 35521, 35522, 35523, 35525, 35533, 35537, 35538, 35539, 35540, 35556, 35558, 35565, 35566, 35570, 35571, 35572, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37617
Spleen and Lymph Nodes	38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780
Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880
Small Intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon	44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700
Rectum	45000, 45020, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45395, 45397, 45400, 45402,

SURGICAL PROCEDURE	CPT CODE
	45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Biliary	47400, 47420, 47425, 47460, 47480, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
Pancreas	48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum & Omentum	27080, 27158, 27202, 27280, 27282, 49000, 49002, 49010, 49020, 49040, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Neurological Surgery	22524, 22551, 22554, 22558, 22600, 22612, 22630, 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, 33365, 33366, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
General Thoracic Surgery	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 33361, 33362, 33363, 33364, 34051, 35021, 35216, 35246, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
Laryngectomy	31400, 31420
Mediastinum and Diaphragm	39501, 39540, 39541, 39545, 39560, 39561
Bariatric	43770, 43771, 43772, 43773, 43774, 43775, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888
Meckel's Diverticulum and Appendix	44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970
Liver	47100, 47120, 47122, 47125, 47130, 47140, 47141, 47142,

SURGICAL PROCEDURE	CPT CODE
	47350, 47370, 47371, 47380, 47381
Gynecologic Surgery	57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
General Surgery	23470, 23472, 23473, 23474, 23616, 24363, 24370, 24371, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

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

Numerator Instructions: There must be documentation of an order (written order, verbal order, or standing order/protocol) for a first OR second generation cephalosporin for antimicrobial prophylaxis OR documentation that a first OR second generation cephalosporin was ***given***.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Order for First or Second Generation Cephalosporin for Antimicrobial Prophylaxis (written order, verbal order, or standing order/protocol)
G9197: Documentation of an order for first OR second generation cephalosporin for antimicrobial prophylaxis

Note: *G9197 is provided for antibiotic* ordered *or antibiotic* given*. Report G9197if a first or second generation cephalosporin was given for antimicrobial prophylaxis.*

OR

Order for First or Second Generation Cephalosporin not Ordered for Medical Reasons
G9196: Documentation of medical reason(s) for not ordering a first OR second generation cephalosporin for antimicrobial prophylaxis

OR

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

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

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

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

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

*Measure #22 (NQF 0271): Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

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

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

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

SURGICAL PROCEDURE	CPT CODE
	44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700
Rectum	45000, 45020, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Biliary	47400, 47420, 47425, 47460, 47480, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900
Pancreas	48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, Peritoneum, & Omentum	27080, 27158, 27202, 27280, 27282, 49000, 49002, 49010, 49020, 49040, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49320, 49321, 49322, 49323, 49505, 49507, 49568
Renal Transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic Surgery	57267, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58951, 58953, 58954, 58956
Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear Implants	69930
Neurological Surgery	22524, 22551, 22554, 22558, 22600, 22612, 22630, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic (Pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
General Thoracic Surgery	0236T, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32096, 32097, 32098, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32505, 32506, 32507 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 33361, 33362, 33363, 33364, 34051, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 64746

SURGICAL PROCEDURE	CPT CODE
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
Spleen and Lymphatic	38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780
Mediastinum and Diaphragm	39501, 39540, 39541, 39545, 39560, 39561
Bariatric	43770, 43771, 43772, 43773, 43774, 43775, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888
Meckel's Diverticulum and Appendix	44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970
Liver	47100, 47120, 47122, 47125, 47130, 47140, 47141, 47142, 47350, 47370, 47371, 47380, 47381
General Surgery	23470, 23472, 23473, 23474, 23616, 24363, 24370, 24371, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Order for Discontinuation of Prophylactic Parenteral Antibiotics (written order, verbal order, or standing order/protocol) Within 24 Hours of Surgical End Time
(Two CPT II codes [4049F & 4046F] are required on the claim form to submit this numerator option)
CPT II 4049F: Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure

*Note: CPT Category II code **4049F** is provided for documentation that antibiotic discontinuation was **ordered** or that antibiotic discontinuation was **accomplished**. Report CPT Category II code **4049F** if antibiotics were discontinued within 24 hours.*

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

OR

Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons
(Two CPT II codes [4049F-1P & 4046F] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 4049F to report documented circumstances that appropriately exclude patients from the denominator.

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

AND

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

OR

If patient is not eligible for this measure because patient did not receive prophylactic parenteral antibiotics within specified timeframe, report:

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

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

OR

Prophylactic Parenteral Antibiotics not Discontinued, Reason not Otherwise Specified

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

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

* Measure #23 (NQF 0239): Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

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

Acoustic Neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
General Surgery	15734, 15830, 15832, 15833, 15834, 15835, 15836, 15837, 19260, 19271, 19272, 19300, 19305, 19306, 19307, 19316, 19318, 19324, 19361, 19364, 19366, 19367, 19368, 19369, 19380, 27080, 27158, 27202, 27280, 27282, 38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38747, 38760, 38765, 38770, 38780, 39501, 39540, 39541, 39545, 39560, 39561, 43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43770, 43771, 43772, 43773, 43774, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 43886, 43887, 43888, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44900, 44950, 44955, 44960, 44970, 45000, 45020, 45100, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 46715, 46716, 46730, 46735, 46740, 46742, 46744, 46746, 46748, 46750, 46751, 46753, 46754, 46760, 46761, 46762, 47010, 47015, 47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400, 47420, 47425, 47460, 47480, 47500, 47505, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900, 48000, 48001, 48020, 48100, 48102, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49000, 49002, 49010, 49020, 49040, 49060, 49203, 49204, 49205, 49215, 49220, 49250, 49255, 49320, 49321, 49322, 49323, 49505, 49507, 49560, 49561, 49565, 49566, 49570, 50320, 50340, 50360, 50365, 50370, 50380, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650

NUMERATOR:
Surgical patients who had an order for LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

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

Definition:
Mechanical Prophylaxis – Does not include TED hose.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Appropriate VTE Prophylaxis Ordered
CPT II 4044F: Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time
*Note: A single CPT Category II code is provided for VTE prophylaxis **ordered** or VTE prophylaxis **given**. If VTE prophylaxis is given, report **4044F**.*

OR

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

OR

VTE Prophylaxis not Ordered, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4044F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4044F *with* 8P: Order was not given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time, reason not otherwise specified

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

Eligible cases are determined, and must be reported, if either of the following conditions are met:

Option 1 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for hip, spine or distal radial fracture (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 808.0, 808.1, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9
Diagnosis for hip, spine or distal radial fracture (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A,

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AND

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

OR

Option 2 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on the date of encounter

AND

Diagnosis for hip, spine or distal radial fracture (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 808.0, 808.1, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

Diagnosis for hip, spine or distal radial fracture (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, , S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A,

S32.452B, S32.453A, S32.453B, S32.454A, S32.454B, S32.455A, S32.455B, S32.456A, S32.456B, S32.461A, S32.461B, S32.462A, S32.462B, S32.463A, S32.463B, S32.464A, S32.464B, S32.465A, S32.465B, S32.466A, S32.466B, S32.471A, S32.471B, S32.472A, S32.472B, S32.473A, S32.473B, S32.474A, S32.474B, S32.475A, S32.475B, S32.476A, S32.476B, S32.481A, S32.481B, S32.482A, S32.482B, S32.483A, S32.483B, S32.484A, S32.484B, S32.485A, S32.485B, S32.486A, S32.486B, S32.491A, S32.491B, S32.492A, S32.492B, S32.499A, S32.499B, S52.501A, S52.501B, S52.501C, S52.502A, S52.502B, S52.502C, S52.509A, S52.509B, S52.509C, S52.511A, S52.511B, S52.511C, S52.512A, S52.512B, S52.512C, S52.513A, S52.513B, S52.513C, S52.514A, S52.514B, S52.514C, S52.515A, S52.515B, S52.515C, S52.516A, S52.516B, S52.516C, S52.521A, S52.522A, S52.529A, S52.531A, S52.531B, S52.531C, S52.532A, S52.532B, S52.532C, S52.539A, S52.539B, S52.539C, S52.541A, S52.541B, S52.541C, S52.542A, S52.542B, S52.542C, S52.549A, S52.549B, S52.549C, S52.551A, S52.551B, S52.551C, S52.552A, S52.552B, S52.552C, S52.559A, S52.559B, S52.559C, S52.561A, S52.561B, S52.561C, S52.562A, S52.562B, S52.562C, S52.569A, S52.569B, S52.569C, S52.571A, S52.571B, S52.571C, S52.572A, S52.572B, S52.572C, S52.579A, S52.579B, S52.579C, S52.591A, S52.591B, S52.591C, S52.592A, S52.592B, S52.592C, S52.599A, S52.599B, S52.599C, S52.609A, S52.609B, S52.609C, S52.621A, S52.622A, S52.90XA, S52.90XB, S52.90XC, S72.001A, S72.001B, S72.001C, S72.002A, S72.002B, S72.002C, S72.009A, S72.009B, S72.009C, S72.011A, S72.011B, S72.011C, S72.012A, S72.012B, S72.012C, S72.019A, S72.019B, S72.019C, S72.021A, S72.021B, S72.021C, S72.022A, S72.022B, S72.022C, S72.023A, S72.023B, S72.023C, S72.024A, S72.024B, S72.024C, S72.025A, S72.025B, S72.025C, S72.026A, S72.026B, S72.026C, S72.031A, S72.031B, S72.031C, S72.032A, S72.032B, S72.032C, S72.033A, S72.033B, S72.033C, S72.034A, S72.034B, S72.034C, S72.035A, S72.035B, S72.035C, S72.036A, S72.036B, S72.036C, S72.041A, S72.041B, S72.041C, S72.042A, S72.042B, S72.042C, S72.043A, S72.043B, S72.043C, S72.044A, S72.044B, S72.044C, S72.045A, S72.045B, S72.045C, S72.046A, S72.046B, S72.046C, S72.051A, S72.051B, S72.051C, S72.052A, S72.052B, S72.052C, S72.059A, S72.059B, S72.059C, S72.061A, S72.061B, S72.061C, S72.062A, S72.062B, S72.062C, S72.063A, S72.063B, S72.063C, S72.064A, S72.064B, S72.064C, S72.065A, S72.065B, S72.065C, S72.066A, S72.066B, S72.066C, S72.091A, S72.091B, S72.091C, S72.092A, S72.092B, S72.092C, S72.099A, S72.099B, S72.099C, S72.101A, S72.101B, S72.101C, S72.102A, S72.102B, S72.102C, S72.109A, S72.109B, S72.109C, S72.111A, S72.111B, S72.111C, S72.112A, S72.112B, S72.112C, S72.113A, S72.113B, S72.113C, S72.114A, S72.114B, S72.114C, S72.115A, S72.115B, S72.115C, S72.116A, S72.116B, S72.116C, S72.121A, S72.121B, S72.121C, S72.122A, S72.122B, S72.122C, S72.123A, S72.123B, S72.123C, S72.124A, S72.124B, S72.124C, S72.125A, S72.125B, S72.125C, S72.126A, S72.126B, S72.126C, S72.131A, S72.131B, S72.131C, S72.132A, S72.132B, S72.132C, S72.133A, S72.133B, S72.133C, S72.134A, S72.134B, S72.134C, S72.135A, S72.135B, S72.135C, S72.136A, S72.136B, S72.136C, S72.141A, S72.141B, S72.141C, S72.142A, S72.142B, S72.142C, S72.143A, S72.143B, S72.143C, S72.144A, S72.144B, S72.144C, S72.145A, S72.145B, S72.145C, S72.146A, S72.146B, S72.146C, S72.21XA, S72.21XB, S72.21XC, S72.22XA, S72.22XB, S72.22XC, S72.23XA, S72.23XB, S72.23XC, S72.24XA, S72.24XB, S72.24XC, S72.25XA, S72.25XB, S72.25XC, S72.26XA, S72.26XB, S72.26XC

AND

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

NUMERATOR:

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

Definition:

Communication – May include documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, DXA report was sent) with the clinician managing the

patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Post Fracture Care Communication Documented
CPT II 5015F: Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

OR

Post Fracture Care not Communicated for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 5015F to report documented circumstances that appropriately exclude patients from the denominator.
5015F *with* 1P: Documentation of medical reason(s) for not communicating with physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
5015F *with* 2P: Documentation of patient reason(s) for not communicating with the physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

OR

Post Fracture Care not Communicated, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 5015F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
5015F *with* 8P: No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified

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

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

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

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

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

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

*Measure #28 (NQF 0092): Aspirin at Arrival for Acute Myocardial Infarction (AMI)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

DENOMINATOR:
All patients, regardless of age, with an emergency department discharge diagnosis of AMI

Denominator Criteria (Eligible Cases):
Diagnosis for acute myocardial infarction (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91
Diagnosis for acute myocardial infarction (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:

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

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

OR

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

OR

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

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

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

*Measure #30 (NQF 0269): Perioperative Care: Timing of Prophylactic Antibiotic – Administering Physician

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

If the clinician providing anesthesia services orders AND administers the prophylactic parenteral antibiotic within the appropriate timeframe, report quality-data code CPT II 4048F. Report CPT II 4048F with the 1P modifier in circumstances where the prophylactic parenteral antibiotic was not given for medical reasons (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 listed CPT codes, and the appropriate CPT Category II code OR the appropriate CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter as the denominator codes.

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

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

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

DENOMINATOR NOTE: Anesthesia services included in denominator are associated with some surgical procedures for which prophylactic parenteral antibiotics may not be indicated. Clinicians should report 4047F-8P for those

instances in which anesthesia services are provided but not associated with surgical procedures for which prophylactic parenteral antibiotics are indicated.

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

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

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

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

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

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

Documentation that Prophylactic Parenteral Antibiotic was Administered Within Specified Timeframe

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

OR

Prophylactic Parenteral Antibiotic not Administered for Medical Reasons (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 initiating administration of prophylactic parenteral antibiotics as specified (eg, contraindicated, patient already receiving antibiotics)

OR

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

Prophylactic Parenteral Antibiotic not Ordered

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

4047F *with* 8P: No documentation of order for prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

OR

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

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

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

Overall, administration of the first dose of antimicrobial beginning within 60 minutes before surgical incision is recommended. Administration of vancomycin and fluoroquinolones should begin within 120 minutes before surgical incision because of the prolonged infusion times required for these drugs. (ASHP, 2013)

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, 2004)

*Measure #31 (NQF 0240): Stroke and Stroke Rehabilitation: Venous Thromboembolism (VTE) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who were administered venous thromboembolism (VTE) prophylaxis the day of or the day after hospital admission

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
AND

Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99291

NUMERATOR:
Patients who were administered venous thromboembolism (VTE) prophylaxis the day of or the day after hospital admission

Definitions:
VTE Prophylaxis – Can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), low-dose subcutaneous heparin, or intermittent pneumatic compression devices.
Day after hospital admission – Ends at 11:59 pm on the second day of hospitalization.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
VTE Prophylaxis Administered
G9201: Venous thromboembolism (VTE) prophylaxis administered the day of or the day after hospital admission

OR

VTE Prophylaxis not Administered for Documented Reasons
G9199: Venous thromboembolism (VTE) prophylaxis not administered the day of or the day after hospital admission for documented reasons (eg, patient is ambulatory, patient expired during inpatient stay, patient already on warfarin or another anticoagulant, other medical reason(s), patient left against medical advice, other patient reason(s))

OR

VTE Prophylaxis not Administered, Reason Not Given
G9200 Venous thromboembolism (VTE) prophylaxis was not administered the day of or the day after hospital admission, reason not given

RATIONALE:
Patients on bed rest are at high risk for venous thromboembolism. VTE 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 VTE 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 VTE 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:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Early implementation of anticoagulant therapy or physical compression modalities should be considered for all stroke patients who cannot ambulate at 2 days and who are at risk for DVT or pulmonary embolus. (Class I) (AHA, 2009)

For acute stroke patients with restricted mobility, we recommend prophylactic low-dose SC heparin or low-molecular-weight heparins. (Class 1) (ACCP, 2008)

For patients who have contraindications to anticoagulants, we recommend intermittent pneumatic compression (IPC) devices or elastic stockings. (Class 1) (ACCP, 2008)

* Measure #32 (NQF 0325): Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

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

NUMERATOR:
Patients who were prescribed antithrombotic therapy at discharge

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

Definitions:
Antithrombotic Therapy – Aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine, warfarin, low molecular weight heparin, dabigatran, rivaroxaban.*

*The above list of medications/drug names is based on clinical guidelines and other evidence. The specified drugs were selected based on the strength of evidence for their clinical effectiveness. This list of selected drugs may not be all-inclusive or current. Physicians and other health care professionals should refer to the FDA's web site page entitled "Drug Safety Communications" for up-to-date drug recall and alert information when prescribing medications.

Prescribed – May include prescription given to the patient for antithrombotic therapy at discharge or antithrombotic therapy to be continued after discharge as documented in the discharge medication list.

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

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

OR

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

OR

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

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

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

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

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

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

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

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

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

* Measure #33 (NQF 0241): Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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

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

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

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

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

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

NUMERATOR:
Patients who were prescribed an anticoagulant at discharge

Definitions:
Anticoagulants – warfarin, low molecular weight heparin, dabigatran, rivaroxaban*

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

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

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

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

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

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

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

* Measure #35 (NQF 0243) : Stroke and Stroke Rehabilitation: Screening for Dysphagia

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who receive any food, fluids or medication by mouth (PO) for whom a dysphagia screening was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50,

I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9

AND

Patient encounter during the reporting period (CPT): 99218, 99219, 99220, 99221, 99222, 99223, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99291

NUMERATOR:

Patients for whom a dysphagia screening was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care

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 – May include, but is not limited to video fluoroscopic swallow evaluation (VSE), fiber optic endoscopic evaluation of swallowing (FEES), modified barium swallow, structured bedside swallowing assessment.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dysphagia Screening Conducted

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

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

AND

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

OR

Dysphagia Screening not Conducted for Medical or Patient Reasons

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

Append a modifier (1P or 2P) 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 (eg, patient expired during inpatient stay, patient without any focal findings and not thought to be having a stroke when initially evaluated, other medical reason(s))

6010F *with* 2P: Documentation of patient reason(s) for not performing a dysphagia screening prior to taking any foods, fluids or medication by mouth (eg, patient left against medical advice, other patient reason(s))

AND

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

OR

Dysphagia Screening not Conducted, Reason not Otherwise Specified

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

AND

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

RATIONALE:

Impairments of swallowing are associated with a high risk of pneumonia. Some patients cannot receive food or fluids because of impairments in swallowing or mental status. Patients with infarctions of the brain stem, multiple strokes, major hemispheric lesions, or depressed consciousness are at the greatest risk for aspiration. Swallowing impairments are associated with an increased risk of death. An abnormal gag reflex, impaired voluntary cough, dysphonia, incomplete oral-labial closure, a high NIHSS score, or cranial nerve palsies should alert the physician to the risk. A preserved gag reflex may not indicate safety with swallowing. An assessment of the ability to swallow is important before the patient is allowed to eat or drink.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Assessment of swallowing before starting eating or drinking is recommended. (Class I, Level of Evidence B) (ASA, 2007)

A swallow screen should be performed in the first 24 hours after stroke, preferably by the speech language pathologist (Class I, Level of Evidence B). Nurses should be familiar with bedside swallow assessment if a formal evaluation cannot be done within the specified period. Stroke patients should be kept NPA until the screen has been performed (Class I, Level of Evidence B). (ASA, 2009)

*Measure #36 (NQF 0244): Stroke and Stroke Rehabilitation: Rehabilitation Services Ordered

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom occupational, physical, or speech rehabilitation services were ordered at or prior to inpatient discharge OR documentation that no rehabilitation services are indicated at or prior to inpatient discharge

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91
Diagnosis for ischemic stroke or intracranial hemorrhage (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
AND

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

NUMERATOR:
Patients for whom occupational, physical, or speech rehabilitation services were ordered at or prior to inpatient discharge OR documentation that no rehabilitation services are indicated at or prior to inpatient discharge

Definition:
Rehabilitation Services – Includes services required in order to improve physical, cognitive (including neuropsychological), behavioral, and speech functions.

NUMERATOR NOTE: Rehabilitation order can include one or more of the services listed.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Rehabilitation Services Ordered
G8699: Rehabilitation services (occupational, physical, or speech) ordered at or prior to discharge

OR

Documentation of Rehabilitation Services not Indicated at or Prior to Discharge
G8700: Rehabilitation services (occupational, physical, or speech) not indicated at or prior to discharge

OR

Rehabilitation Services not Ordered, Reason not Given
G8701: Rehabilitation services were not ordered, reason not given

RATIONALE:
Specifically, stroke rehabilitation programs are provided to optimize neurological recovery, teach compensatory strategies for residual deficits, teach activities of daily living (ADLs) and skills required for community living, and provide psychosocial and medical interventions to manage depression.

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

The use of comprehensive specialized stroke care (stroke units) incorporating rehabilitation is recommended. (Class I, Level of Evidence A) (ASA, 2007)

The use of standardized stroke care order sets is recommended to improve general management. (Class I, Level of Evidence B) (ASA, 2007)

Based on the results from meta-analyses, there is strong evidence that specialized, interdisciplinary rehabilitation provided in the subacute phase of stroke is associated with reductions in mortality or the combined outcome of death or dependency, but is not associated with a reduced need for institutionalization or length of hospital stay, compared to conventional care on a general medical ward. (Level of Evidence 1a) (Foley, et al, 2011)

*Measure #39 (NQF 0046): Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

DENOMINATOR:
All female patients aged 65 years and older

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

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

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

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

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

OR

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

OR

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* Measure #40 (NQF 0048): Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

Eligible cases are determined, and must be reported, if either of the following conditions are met:

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

Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB,S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A,

S32.452B, S32.453A, S32.453B, S32.454A, S32.454B, S32.455A, S32.455B, S32.456A, S32.456B, S32.461A, S32.461B, S32.462A, S32.462B, S32.463A, S32.463B, S32.464A, S32.464B, S32.465A, S32.465B, S32.466A, S32.466B, S32.471A, S32.471B, S32.472A, S32.472B, S32.473A, S32.473B, S32.474A, S32.474B, S32.475A, S32.475B, S32.476A, S32.476B, S32.481A, S32.481B, S32.482A, S32.482B, S32.483A, S32.483B, S32.484A, S32.484B, S32.485A, S32.485B, S32.486A, S32.486B, S32.491A, S32.491B, S32.492A, S32.492B, S32.499A, S32.499B, S52.501A, S52.501B, S52.501C, S52.502A, S52.502B, S52.502C, S52.509A, S52.509B, S52.509C, S52.511A, S52.511B, S52.511C, S52.512A, S52.512B, S52.512C, S52.513A, S52.513B, S52.513C, S52.514A, S52.514B, S52.514C, S52.515A, S52.515B, S52.515C, S52.516A, S52.516B, S52.516C, S52.521A, S52.522A, S52.529A, S52.531A, S52.531B, S52.531C, S52.532A, S52.532B, S52.532C, S52.539A, S52.539B, S52.539C, S52.541A, S52.541B, S52.541C, S52.542A, S52.542B, S52.542C, S52.549A, S52.549B, S52.549C, S52.551A, S52.551B, S52.551C, S52.552A, S52.552B, S52.552C, S52.559A, S52.559B, S52.559C, S52.561A, S52.561B, S52.561C, S52.562A, S52.562B, S52.562C, S52.569A, S52.569B, S52.569C, S52.571A, S52.571B, S52.571C, S52.572A, S52.572B, S52.572C, S52.579A, S52.579B, S52.579C, S52.591A, S52.591B, S52.591C, S52.592A, S52.592B, S52.592C, S52.599A, S52.599B, S52.599C, S52.609A, S52.609B, S52.609C, S52.621A, S52.622A, S52.90XA, S52.90XB, S52.90XC, S72.001A, S72.001B, S72.001C, S72.002A, S72.002B, S72.002C, S72.009A, S72.009B, S72.009C, S72.011A, S72.011B, S72.011C, S72.012A, S72.012B, S72.012C, S72.019A, S72.019B, S72.019C, S72.021A, S72.021B, S72.021C, S72.022A, S72.022B, S72.022C, S72.023A, S72.023B, S72.023C, S72.024A, S72.024B, S72.024C, S72.025A, S72.025B, S72.025C, S72.026A, S72.026B, S72.026C, S72.031A, S72.031B, S72.031C, S72.032A, S72.032B, S72.032C, S72.033A, S72.033B, S72.033C, S72.034A, S72.034B, S72.034C, S72.035A, S72.035B, S72.035C, S72.036A, S72.036B, S72.036C, S72.041A, S72.041B, S72.041C, S72.042A, S72.042B, S72.042C, S72.043A, S72.043B, S72.043C, S72.044A, S72.044B, S72.044C, S72.045A, S72.045B, S72.045C, S72.046A, S72.046B, S72.046C, S72.051A, S72.051B, S72.051C, S72.052A, S72.052B, S72.052C, S72.059A, S72.059B, S72.059C, S72.061A, S72.061B, S72.061C, S72.062A, S72.062B, S72.062C, S72.063A, S72.063B, S72.063C, S72.064A, S72.064B, S72.064C, S72.065A, S72.065B, S72.065C, S72.066A, S72.066B, S72.066C, S72.091A, S72.091B, S72.091C, S72.092A, S72.092B, S72.092C, S72.099A, S72.099B, S72.099C, S72.101A, S72.101B, S72.101C, S72.102A, S72.102B, S72.102C, S72.109A, S72.109B, S72.109C, S72.111A, S72.111B, S72.111C, S72.112A, S72.112B, S72.112C, S72.113A, S72.113B, S72.113C, S72.114A, S72.114B, S72.114C, S72.115A, S72.115B, S72.115C, S72.116A, S72.116B, S72.116C, S72.121A, S72.121B, S72.121C, S72.122A, S72.122B, S72.122C, S72.123A, S72.123B, S72.123C, S72.124A, S72.124B, S72.124C, S72.125A, S72.125B, S72.125C, S72.126A, S72.126B, S72.126C, S72.131A, S72.131B, S72.131C, S72.132A, S72.132B, S72.132C, S72.133A, S72.133B, S72.133C, S72.134A, S72.134B, S72.134C, S72.135A, S72.135B, S72.135C, S72.136A, S72.136B, S72.136C, S72.141A, S72.141B, S72.141C, S72.142A, S72.142B, S72.142C, S72.143A, S72.143B, S72.143C, S72.144A, S72.144B, S72.144C, S72.145A, S72.145B, S72.145C, S72.146A, S72.146B, S72.146C, S72.21XA, S72.21XB, S72.21XC, S72.22XA, S72.22XB, S72.22XC, S72.23XA, S72.23XB, S72.23XC, S72.24XA, S72.24XB, S72.24XC, S72.25XA, S72.25XB, S72.25XC, S72.26XA, S72.26XB, S72.26XC

AND

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

OR

Option 2 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter

AND

Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46,

813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A, S32.452B, S32.453A, S32.453B, S32.454A, S32.454B, S32.455A, S32.455B, S32.456A, S32.456B, S32.461A, S32.461B, S32.462A, S32.462B, S32.463A, S32.463B, S32.464A, S32.464B, S32.465A, S32.465B, S32.466A, S32.466B, S32.471A, S32.471B, S32.472A, S32.472B, S32.473A, S32.473B, S32.474A, S32.474B, S32.475A, S32.475B, S32.476A, S32.476B, S32.481A, S32.481B, S32.482A,

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

AND

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

NUMERATOR:

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

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Central DXA Measurement Ordered or Results Documented or Pharmacologic Therapy Prescribed
CPT II 3096F: Central Dual-energy X-Ray Absorptiometry (DXA) ordered
OR
CPT II 3095F: Central Dual-energy X-Ray Absorptiometry (DXA) results documented
OR
G8633: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

OR

Central DXA Measurement not Ordered or Results not Documented for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II codes 3096F or 3095F to report documented circumstances that appropriately exclude patients from the denominator.
3096F or 3095F *with* 1P: Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement
3096F or 3095F *with* 2P: Documentation of patient reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement
3096F or 3095F *with* 3P: Documentation of system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement
OR
Pharmacologic Therapy not Prescribed for Documented Reasons
G8634: Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis

OR

Central DXA Measurement not Ordered or Results not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3096F or 3095F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3096F or 3095F *with* 8P: Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed, reason not otherwise specified
OR
Pharmacologic Therapy not Prescribed, Reason not Given
G8635: Pharmacologic therapy for osteoporosis was not prescribed, reason not given

RATIONALE:
Patients with a history of fracture should have a baseline bone mass measurement and/or receive treatment for osteoporosis. Given that the majority of osteoporotic fractures occur in patients with a diagnosis of osteoporosis by bone mass measurement, exclusion of osteoporosis by bone mass testing does not preclude treatment of osteoporosis in a patient with a history of fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

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

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

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

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

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

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

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

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

*Measure #41 (NQF 0049): Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for osteoporosis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 733.00, 733.01, 733.02, 733.03, 733.09
Diagnosis for osteoporosis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M80.00XA, M80.00XD, M80.00XG, M80.00XK, M80.00XP, M80.00XS, M80.011A, M80.011D, M80.011G, M80.011K, M80.011P, M80.011S, M80.012A, M80.012D, M80.012G, M80.012K, M80.012P, M80.012S, M80.019A, M80.019D, M80.019G, M80.019K, M80.019P, M80.019S, M80.021A, M80.021D, M80.021G, M80.021K, M80.021P, M80.021S, M80.022A, M80.022D, M80.022G, M80.022K, M80.022P, M80.022S, M80.029A, M80.029D, M80.029G, M80.029K, M80.029P, M80.029S, M80.031A, M80.031D, M80.031G, M80.031K, M80.031P, M80.031S, M80.032A, M80.032D, M80.032G, M80.032K, M80.032P, M80.032S, M80.039A, M80.039D, M80.039G, M80.039K, M80.039P, M80.039S, M80.041A, M80.041D, M80.041G, M80.041K, M80.041P, M80.041S, M80.042A, M80.042D, M80.042G, M80.042K, M80.042P, M80.042S, M80.049A, M80.049D,

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

AND

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

NUMERATOR:

Patients who were prescribed pharmacologic therapy for osteoporosis within 12 months

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pharmacologic Therapy Prescribed

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

OR

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

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

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

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

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

OR

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

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

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

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

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

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

Ω Measure #43 (NQF 0134): Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

DENOMINATOR:
All patients undergoing isolated CABG

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

NUMERATOR:
Patients undergoing isolated CABG who received an IMA graft

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

OR

IMA Graft not Performed for Medical Reasons
Append a modifier (1P) to the CPT Category II code 4110F to report documented circumstances that appropriately exclude patients from the denominator.

4110F *with* 1P: Documentation of medical reason(s) for not performing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure. Acceptable medical reasons include: subclavian stenosis, previous cardiac or thoracic surgery, previous mediastinal radiation, emergent or salvage procedure, no left anterior descending artery disease.

OR

IMA Graft not Performed, Reason not Otherwise Specified

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

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

Class I

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

(*Level of Evidence: B*)

♠ Measure #44 (NQF 0236): Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

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

OR

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

NUMERATOR:

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

Definitions:
Medical Reason - Eligible professional must document specific reason(s) for not administering beta-blockers.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Preoperative Beta-blocker Administration Documented
CPT II 4115F: Beta blocker administered within 24 hours prior to surgical incision

OR

Preoperative Beta-blocker not Administered for Documented Medical Reasons
Append a 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 (eg, not indicated, contraindicated, other medical reason)

OR

Preoperative Beta-blocker not Received, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4115F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4115F *with* 8P: Beta blocker not administered within 24 hours prior to surgical incision, reason not otherwise specified

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

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

CLINICAL RECOMMENDATION STATEMENTS:
Preoperative Beta-blockers
Class I

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

Class IIa

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

2.Beta-blockers can be effective in reducing the incidence of perioperative myocardial ischemia. *(Level of Evidence: B),* (ACCF/AHA, 2011)

Class IIb

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

* Measure #45 (NQF 0637): Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Cardiac Procedures)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

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

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

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

SURGICAL PROCEDURE	CPT CODE
Cardiothoracic Surgery	33120, 33130, 33140, 33141, 33250, 33251, 33256, 33261, 33305, 33315, 33332, 33335, 33365, 33366, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572

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

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that the prophylactic parenteral 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 (eg, "to be given every 8 hours for three doses" or for "one time" IV dose orders) OR documentation that prophylactic parenteral antibiotic ***was*** discontinued within 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 Parenteral Antibiotics (written order, verbal order, or standing order/protocol) within 48 hours of surgical end time
(One CPT II code and one quality-data code [4043F & G8702] are required on the claim form to submit this numerator option)
CPT II 4043F: Documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures
*Note: CPT Category II code **4043F** may be provided for documentation that antibiotic discontinuation within 48 hours was **ordered** or that antibiotic discontinuation was **accomplished**.*
AND
G8702: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or intraoperatively

OR

Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons
(One CPT II code and one quality-data code [4043F-1P & G8702] are required on the claim form to submit this numerator option)
Append a modifier (1P) to CPT Category II code 4043F to report documented circumstances that appropriately exclude patients from the denominator.
4043F *with* 1P: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures
AND
G8702: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or intraoperatively

OR

If patient is not eligible for this measure because patient was not documented to have prophylactic parenteral antibiotics given within 4 hours prior to surgical incision, report:
(One quality-data code [G8703] is required on the claim form to submit this numerator option)
G8703: Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor intraoperatively

OR

Prophylactic Parenteral Antibiotics not Discontinued, Reason not Otherwise Specified
(One CPT II code and quality-data code [4043F-8P & G8702] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4043F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4043F *with* 8P: Order was not given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedures, reason not otherwise specified

AND

G8702: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or intraoperatively

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

CLINICAL RECOMMENDATION STATEMENTS:
At a minimum, antimicrobial coverage must be provided from the time of incision to closure of the incision. For most procedures, the duration of antimicrobial prophylaxis should be 24 hours or less, with the exception of cardiothoracic procedures (up to 72 hours' duration) and ophthalmic procedures (duration not clearly established). (ASHP) 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. (Class IIa, Level B) (STS, 2005)

*Measure #46 (NQF 0097): Medication Reconciliation

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

DENOMINATOR:
All patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

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 physician, prescribing practitioner, registered nurse, or clinical pharmacist providing ongoing care is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.

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

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

OR

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

OR

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

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

CLINICAL RECOMMENDATION STATEMENTS:
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 (NQF 0326): Advance Care Plan

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

This measure is appropriate for use in all healthcare settings (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 or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

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

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

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

DENOMINATOR:
All patients aged 65 years and older

*DENOMINATOR NOTE: *Clinicians indicating the Place of Service as the emergency department will not be included in this measure.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

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

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

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

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

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

OR

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

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

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

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

Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.

- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

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

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

*Measure #48 (NQF 0098): Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

DENOMINATOR:
All female patients aged 65 years and older

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

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

Definition:
Urinary Incontinence – Any involuntary leakage of urine.

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

OR

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

OR

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

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

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

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

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

*Measure #49 (NQF 0099): Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> All female patients aged ≥ 65 years on date of encounter
> AND
> Diagnosis for urinary incontinence (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39
> Diagnosis for urinary incontinence (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F98.0, N39.3, N39.41, N39.42, N39.43, N39.44, N39.45, N39.46, N39.490, N39.498, R32
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

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

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

OR

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

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

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

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

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

*Measure #50 (NQF 0100): Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> All female patients aged ≥ 65 years on date of encounter
> AND
> Diagnosis for urinary incontinence (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39
> Diagnosis for urinary incontinence (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F98.0, N39.3, N39.41, N39.42, N39.43, N39.44, N39.45, N39.46, N39.490, N39.498, R32
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

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

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

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

OR

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

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

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

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

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

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

▲ Measure #51 (NQF 0091): Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for COPD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496
> Diagnosis for COPD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

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

OR

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

OR

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

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

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

For the diagnosis and assessment of COPD, spirometry is the gold standard as it is the most reproducible, standardized, and objective way of measuring airflow limitation. $FEV_1/FVC < 70\%$ and a post bronchodilator FEV1 < 80% predicted confirms the presence of airflow limitation that is not fully reversible. (NHLBI/WHO)

▲ Measure #52 (NQF 0102): Chronic Obstructive Pulmonary Disease (COPD): Inhaled Bronchodilator Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for COPD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 493.20, 493.21, 493.22, 496
> Diagnosis for COPD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J41.0, J41.1, J41.8, J42, J43.0, J43.1, J43.2, J43.8, J43.9, J44.0, J44.1, J44.9
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were prescribed an inhaled bronchodilator

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Prescribed Inhaled Bronchodilator Therapy
(One CPT II code & one quality-data code [4025F & G8924] are required on the claim form to submit this numerator option)
CPT II 4025F: Inhaled bronchodilator prescribed
AND
G8924: Spirometry test results demonstrate $FEV_1/FVC < 60\%$ with COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed for Medical, Patient, or System Reasons
(One CPT II code & one quality-data code [4025F-xP & G8924] are required on the claim form to submit this numerator option)
Append a modifier (1P, 2P or 3P) to CPT Category II code 4025F to report documented circumstances that appropriately exclude patients from the denominator.
4025F *with* 1P: Documentation of medical reason(s) for not prescribing an inhaled bronchodilator
4025F *with* 2P: Documentation of patient reason(s) for not prescribing an inhaled bronchodilator
4025F *with* 3P: Documentation of system reason(s) for not prescribing an inhaled bronchodilator
AND
G8924: Spirometry test results demonstrate $FEV_1/FVC < 60\%$ with COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

OR

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

OR

Patient not Documented to have Inhaled Bronchodilator Prescribed, Reason not Otherwise Specified
(One CPT II code & one quality-data code [4025F-8P & G8924] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 4025F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4025F *with* 8P: Inhaled bronchodilator not prescribed, reason not otherwise specified
AND

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

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

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

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

❑ Measure #53 (NQF 0047): Asthma: Pharmacologic Therapy for Persistent Asthma - Ambulatory Care Setting

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 5 through 64 years with a diagnosis of persistent asthma who were prescribed long-term control medication

INSTRUCTIONS:

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

This measure will be calculated with 3 performance rates:

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

Measure Reporting via Registry:

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

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

DENOMINATOR:

All patients aged 5 through 64 years with a diagnosis of persistent asthma

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

Denominator Criteria (Eligible Cases):
Patients aged 5 through 64 years on date of encounter
AND
Diagnosis for asthma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
Diagnosis for asthma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Persistent Asthma (mild, moderate or severe) (1038F)

NUMERATOR:

Patients who were prescribed long-term control medication

Definitions:
Long-Term Control Medication Includes:
Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy)
OR
Patients prescribed alternative long-term control medications (inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, methylxanthines).
Prescribed – May include prescription given to the patient for inhaled corticosteroid OR an acceptable alternative long-term control medication at one or more visits in the 12-month period OR patient already taking inhaled corticosteroid OR an acceptable alternative long-term control medication as documented in current medication list.

Numerator Options:
Inhaled corticosteroids prescribed (4140F)
OR
Alternative long-term control medication prescribed (4144F)

OR

Documentation of patient reason(s) for not prescribing inhaled corticosteroids or alternative long-term control medication (eg, patient declined, other patient reason) (4140 *with* 2P)

OR

Inhaled corticosteroids or alternative long-term control medication not prescribed, reason not otherwise specified (4140F *with* 8P)

RATIONALE:
The following statement is quoted verbatim from the NHLBI/NAEPP guideline (NHLBI, 2007):
"The broad action of ICS on the inflammatory process may account for their efficacy as preventive therapy. Their clinical effects include reduction in severity of symptoms; improvement in asthma control and quality of life; improvement in PEF and spirometry; diminished airway hyper-responsiveness; prevention of exacerbations; reduction in systemic corticosteroid courses; emergency department (ED) care; hospitalizations, and deaths due to asthma; and possibly the attenuation of loss of lung function in adults." (Rafferty P 1985; Haahtela T 1991; Jeffery PK 1992; Van Essesn-Zandvliet EE 1992; Barnes NC 1993; Fabbri L 1993; Gustafsson P 1993; Kamada AK 1996; Suissa S 2000; Pauwels RA 2003; Barnes PJ October 1992)

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

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

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

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

*Measure #54 (NQF 0090): Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 40 years on date of encounter
AND
Diagnosis for non-traumatic chest pain (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59
Diagnosis for non-traumatic chest pain (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.1, I20.8, I20.9, I25.111, I25.118, I25.119, I25.701, I25.708, I25.709, I25.711, I25.718, I25.719, I25.721, I25.728, I25.729, I25.731, I25.738, I25.739, I25.751, I25.758, I25.759, I25.761, I25.768, I25.769, I25.791, I25.798, I25.799, R07.1, R07.2, R07.81, R07.82, R07.89, R07.9
AND

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

NUMERATOR:
Patients who had a 12-lead ECG performed

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
12-Lead ECG Performed
CPT II 3120F: 12-Lead ECG performed
OR
12-Lead ECG not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 3120F to report documented circumstances that appropriately exclude patients from the denominator.
3120F *with* 1P: Documentation of medical reason(s) for not performing a 12-Lead ECG
OR
3120F *with* 2P: Documentation of patient reason(s) for not performing a 12-Lead ECG
OR
12-Lead ECG not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3120F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3120F *with* 8P: 12-Lead ECG not performed, reason not otherwise specified

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

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

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

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

*Measure #55 (NQF 0093): Emergency Medicine: 12-Lead Electrocardiogram (ECG) Performed for Syncope

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 60 years on date of encounter
AND
Diagnosis for syncope (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 780.2
Diagnosis for syncope (ICD-10-CM) [for use 10/01/2014-12/31/2014]: R55
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:

Patients who had a 12-lead ECG performed

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
12-Lead ECG Performed
G8704: 12-Lead Electrocardiogram (ECG) performed

OR

12-Lead ECG not Performed for Medical or Patient Reasons
G8705: Documentation of medical reason(s) for not performing a 12-lead electrocardiogram (ECG)
OR
G8706: Documentation of patient reason(s) for not performing a 12-lead electrocardiogram (ECG)

OR

12-Lead ECG not Performed, Reason not Given
G8707: 12-Lead Electrocardiogram (ECG) not performed, reason not given

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. (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 (NQF 0232): Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Vital Signs

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia should have documentation in the medical record of having vital signs recorded and reviewed. It is anticipated that clinicians who provide care in the emergency department or office setting, or clinicians who provide initial care in the inpatient hospital setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department Place of Service code in order to be counted in the measure's denominator. Clinicians utilizing the inpatient hospital codes must indicate a principal physician of record modifier in order to be counted in the measure's denominator.

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

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

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

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

There are three reporting criteria for this measure:

(1) All patients aged 18 years and older with a diagnosis of CAP evaluated in an office/outpatient setting
OR

(2) All patients aged 18 years and older with a diagnosis of CAP evaluated in an emergency department setting
OR

(3) All patients aged 18 years and older with a diagnosis of CAP evaluated in an inpatient/hospital setting

REPORTING CRITERIA 1: All patients with a diagnosis of CAP evaluated in an office/outpatient setting

DENOMINATOR (REPORTING CRITERIA 1): *[Office/Outpatient Setting]*
All patients aged 18 years and older with a diagnosis of CAP

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for community-acquired bacterial pneumonia (ICD-10-CM) [for use 10/01/2014-12/31/2014]: A48.1, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9
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

NUMERATOR (REPORTING CRITERIA 1):
Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

Definitions:
Vital Signs – Are defined as temperature, pulse, respiratory rate, and blood pressure.
Documented and Reviewed – May include one of the following: Clinician documentation that vital signs were reviewed, dictation by the clinician including vital signs, clinician initials in the chart that vital signs were reviewed, or other indication that vital signs had been acknowledged by the clinician.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Vital Signs Documented and Reviewed
CPT II 2010F: Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

OR

Vital Signs not Documented and Reviewed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2010F *with* 8P: Vital signs (temperature, pulse, respiratory rate, and blood pressure) not documented and reviewed, reason not otherwise specified

REPORTING CRITERIA 2: All patients with a diagnosis of CAP evaluated in an emergency department setting

DENOMINATOR (REPORTING CRITERIA 2): *[Emergency Department Setting]*
All patients aged 18 years and older with a diagnosis of CAP

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for community-acquired bacterial pneumonia (ICD-10-CM) [for use 10/01/2014-12/31/2014]: A48.1, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9

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

OR

Patient encounter during the reporting period (CPT): 99291
WITH
Place of Service Modifier: 23

NUMERATOR (REPORTING CRITERIA 2):
Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

Definitions:

Vital Signs – Are defined as temperature, pulse, respiratory rate, and blood pressure.

Documented and Reviewed – May include one of the following: Clinician documentation that vital signs were reviewed, dictation by the clinician including vital signs, clinician initials in the chart that vital signs were reviewed, or other indication that vital signs had been acknowledged by the clinician.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Vital Signs Documented and Reviewed
CPT II 2010F: Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

OR

Vital Signs not Documented and Reviewed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2010F *with* 8P: Vital signs (temperature, pulse, respiratory rate, and blood pressure) not documented and reviewed, reason not otherwise specified

REPORTING CRITERIA 3: All patients with a diagnosis of CAP evaluated in an inpatient/hospital setting

DENOMINATOR (REPORTING CRITERIA 3): *[Inpatient Hospital Setting]*
All patients aged 18 years and older with a diagnosis of CAP

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for community-acquired bacterial pneumonia (ICD-10-CM) [for use 10/01/2014-12/31/2014]: A48.1, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9
AND
Patient encounter during the reporting period (CPT): 99221, 99222, 99223
WITH
Principal Physician of Record Modifier: AI

NUMERATOR (REPORITNG CRITERIA 3):
Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

Definitions:

Vital Signs – Are defined as temperature, pulse, respiratory rate, and blood pressure.

Documented and Reviewed – May include one of the following: Clinician documentation that vital signs were reviewed, dictation by the clinician including vital signs, clinician initials in the chart that vital signs were reviewed, or other indication that vital signs had been acknowledged by the clinician.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Vital Signs Documented and Reviewed

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

OR

Vital Signs not Documented and Reviewed, Reason not Otherwise Specified

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

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

RATIONALE:

Each of the vital signs should be recorded in the emergency department. While vital signs may be routinely recorded, there likely is a gap in care on acting on those values that warrant further evaluation. Moreover, it is important for physicians to review the vital signs to ensure continuous quality improvement and consistent patient care.

CLINICAL RECOMMENDATION STATEMENTS:

It is necessary to assess the severity of illness. This includes the radiographic findings (multilobar pneumonia or pleural effusion) and physical findings (respiratory rate, systolic and diastolic blood pressure, signs of dehydration and mental status). (ATS, 2001) (Level II Evidence)

*Measure #59 (NQF 0096): Emergency Medicine: Community-Acquired Bacterial Pneumonia (CAP): Empiric Antibiotic

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported once for each occurrence of community-acquired bacterial pneumonia during the reporting period. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia. Claims data will be analyzed to determine unique occurrences. All patients 18 years and older with a diagnosis of community-acquired bacterial pneumonia should have documentation in the medical record of having an appropriate empiric antibiotic prescribed. It is anticipated that clinicians who provide care in the emergency department or office setting, or clinicians who provide initial care in the inpatient hospital setting will submit this measure. Clinicians utilizing the critical care code must indicate the emergency department Place of Service code in order to be counted in the measure's denominator. Clinicians utilizing the inpatient hospital codes must indicate a principal physician of record modifier in order to be counted in the measure's denominator.

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

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

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

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

There are three reporting criteria for this measure:

(1) All patients aged 18 years and older with a diagnosis of CAP evaluated in an office/outpatient setting

OR

(2) All patients aged 18 years and older with a diagnosis of CAP evaluated in an emergency department setting

OR

(3) All patients aged 18 years and older with a diagnosis of CAP evaluated in an inpatient/hospital setting

REPORTING CRITERIA 1: All patients with a diagnosis of CAP evaluated in an office/outpatient setting

DENOMINATOR (REPORTING CRITERIA 1): *[Office/Outpatient Setting]*
All patients aged 18 years and older with a diagnosis of CAP

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for community-acquired bacterial pneumonia (ICD-10-CM) [for use 10/01/2014-12/31/2014]: A48.1, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9
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

NUMERATOR (REPORTING CRITERIA 1):
Patients with appropriate empiric antibiotic prescribed

Definitions:
Appropriate Empiric Antibiotic – 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. (classes as defined by current ATS/IDSA guidelines; antibiotics within these classes and FDA-approved for outpatient CAP treatment may be considered).
Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Appropriate Empiric Antibiotic Prescribed
CPT II 4045F: Appropriate empiric antibiotic prescribed

OR

Appropriate Empiric Antibiotic not Prescribed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 4045F to report documented circumstances that appropriately exclude patients from the denominator.
4045F *with* 1P: Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic
4045F *with* 2P: Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic
4045F *with* 3P: Documentation of system reason(s) for not prescribing appropriate empiric antibiotic

OR

Appropriate Empiric Antibiotic not Prescribed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4045F *with* 8P: Appropriate empiric antibiotic not prescribed, reason not otherwise specified

REPORTING CRITERIA 2: All patients with a diagnosis of CAP evaluated in an emergency department setting

DENOMINATOR (REPORTING CRITERIA 2): *[Emergency Department Setting]*
All patients aged 18 years and older with a diagnosis of CAP

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for community-acquired bacterial pneumonia (ICD-10-CM) [for use 10/01/2014-12/31/2014]: A48.1, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285

OR

Patient encounter during the reporting period (CPT): 99291
WITH
Place of Service Modifier: 23

NUMERATOR (REPORTING CRITERIA 2):
Patients with appropriate empiric antibiotic prescribed

Definitions:
Appropriate Empiric Antibiotic – 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. (classes as defined by current ATS/IDSA guidelines; antibiotics within these classes and FDA-approved for outpatient CAP treatment may be considered).
Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

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

OR

Appropriate Empiric Antibiotic not Prescribed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 4045F to report documented circumstances that appropriately exclude patients from the denominator.
4045F *with* 1P: Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic
4045F *with* 2P: Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic
4045F *with* 3P: Documentation of system reason(s) for not prescribing appropriate empiric antibiotic

OR

Appropriate Empiric Antibiotic not Prescribed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4045F *with* 8P: Appropriate empiric antibiotic not prescribed, reason not otherwise specified

REPORTING CRITERIA 3: All patients with a diagnosis of CAP evaluated in an inpatient/hospital setting

DENOMINATOR (REPORTING CRITERIA 3): *[Inpatient Hospital Setting]*
All patients aged 18 years and older with a diagnosis of CAP

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for community-acquired bacterial pneumonia (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Diagnosis for community-acquired bacterial pneumonia (ICD-10-CM) [for use 10/01/2014-12/31/2014]: A48.1, J13, J14, J15.0, J15.1, J15.20, J15.211, J15.212, J15.29, J15.3, J15.4, J15.5, J15.6, J15.7, J15.8, J15.9, J16.0, J16.8, J18.0, J18.1, J18.8, J18.9
AND
Patient encounter during the reporting period (CPT): 99221, 99222, 99223
WITH
Principal Physician of Record Modifier: AI

NUMERATOR (REPORTING CRITERIA 3):
Patients with appropriate empiric antibiotic prescribed

Definitions:
Appropriate Empiric Antibiotic – 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. (classes as defined by current ATS/IDSA guidelines; antibiotics within these classes and FDA-approved for outpatient CAP treatment may be considered).
Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

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

OR

Appropriate Empiric Antibiotic not Prescribed for Medical, Patient, or System Reasons
Append a modifier (1P, 2P or 3P) to CPT Category II code 4045F to report documented circumstances that appropriately exclude patients from the denominator.
4045F *with* 1P: Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic
4045F *with* 2P: Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic
4045F *with* 3P: Documentation of system reason(s) for not prescribing appropriate empiric antibiotic

OR

Appropriate Empiric Antibiotic not Prescribed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4045F *with* 8P: Appropriate empiric antibiotic not prescribed, reason not otherwise specified

RATIONALE:
All patients need to be treated empirically according to the guideline recommendations.

Current diagnostic methods to determine CAP pathogens are limited. Guidelines state that infections with the overwhelming majority of CAP pathogens will be adequately treated by use of the recommended empirical regimens. Additionally, rapid and appropriate empirical antibiotic therapy is consistently associated with improved outcome (IDSA/ATS, 2007)

CLINICAL RECOMMENDATION STATEMENTS:

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)

Recommended empirical antibiotics for community-acquired pneumonia
Outpatient treatment (IDSA/ATS, 2007)

1. Previously healthy and no use of antimicrobials within the previous 3 months
   - A macrolide (strong recommendation; level I evidence)
   - Doxycycline (weak recommendation; level III evidence)

2. Presence of comorbidities such as chronic heart, lung, liver or renal disease; diabetes mellitus; alcoholism; malignancies; asplenia; immunosuppressing conditions or use of immunosuppressing drugs; or use of antimicrobials within the previous 3 months (in which case an alternative from a different class should be selected)
   - A respiratory fluoroquinolone (moxifloxacin, gemifloxacin, or levofloxacin [750 mg]) (strong recommendation; level I evidence)
   - A b-lactam plus a macrolide (strong recommendation; level I evidence)

2. In regions with a high rate (125%) of infection with high-level (MIC _16 mg/mL) macrolide-resistant *Streptococcus pneumoniae,* consider use of alternative agents listed above in (2) for patients without comorbidities (moderate recommendation; level III evidence)

❑ Measure #64 (NQF 0001): Asthma: Assessment of Asthma Control - Ambulatory Care Setting

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 5 through 64 years with a diagnosis of asthma who were evaluated at least once during the measurement period for asthma control (comprising asthma impairment and asthma risk)

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

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

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

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

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

DENOMINATOR:
All patients aged 5 through 64 years with a diagnosis of asthma

> Denominator Criteria (Eligible Cases):
> Patients aged 5 through 64 years on date of encounter
> AND
> Diagnosis for asthma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
> Diagnosis for asthma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who were evaluated at least once during the measurement period for asthma control

Numerator Instructions: Completion of a validated questionnaire will also meet the numerator requirement for this component of the measure. Validated questionnaires for asthma assessment include, but are not limited to, the Asthma Therapy Assessment Questionnaire [ATAQ], the Asthma Control Questionnaire [ACQ], or the Asthma Control Test [ACT].

The specifications of this numerator enable documentation for the impairment and risk components separately to facilitate quality improvement. Evaluation of asthma impairment and asthma risk must occur during the same medical encounter.

Definition:
Evaluation of Asthma Control - Documentation of an evaluation of asthma impairment which must include: daytime symptoms AND nighttime awakenings AND interference with normal activity AND short-acting beta$_2$-agonist use for symptom control AND documentation of asthma risk which must include the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Asthma impairment assessed (CPT II 2015F)
AND
Asthma risk assessed (CPT II 2016F)

OR

Asthma impairment not assessed, reason not otherwise specified (2015F *with* 8P)
OR
Asthma risk not assessed, reason not otherwise specified (2016F *with* 8P)

RATIONALE:
The goal of asthma therapy is to achieve asthma control. The level of asthma control serves as a basis for treatment modification (ie, whether or not a patient needs a step up or step down in therapy). Patients with poorly controlled asthma can experience significant asthma burden (Fuhlbrigge AL, 2002), decreased quality of life (Schatz M, 2005), and increased health utilization. (Vollmer WM, 2002; Schatz M, 2005) A large international study found that guideline-defined asthma control can be achieved. In their trial, 30% of the patients achieved total control (defined as absence of asthma symptoms) and 60% achieve well-controlled asthma (defined as low-level of symptoms or rescue medication use. (Bateman ED, 2004) A follow-up to this study found that this control can be maintained, which can lead to a decrease in the use of unscheduled health care visits. (Bateman ED, 2008)

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

The Expert Panel recommends that asthma control be defined as follows: (Evidence A) (NHLBI, 2007)

- Reduce Impairment
- Prevent chronic and troublesome symptoms (eg, coughing or breathlessness in the daytime, night, or after exertion)
- Require infrequent use (≤ 2 days a week) of SABA for quick relief of symptoms
- Maintain (near) "normal" pulmonary function
- Maintain normal activity levels (including exercise and other physical activity and attendance at work or school)
- Meet patients' and families' expectations of satisfaction with asthma care
- Reduce risk
- Prevent recurrent exacerbations of asthma and minimize the need for ED visits or hospitalizations
- Prevent progressive loss of lung function; for children, prevent reduced lung growth
- Provide optimal pharmacotherapy with minimal or no adverse effects

The Expert Panel recommends that ongoing monitoring of asthma control be performed to determine whether all the goals of therapy are met—that is reducing both impairment and risk. (Evidence B) (NHLBI, 2007)

The Expert Panel recommends that the frequency of visits to a clinician for a review of asthma control is a matter of clinical judgment; in general, patients who have intermittent or mild persistent asthma that has been under control for at least 3 months should be seen by a physician about every 6 months, and patients who have uncontrolled and/or severe persistent asthma and those who need additional supervision to help them follow their treatment plan need to be seen more often. (NHLBI, 2007)

The Expert Panel recommends that symptoms and clinical signs of asthma should be assessed at each health care visit through physical examination and appropriate questions. (EPR-2, 1997) (NHLBI/NAEPP, 2007)

♦ Measure #65 (NQF 0069): Appropriate Treatment for Children with Upper Respiratory Infection (URI)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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

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

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

> Denominator Instructions: To determine eligibility, look for any of the listed antibiotic drugs below in the 30 days prior to the visit with the URI diagnosis. As long as there are no prescriptions for the listed antibiotics during this time period, the patient is eligible for denominator inclusion.
>
> Denominator Criteria (Eligible Cases):
> Patients aged 3 months through 18 years on date of encounter
> AND
> Diagnosis for URI (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 460, 465.0, 465.8, 465.9
> Diagnosis for URI (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J00, J06.0, J06.9
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99281, 99282, 99283, 99284, 99285, G0402

Antibiotic Medications

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

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

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

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

Numerator Options:

Patient not prescribed or dispensed antibiotic (G8708)

OR

Patient prescribed or dispensed antibiotic for documented medical reason(s) (e.g. intestinal infection, pertussis, bacterial infection, Lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis, mastoiditis, or bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia/gonococcal infections, venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis or UTI, and acne (G8709)

OR

Patient prescribed or dispensed antibiotic (G8710)

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

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

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

CLINICAL RECOMMENDATION STATEMENTS:
American Family Physician (Wong, Blumberg, and Lowe 2006)

- A diagnosis of acute bacterial rhinosinusitis should be considered in patients with symptoms of a viral upper respiratory infection that have not improved after 10 days or that worsen after five to seven days. (C)

- Treatment of sinus infection with antibiotics in the first week of symptoms is not recommended. (C)
- Telling patients not to fill an antibiotic prescription unless symptoms worsen or fail to improve after several days can reduce the inappropriate use of antibiotics. (B)

♦ Measure #66 (NQF 0002): Appropriate Testing for Children with Pharyngitis

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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

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

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

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

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

Denominator Instructions: To determine eligibility, look for any of the listed antibiotic drugs below in the 30 days prior to the visit with the pharyngitis diagnosis. As long as there are no prescriptions for the listed antibiotics during this time period, the patient is eligible for denominator inclusion.

Denominator Criteria (Eligible Cases):
Patients aged 2 through 18 years on date of encounter
AND
Diagnosis for pharyngitis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 034.0, 462, 463
Diagnosis for pharyngitis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J02.8, J02.9, J03.80, J03.81, J03.90, J03.91
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99281, 99282, 99283, 99284, 99285, G0402
AND
Prescribed or dispensed antibiotic (G8711)

Antibiotic Medications

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

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

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

Numerator Options:

Group A Strep Test Performed (3210F)

OR

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

RATIONALE:
Group A streptococcal bacterial infections and other infections that cause pharyngitis (which are most often viral) often produce the same signs and symptoms (IDSA 2002). The American Academy of Pediatrics, the Centers for Disease Control and Prevention, and the Infectious Diseases Society of America all recommend a diagnostic test for Strep A to improve diagnostic accuracy and avoid unnecessary antibiotic treatment (Linder et al. 2005). A study on

antibiotic treatment of children with sore throat found that although only 15 to 36 percent of children with sore throat have Strep A pharyngitis, physicians prescribed antibiotics to 53 percent of children with a chief complaint of sore throat between 1995 and 2003 (Linder et al., 2005).

CLINICAL RECOMMENDATION STATEMENTS:

Institute for Clinical Systems Improvement (ICSI) (2007)

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

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

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

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

Michigan Quality Improvement Consortium (2007)

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

♣ Measure #67 (NQF 0377): Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDS or acute leukemia – not in remission (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 207.22, 208.00, 208.02, 238.72, 238.73, 238.74, 238.75
> Diagnosis for MDS or acute leukemia – not in remission (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C91.00, C91.02, C92.00, C92.02, C92.40, C92.42, C92.50, C92.52, C92.60, C92.62, C92.A0, C92.A2, C93.00, C93.02, C94.00, C94.02, C94.20, C94.22, C95.00, C95.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Baseline Cytogenetic Testing Performed

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

OR

Baseline Cytogenetic Testing not Performed for Medical, Patient, or System Reasons

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

3155F *with* 1P: Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, no liquid bone marrow or fibrotic marrow)

3155F *with* 2P: Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, at time of diagnosis receiving palliative care or not receiving treatment as defined above)

3155F *with* 3P: Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (eg, patient previously treated by another physician at the time cytogenetic testing performed)

OR

Baseline Cytogenetic Testing not Performed, Reason not Otherwise Specified

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

3155F *with* 8P: Cytogenetic testing not performed on bone marrow at time of diagnosis or prior to initiating treatment, reason not otherwise specified

RATIONALE:

For MDS:

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

For acute leukemias:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

For MDS:

Bone marrow aspiration with Prussian blue stain for iron and biopsy are needed to evaluate the degree of hematopoietic cell maturation abnormalities and relative proportions, percentage of marrow blasts, marrow cellularity, presence or absence of ringed sideroblasts (and presence of iron per se), and fibrosis. Cytogenetics for bone marrow samples (by standard karyotyping methods) should be obtained because they are of major importance for prognosis. (Category 2A Recommendation) (NCCN, 2013)

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 (British Committee for Standards in Haematology, 2003)

Acute Lymphoblastic Leukemia:
Hematopathology evaluations should include morphologic examination of malignant lymphocytes using Wright-Giemsa-stained slides and hemtoxylin and eosin (H&E)-stained core biopsy and clot sections, comprehensive immunophenotyping with flow cytometry, and assessment of cytogenetic or molecular abnormalities. Identification of specific recurrent genetic abnormalities is critical for disease evaluation, optimal risk stratification, and treatment planning. (Category 2A Recommendation) (NCCN, 2012)

Acute Myeloid Leukemia:
The initial evaluation of AML has two objectives. The first is to characterize the disease process based upon factors such as 1) prior toxic exposure; 2) antecedent myelodysplasia; and 3) karyotypic or molecular abnormalities, which may provide prognostic information that may impact responsiveness to chemotherapy and risk of relapse. The second objective focuses on patient-specific factors including assessment of comorbid conditions, which may affect an individual's ability to tolerate chemotherapy. (Category 2A Recommendation) (NCCN, 2013)

♣ Measure #68 (NQF 0378): Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for MDS (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 238.72, 238.73, 238.74, 238.75
> Diagnosis for MDS (ICD-10-CM) [for use 10/01/2014-12/31/2014]: D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

> Definitions:

Documentation of Iron Stores – Includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and total iron-binding capacity (TIBC).
Erythropoietin Therapy – Includes the following medications: epoetin and darbepoetin for the purpose of this measure.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation of Iron Stores within 60 Days Prior to Initiating Erythropoietin Therapy Performed
*(Two CPT II codes [*3160F & 4090F*] are required on the claim form to submit this numerator option)*
CPT II 3160F: Documentation of iron stores prior to initiating erythropoietin therapy
AND
CPT II 4090F: Patient receiving erythropoietin therapy

OR

Documentation of Iron Stores within 60 Days Prior to Initiating Erythropoietin Therapy not Performed for System Reasons
*(Two CPT II codes [*3160F-3P & 4090F*] are required on the claim form to submit this numerator option)*
Append a modifier (3P) to CPT Category II code 3160F to report documented circumstances that appropriately exclude patients from the denominator.
3160F *with* 3P: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy
AND
CPT II 4090F: Patient receiving erythropoietin therapy

OR

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

OR

Documentation of Iron Stores within 60 Days Prior to Initiating Erythropoietin Therapy not Performed, Reason not Otherwise Specified
*(Two CPT II codes [*3160F-8P & 4090F*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 3160F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3160F *with* 8P: Iron stores prior to initiating erythropoietin therapy not documented, reason not otherwise specified
AND
CPT II 4090F: Patient receiving erythropoietin therapy

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

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

(Category 2A Recommendation) (NCCN, 2013)

♣ Measure #69 (NQF 0380): Hematology: Multiple Myeloma: Treatment with Bisphosphonates

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for multiple myeloma – not in remission (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 203.00, 203.02
> Diagnosis for multiple myeloma – not in remission (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C90.00, C90.02
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

> Definitions:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Intravenous Bisphosphonate Therapy Prescribed or Received
CPT II 4100F: Bisphosphonate therapy, intravenous, ordered or received

OR

Intravenous Bisphosphonate Therapy not Prescribed or Received for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4100F to report documented circumstances that appropriately exclude patients from the denominator.
4100F *with* 1P: Documentation of medical reason(s) for not prescribing bisphosphonates (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

OR

Intravenous Bisphosphonate Therapy not Prescribed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4100F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4100F *with* 8P: Bisphosphonate therapy, intravenous, not ordered or received, reason not otherwise specified

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

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

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

Bony manifestations of myeloma, in the form of diffuse osteopenia and/or osteolytic lesions develop in 85% of patients. Related complications are the major cause of limitations in quality of life and performance status in patient with MM. A recent meta-analysis of 20 randomized controlled trials of comparing bisphosphonates with either placebo or a different bisphosphonate as a comparator concluded that adding bisphosphonates to the treatment of MM reduces vertebral fractures and probably pain. The NCCN Multiple Myeloma Guidelines recommend bisphosphonates for all patients receiving myeloma therapy for symptomatic disease. (Category 1 Recommendation) (NCCN, 2012)

In patients with smoldering or stage I MM, according to the NCCN Panel, bisphosphonates may be considered but preferably in a clinical trial. (Category 2A Recommendation) (NCCN, 2012)

♣ Measure #70 (NQF 0379): Hematology: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period, regardless of when the baseline flow cytometry studies are performed. It is anticipated that clinicians who provide services for patients with the diagnosis of chronic lymphocytic leukemia, not in remission, will submit this measure.

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

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

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

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

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

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for CLL – not in remission (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 204.10, 204.12
> Diagnosis for CLL – not in remission (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C91.10, C91.12
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Baseline Flow Cytometry Studies Performed and Documented in the Chart

CPT II 3170F: Flow cytometry studies performed at time of diagnosis or prior to initiating treatment

OR

Baseline Flow Cytometry Studies not Performed or Documented in the Chart 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 (eg, receiving palliative care or not receiving treatment as defined above)

3170F *with* 3P: Documentation of system reason(s) for not performing baseline flow cytometry studies (eg, patient previously treated by another physician at the time baseline flow cytometry studies were performed)

OR

Baseline Flow Cytometry Studies not Performed or Documented in the Chart, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 3170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines:
Adequate immunophenotyping using flow cytometry of peripheral blood or paraffin-section immunohistochemistry is required to confirm the diagnosis of CLL/SLL. (Category 2A Recommendation) (NCCN, 2013)

¥ Measure #71 (NQF 0387): Breast Cancer: Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all female patients with breast cancer seen during the reporting period. Review estrogen receptor (ER) or progesterone receptor (PR) AND breast cancer stage status AND tumor size to determine which quality-data codes should be submitted. It is anticipated that clinicians who treat female breast cancer patients will submit this measure.

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

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

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

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

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for breast cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9
Diagnosis for breast cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919
AND

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

NUMERATOR:
Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period

Definition:
Prescribed – Prescribed may include prescription given to the patient for tamoxifen or aromatase inhibitor (AI) at one or more visits in the 12-month period OR patient already taking tamoxifen or aromatase inhibitor (AI) as documented in the current medication list.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Tamoxifen or Aromatase Inhibitor Prescribed
(Three CPT II codes [4179F & 337xF & 3315F] are required on the claim form to submit this numerator option)
CPT II 4179F: Tamoxifen or aromatase inhibitor (AI) prescribed
AND

CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1 cm to 2 cm), documented
OR
CPT II 3376F: AJCC Breast Cancer Stage II, documented
OR
CPT II 3378F: AJCC Breast Cancer Stage III, documented

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

OR

Tamoxifen or Aromatase Inhibitor not Prescribed for Medical, Patient, or System Reasons
(Three CPT II codes [4179F-xP & 337xF & 3315F] are required on the claim form to submit this numerator option)
Append a modifier (1P, 2P or 3P) to CPT Category II code 4179F to report documented circumstances that appropriately exclude patients from the denominator.
4179F *with* 1P: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient's disease has progressed to metastatic; patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was ≥ 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12-month reporting period, other medical reasons)
4179F *with* 2P: Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient refusal, other patient reasons)
4179F *with* 3P: Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient is currently enrolled in a clinical trial, other system reasons)
AND

CPT II 3374F: AJCC Breast Cancer Stage I: T1C (tumor size > 1 cm to 2 cm), documented
OR

CPT II 3376F: AJCC Breast Cancer Stage II, documented

OR

CPT II 3378F: AJCC Breast Cancer Stage III, documented

AND

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

OR

If patient is not eligible for this measure because patient is not stage IC through IIIC breast cancer, report:

Patient not Stage IC through IIIC Breast Cancer

(One CPT II code [33xxF] is required on the claim form to submit this numerator option)

Note: If reporting a code from the category below (3370F or 3372F or 3380F), it is not necessary to report the patient's ER/PR status.

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 ≤ 1 cm), documented

OR

CPT II 3380F: AJCC Breast Cancer Stage IV, documented

OR

If patient is not eligible for this measure because patient is estrogen receptor (ER) and progesterone receptor (PR) negative, report:

Patient is Estrogen Receptor (ER) and Progesterone Receptor (PR) Negative

(One CPT II code [3316F] is required on the claim form to submit this numerator option)

Note: If reporting code 3316F, it is not necessary to report the patient's AJCC Cancer Stage.

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

OR

If patient is not eligible for this measure because the cancer stage is not documented OR the ER/PR is not documented, report:

Cancer Stage not Documented OR ER/PR not Documented

(One CPT II code [33xxF-8P] is required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II codes 3370F or 3316F to report circumstances when the patient is not eligible for the measure.

3370F *with* 8P: No documentation of cancer stage

OR

3316F *with* 8P: No documentation of estrogen receptor (ER) and progesterone receptor (PR) status

OR

Tamoxifen or Aromatase Inhibitor not Prescribed, Reason not Otherwise Specified

(Three CPT II codes [4179F-8P & 337xF & 3315F] are required on the claim form to submit this numerator option)

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

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

AND

CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1 cm to 2 cm), documented
OR
CPT II 3376F: AJCC Breast Cancer Stage II, documented
OR
CPT II 3378F: AJCC Breast Cancer Stage III, documented

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

RATIONALE:
Despite evidence suggesting the role of adjuvant endocrine therapy in lowering the risk of tumor recurrence, many female patients who should be receiving this therapy are not. This measure assesses whether patients with a certain stage of breast cancer (IC through IIIC) and ER/PR+ are currently receiving the therapy. There are allowable medical, patient, and system reasons to document instances in which a woman with stage IC through IIIC, ER/PR+ may not be a candidate for the therapy.

Note: The reporting/managing physician does not need to have actually written the prescription; however, the reporting/managing physician must verify that the patient already has been prescribed the hormonal therapy by another physician.

CLINICAL RECOMMENDATION STATEMENTS:
Adjuvant therapy for postmenopausal women with hormone receptor–positive breast cancer should include an aromatase inhibitor in order to lower the risk of tumor recurrence. Aromatase inhibitors are appropriate as initial treatment for women with contraindications to tamoxifen. For all other postmenopausal women, treatment options include 5 years of aromatase inhibitors treatment or sequential therapy consisting of tamoxifen (for either 2 to 3 years or 5 years) followed by aromatase inhibitors for 2 to 3, or 5 years. (ASCO guidelines include narrative rankings) (ASCO, 2009)

Patients intolerant of aromatase inhibitors should receive tamoxifen. Women with hormone receptor–negative tumors should not receive adjuvant endocrine therapy. (ASCO guidelines include narrative rankings) (ASCO, 2009)

Patients with invasive breast cancers that are estrogen or progesterone receptor positive should be considered for adjuvant endocrine therapy regardless of patient age, lymph node status, or whether or not adjuvant chemotherapy is to be administered. (Category 2A) (NCCN, 2011)

The most firmly established adjuvant endocrine therapy is tamoxifen for both premenopausal and postmenopausal women. Prospective, randomized trials demonstrate that the optimal duration of tamoxifen appears to be five years. In patients receiving both tamoxifen and chemotherapy, chemotherapy should be given first, followed by sequential tamoxifen. A number of studies have evaluated aromatase inhibitors in the treatment of postmenopausal women with early-stage breast cancer. (Category 2A) (NCCN, 2011)
Patients with lymph node involvement or with tumors greater than 1 cm in diameter are appropriate candidates for adjuvant systemic therapy. (Category 1) For those with lymph node-negative, hormone receptor-positive breast cancer tumors greater than 1 cm, endocrine therapy with chemotherapy is recommended. (Category 1) (NCCN, 2011)

¥ Measure #72 (NQF 0385): Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period

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

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

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

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

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

DENOMINATOR:
All patients aged 18 through 80 years with AJCC Stage III colon cancer

Denominator Criteria (Eligible Cases):
Patients aged 18 through 80 years on date of encounter
AND
Diagnosis for colon cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 153.0, 153.1, 153.2, 153.3, 153.4, 153.6, 153.7, 153.8, 153.9
Diagnosis for colon cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C18.0, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who are referred for chemotherapy, prescribed chemotherapy, or who have previously received adjuvant chemotherapy within the 12 month reporting period

Definitions:
Adjuvant Chemotherapy – According to current NCCN guidelines, the following therapies are recommended: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (category 1); bolus 5-FU/LV/oxaliplatin (FLOX, category 1); capecitabine/oxaliplatin (CapeOx, category 1); or single agent capecitabine (category 2A) or 5-FU/LV (category 2A) in patients felt to be inappropriate for oxaliplatin therapy (NCCN, 2012). See clinical recommendation statement for cases where leucovorin is not available.
Prescribed – May include prescription ordered for the patient for adjuvant chemotherapy at one or more visits in the 12-month period OR patient already receiving adjuvant chemotherapy as documented in the current medication list.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Adjuvant Chemotherapy Referred, Prescribed or Previously Received
*(One quality-data code & one CPT II code [*G8927 & 3388F*] are required on the claim form to submit this numerator option)*
G8927: Adjuvant chemotherapy referred, prescribed or previously received for AJCC Stage III colon cancer
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

OR

Adjuvant Chemotherapy not Referred, Prescribed or Previously Received for Documented Reasons
*(One quality-data code & one CPT II code [*G8928 & 3388F*] are required on the claim form to submit this numerator option)*
G8928: Adjuvant chemotherapy not prescribed or previously received for documented reasons (e.g., medical co-morbidities, diagnosis date more than 5 years prior to the current visit date, patient's cancer has metastasized, medical contraindication/allergy, poor performance status, other medical reasons, patient refusal, other patient reasons, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy, other system reasons)
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

OR

If patient is not eligible for this measure because patient is not stage III colon cancer, report:
Patient not Stage III Colon Cancer
*(One CPT II code [*33xxF*] is required on the claim form to submit this numerator option)*
CPT II 3382F: AJCC Colon Cancer Stage 0, documented
OR
CPT II 3384F: AJCC Colon Cancer Stage I, documented
OR
CPT II 3386F: AJCC Colon Cancer Stage II, documented
OR
CPT II 3390F: AJCC Colon Cancer Stage IV, documented

OR

If patient is not eligible for this measure because cancer stage is not documented, report:
Cancer Stage not Documented

(One CPT II code [3382F-8P] is required on the claim form to submit this category)
Append a reporting modifier (8P) to CPT Category II code 3382F to report circumstances when the patient is not eligible for the measure.
3382F *with* 8P: No documentation of cancer stage

OR

Adjuvant Chemotherapy not Referred, Prescribed or Previously Received, Reason not Given
(One quality-data code & one CPT II code [G8929 & 3388F] are required on the claim form to submit this numerator option)
Report G8929 in circumstances when the action described in the numerator is not performed and the reason is not given.
G8929: Adjuvant chemotherapy not prescribed or previously received, reason not given
AND
CPT II 3388F: AJCC Colon Cancer Stage III, documented

RATIONALE:
The receipt of adjuvant chemotherapy in AJCC Stage III colon cancer patients following primary surgical treatment is associated with a significant survival benefit.

CLINICAL RECOMMENDATION STATEMENTS:
For stage III patients (T1-4, N1-2, M0), the panel recommends 6 months of adjuvant chemotherapy following primary surgical treatment. The treatment options are: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (category 1); bolus 5-FU/LV/oxaliplatin (FLOX, category 1), capecitabine/oxaliplatin (CapeOx, category 1); or single agent capecitabine (category 2A) or 5-FU/LV (category 2A) in patients felt to be inappropriate for oxaliplatin therapy. (NCCN, 2012)

There is currently a shortage of leucovorin in the United States. There are no specific data to guide management under these circumstances, and all proposed strategies are empiric. The panel recommends several possible options to help alleviate the problems associated with this shortage. One is the use of levo-leucovorin, which is commonly used in Europe. A dose of 200 mg/m^2 of levo–leucovorin is equivalent to 400 mg/m^2 of standard leucovorin. Another option is for practices or institutions to use lower doses of leucovorin for all doses in all patients, since the panel feels that lower doses are likely to be as efficacious as higher doses, based on several studies. Finally, if none of the above options are available, treatment without leucovorin would be reasonable. (NCCN, 2012)

▲ Measure #76 (NQF 0464): Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique [cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed

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

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

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

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

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

DENOMINATOR:
All patients, regardless of age, who undergo CVC insertion

> Denominator Criteria (Eligible Cases):
> Patient encounter during the reporting period (CPT): 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 93503

NUMERATOR:
Patients for whom central venous catheter (CVC) was inserted with all elements of maximal sterile barrier technique [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 all of the following: Cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

All Elements of Maximal Sterile Barrier Technique Followed

CPT II 6030F: All elements of maximal sterile barrier technique followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)

OR

All Elements of Maximal Sterile Barrier Technique not Followed for Medical Reasons

Append a modifier (1P) to CPT Category II code 6030F to report documented circumstances that appropriately exclude patients from the denominator.

6030F *with* 1P: Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including CVC insertion performed on emergency basis)

OR

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

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

6030F *with* 8P: All elements of maximal sterile barrier technique not followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline), reason not otherwise specified

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

▲ Measure #81 (NQF 0323): Adult Kidney Disease: Hemodialysis Adequacy: Solute

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis three times a week for ≥ 90 days have a spKt/V ≥ 1.2

INSTRUCTIONS:
This measure is to be reported each calendar month the patient meets denominator criteria for End Stage Renal Disease (ESRD) patients seen during the reporting period. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

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

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

DENOMINATOR:
All calendar months during which patients aged 18 years and older with a diagnosis of ESRD are receiving hemodialysis three times a week for ≥ 90 days

DENOMINATOR NOTE: There should be documentation in the patient's chart that he/she is receiving hemodialysis three times per week for ***≥ 90 days****.*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.6
Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.6
AND
Encounter for Dialysis and Dialysis Catheter Care (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V56.0, V56.1, V56.32
Encounter for Dialysis and Dialysis Catheter Care (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z49.01, Z49.31, Z49.32
AND
Hemodialysis treatment performed exactly three times per week **for ≥ 90 days:** G8714
AND
Patient encounter during the reporting period (CPT): 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

NUMERATOR:
Calendar months during which patients have a spKt/V ≥ 1.2

NUMERATOR NOTE: *Urea kinetic modeling (UKM) or the second generation Daugirdas formula (simplified multivariable equation) are the most appropriate ways to calculate spKt/V, and the two accepted methods for calculating spKt/V per the KDOQI guidelines. For more information on these methods, please refer to National Kidney Foundation's KDOQI Clinical Practice Guidelines and Clinical Practice Recommendations for 2006 Updates: Hemodialysis Adequacy, Peritoneal Dialysis Adequacy and Vascular Access. Am J Kidney Dis 48:S1-S322, 2006 (suppl 1).*

Numerator Options:

spKt/V greater than or equal to 1.2 (single-pool clearance of urea [Kt] / volume [V]) (G8713)

OR

spKt/V less than 1.2 (single-pool clearance of urea [Kt] / volume [V]), reason not given (G8717)

RATIONALE:

Adequate dialysis dose (Kt/V ≥ 1.2), is strongly associated with better outcomes, including decreased mortality, fewer hospitalizations, decreased length of hospitalizations, and decreased hospital costs. (Plantinga et al, 2007 and Sehgal et al, 2001)

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.
The minimally adequate dose of HD given 3 times per week to patients with Kr less than 2 mL/min/1.73m2 should be an spKt/V (excluding RKF) of 1.2 per dialysis. For treatment times less than 5 hours, an alternative minimum dose is a URR of 65% (A). The target dose for HD given 3 times per week with Kr less than 2mL/min/1.73m2 should be an spKt/V of 1.4 per dialysis not including RKF, or URR of 70% (A). (KDOQI, 2006)

▲ Measure #82 (NQF 0321): Adult Kidney Disease: Peritoneal Dialysis Adequacy: Solute

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving peritoneal dialysis who have a total Kt/V ≥ 1.7 per week measured once every 4 months

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

- 1 to 4 consecutive months of treatment – report once during the reporting year
- 5 to 8 consecutive months of treatment – report twice during the reporting year
- 9 to 12 consecutive months of treatment – report three times during the reporting year

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

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.6
Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.6
AND
Encounter for Dialysis and Dialysis Catheter Care (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V56.2, V56.32, V56.8
Encounter for Dialysis and Dialysis Catheter Care (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z49.02, Z49.32
AND
Patient encounter during the reporting period (CPT): 90945, 90947, 90957, 90958, 90959, 90960, 90961, 90962, 90965, 90966, 90969, 90970

NUMERATOR:
Patients who have a total Kt/V ≥ 1.7 per week measured once every 4 months

Definition:

Total Kt/V - Total Kt/V includes residual kidney function and equals peritoneal dialysate Kt/V plus renal Kt/V.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Total Kt/V greater than or equal to 1.7 per week (Total clearance of urea [Kt]/volume [V]) (G8718)

OR

Total Kt/V less than 1.7 per week (Total clearance of urea [Kt]/volume [V]), reason not given (G8720)

RATIONALE:

Adequate dialysis dose is strongly associated with better outcomes, including decreased mortality, fewer hospitalizations, fewer days in the hospital, and decreased hospital costs. (Plantinga et al, 2007)

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Total solute clearance (residual kidney and peritoneal, in terms of Kt/V urea) should be measured within the first month after initiating dialysis therapy and at least once every 4 months thereafter (B). (KDOQI, 2006)

For patients with residual kidney function (considered to be significant when urine volume is > 100 mL/d): The minimal "delivered" dose of total small-solute clearance should be a total (peritoneal and kidney) Kt/V urea of at least 1.7 per week (B). For patients without RKF (considered insignificant when urine volume is ≤ 100 mL/d): The minimal "delivered" dose of total small-solute clearance should be a peritoneal Kt/V urea of at least 1.7 per week measured within the first month after starting dialysis therapy and at least once every 4 months thereafter (B). (KDOQI, 2006)

▲ Measure #83 (NQF 0393): Hepatitis C: Confirmation of Hepatitis C Viremia

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older who are hepatitis C antibody positive seen for an initial evaluation for whom hepatitis C virus (HCV) RNA testing was ordered or previously performed

INSTRUCTIONS:
This measure should be reported on the initial evaluation visit occurring during the reporting period for all patients who are hepatitis C antibody positive 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:
CPT codes, CPT Category II codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who are hepatitis C antibody positive seen for an initial evaluation

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patients with a positive Hepatitis C antibody test: G9202
AND
Initial evaluation for condition (CPT II): 1119F
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients for whom HCV RNA testing was ordered or previously performed

Numerator Options:
Ribonucleic acid (RNA) testing for Hepatitis C viremia ordered or results documented (3265F)
OR
Documentation of medical reason(s) for not ordering or performing RNA testing for HCV (eg, limited life expectancy, patient not a candidate for therapy, other medical reasons) (3265F *with* 1P)
OR
Documentation of patient reason(s) for not ordering or performing RNA testing for HCV (eg, patient declined, other patient reasons) (3265F *with* 2P)
OR

RNA testing for HCV was not ordered or results not documented, reason not otherwise specified (3265F *with* 8P)

RATIONALE:

A meta-analysis of 31 studies found a consistent overall estimate of 15 to 20 percent of people who become infected with acute hepatitis C will clear the virus. The absence of confirmatory viral testing may then leave these 15 to 20 percent of patients with the mistaken belief that they have chronic hepatitis C, subjecting these patients to unnecessary anxiety and other harms. The remaining viral positive patients could benefit from the additional counseling for their own and for transmission risk, namely avoiding alcohol, getting vaccinated, and providing counseling regarding transmission and remaining engaged in care. Thus, this test is critically important in differentiating whether or not people have resolved infection or are currently infected with HCV, regardless of whether antiviral treatment is contemplated.

CLINICAL RECOMMENDATION STATEMENTS:

HCV ribonucleic acid (RNA) testing should be performed in:

a) patients with a positive anti-HCV test
b) patients for whom antiviral treatment is being considered, using a sensitive quantitative assay
c) patients with unexplained liver disease whose anti-HCV test is negative and who are immunocompromised or suspected of having acute HCV infection (AASLD, 2009)

For the diagnosis of acute hepatitis C, HCV RNA testing is required since HCV RNA appears before anti-HCV antibodies may be detectable. (EASL, 2011)

▲ Measure #84 (NQF 0395): Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

If reporting Measure #84: Hepatitis C: Ribonucleic Acid (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 started antiviral treatment within the 12 month reporting period for whom quantitative hepatitis C virus (HCV) RNA testing was performed within 12 months prior to initiation of antiviral treatment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who started antiviral treatment within the 12 month reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes OR a CPT Category II code are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code(s) OR the CPT Category II code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who started antiviral treatment within the 12 month reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 070.54
Diagnosis for chronic hepatitis C (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B18.2
AND
Patient starting antiviral treatment for Hepatitis C during the measurement period (G9205)
AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients for whom quantitative HCV RNA testing was performed within 12 months prior to initiation of antiviral treatment

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

RNA testing for Hepatitis C documented as performed within 12 months prior to initiation of antiviral treatment for Hepatitis C (G9203)

OR

RNA testing for Hepatitis C was not documented as performed within 12 months prior to initiation of antiviral treatment for Hepatitis C, reason not given (G9204)

RATIONALE:
A sensitive quantitative HCV RNA assay is recommended prior to initiating treatment because it provides information on the level of virus which is helpful in management. Establishment of the baseline viral RNA level is very important in interpreting the response to therapy. Use of this measure should help to guide treatment decisions regarding duration of therapy and likelihood of response, which should improve outcomes.

CLINICAL RECOMMENDATION STATEMENTS:
HCV RNA testing should be performed in:
a) Patients with a positive anti-HCV test
b) Patients for whom antiviral treatment is being considered, using a sensitive quantitative assay
c) Patients with unexplained liver disease whose anti-HCV test is negative and who are immunocompromised or suspected of having acute HCV infection (AASLD, 2009)

HCV RNA should be tested by a highly sensitive quantitative assay at the initiation of or shortly before treatment and at week 12 of therapy. (AASLD, 2009)

▲ Measure #85 (NQF 0396): Hepatitis C: HCV Genotype Testing Prior to Treatment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

If reporting Measure #85: Hepatitis C: HCV Genotype Testing Prior to Treatment, also report Measure #84: Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who started antiviral treatment within the 12 month reporting period for whom hepatitis C virus (HCV) genotype testing was performed within 12 months prior to initiation of antiviral treatment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who started antiviral treatment within the 12 month reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
Measure Reporting via Claims:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code(s). All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who started antiviral treatment within the 12 month reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 070.54
Diagnosis for chronic hepatitis C (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B18.2
AND
Patient starting antiviral treatment for Hepatitis C during the measurement period (G9206)
AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients for whom HCV genotype testing was performed within 12 months prior to initiation of antiviral treatment

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis C genotype testing documented as performed within 12 months prior to initiation of antiviral treatment for Hepatitis C (G9207)

OR

Hepatitis C genotype testing was not documented as performed within 12 months prior to initiation of antiviral treatment for Hepatitis C, reason not given (G9208)

RATIONALE:
The rationale for the measure is to guide treatment decisions regarding duration of therapy and likelihood of response, which should improve outcomes. 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) More recently, treatment of genotype 1b has shown the most favorable outcomes leading to differences in the licensure and use of new therapies by sub-genotype.

CLINICAL RECOMMENDATION STATEMENTS:
HCV genotyping should be performed in all HCV-infected persons prior to interferon-based treatment in order to plan for the dose and duration of therapy and to estimate the likelihood of response. (AASLD, 2009)

The HCV genotype must be assessed prior to antiviral treatment initiation and will determine the dose of ribavirin and treatment decision. (EASL, 2011)

▲ Measure #87 (NQF 0398): Hepatitis C: Hepatitis C Virus (HCV) Ribonucleic Acid (RNA) Testing Between 4-12 Weeks After Initiation of Treatment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative hepatitis C virus (HCV) RNA testing was performed between 4-12 weeks after the initiation of antiviral treatment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, quality-data code, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 070.54
Diagnosis for chronic hepatitis C (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B18.2
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Patient receiving antiviral treatment for Hepatitis C (G8461)

NUMERATOR:
Patients for whom quantitative HCV RNA testing was performed between 4-12 weeks after the initiation of antiviral treatment

Definition:
4 -12 Weeks after Initiation – Patients for whom testing was performed between 4-12 weeks from the initiation of antiviral treatment will meet the numerator for this measure, acknowledging that there may be different recommended follow-up testing based on the specific antiviral therapy used to treat a particular patient.

Numerator Options:

Hepatitis C quantitative RNA testing documented as performed between 4-12 weeks after the initiation of antiviral treatment (G9209)

OR

Hepatitis C quantitative RNA testing not performed between 4-12 weeks after the initiation of antiviral treatment for reasons documented by clinician (e.g., patients whose treatment was discontinued during the testing period prior to testing, other medical reasons, patient declined, other patient reasons) (G9210)

OR

Hepatitis C quantitative RNA testing was not documented as performed between 4-12 weeks after the initiation of antiviral treatment, reason not given (G9211)

RATIONALE:

Monitoring effectiveness of antiviral therapy is essential to effective treatment. An early virologic response (EVR), during the first 12 weeks of therapy, is a valuable clinical milestone.

Patients should be monitored during therapy to assess the response to treatment and for the occurrence of side effects. A reasonable schedule would be monthly visits during the first 12 weeks of treatment followed by visits at 8 to 12 week intervals thereafter until the end of therapy. At each visit the patient should be questioned regarding the presence of side effects and depression. They should also be queried about adherence to treatment. Laboratory monitoring should include measurement of the complete blood count, serum creatinine and ALT levels, and HCV RNA by a sensitive assay at weeks 4, 12, 24, 4 to 12 week intervals thereafter, the end of treatment, and 24 weeks after stopping treatment. (AASLD, 2009)

CLINICAL RECOMMENDATION STATEMENTS:

HCV RNA should be tested by a highly sensitive quantitative assay at the initiation of or shortly before treatment and at week 12 of therapy. (AASLD, 2009)

Patients [with genotype 1] without cirrhosis treated with boceprevir, peginterferon, and ribavirin, preceded by 4 weeks of lead-in peginterferon and ribavirin, whose HCV RNA level at weeks 8 and 24 is undetectable, may be considered for a shortened duration of treatment of 28 weeks in total (4 weeks lead-in with peginterferon and ribavirin followed by 24 weeks of triple therapy). (AASLD, 2011)

Patients [with genotype 1] without cirrhosis treated with telaprevir, peginterferon, and ribavirin, whose HCV RNA level at weeks 4 and 12 is undetectable, should be considered for a shortened duration of therapy of 24 weeks. (AASLD, 2011)

▲ Measure #91 (NQF 0653): Acute Otitis Externa (AOE): Topical Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations

INSTRUCTIONS:
This measure is to be reported once for each occurrence of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

Denominator Criteria (Eligible Cases):
Patients aged ≥ 2 years on date of encounter
AND
Diagnosis for AOE (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 380.10, 380.11, 380.12, 380.13, 380.22
Diagnosis for AOE (ICD-10-CM) [for use 10/01/2014-12/31/2014]: H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8X1, H62.8X2, H62.8X3, H62.8X9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

NUMERATOR:
Patients who were prescribed topical preparations

Definition:
Prescribed – May include prescription given to the patient for topical preparations at one or more visits during the episode of AOE OR patient already receiving topical preparations as documented in the current medication list.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Topical Preparations Prescribed
CPT II 4130F: Topical preparations (including OTC) prescribed for acute otitis externa

OR

Topical Preparations not Prescribed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4130F to report documented circumstances that appropriately exclude patients from the denominator.
4130F *with* 1P: Documentation of medical reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa (eg, coexisting acute otitis media, tympanic membrane perforation)
4130F *with* 2P: Documentation of patient reason(s) for not prescribing topical preparations (including OTC) for acute otitis externa

OR

Topical Preparations not Prescribed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4130F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4130F *with* 8P: Topical preparations (including OTC) for acute otitis externa (AOE) not prescribed, reason not otherwise specified

RATIONALE:
Topical preparations should be used to treat AOE as they are active against the most common bacterial pathogens in AOE, Pseudomonas aeruginosa and Staphylococcus aureus. Topical preparations have demonstrated efficacy in the treatment of AOE with resolution in about 65-90% of patients.

CLINICAL RECOMMENDATION STATEMENTS:
Clinicians should use topical preparations for initial therapy of diffuse, uncomplicated AOE. (Recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF, 2006)

▲ Measure #93 (NQF 0654): Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy

INSTRUCTIONS:
This measure is to be reported once for each occurrence of AOE during the reporting period. Each unique occurrence is defined as a 30-day period from onset of AOE. Claims data will be analyzed to determine unique occurrences. If multiple claims are submitted within that 30-day period, only one instance of reporting will be counted. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 2 years and older with a diagnosis of AOE

Denominator Criteria (Eligible Cases):
Patients aged ≥ 2 years on date of encounter
AND
Diagnosis for AOE (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 380.10, 380.11, 380.12, 380.13, 380.22
Diagnosis for AOE (ICD-10-CM) [for use 10/01/2014-12/31/2014]: H60.00, H60.01, H60.02, H60.03, H60.10, H60.11, H60.12, H60.13, H60.311, H60.312, H60.313, H60.319, H60.321, H60.322, H60.323, H60.329, H60.331, H60.332, H60.333, H60.339, H60.391, H60.392, H60.393, H60.399, H60.501, H60.502, H60.503, H60.509, H60.511, H60.512, H60.513, H60.519, H60.521, H60.522, H60.523, H60.529, H60.531, H60.532, H60.533, H60.539, H60.541, H60.542, H60.543, H60.549, H60.551, H60.552, H60.553, H60.559, H60.591, H60.592, H60.593, H60.599, H61.90, H61.91, H61.92, H61.93, H62.40, H62.41, H62.42, H62.43, H62.8X1, H62.8X2, H62.8X3, H62.8X9
AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

NUMERATOR:
Patients who were not prescribed systemic antimicrobial therapy

Numerator Instructions: For performance, the measure will be calculated as the number of patients for whom systemic antimicrobial therapy was not prescribed over the number of patients in the denominator (patients aged 2 years and older with acute otitis externa). A higher score indicates appropriate treatment of patients with AOE (eg, the proportion for whom systemic antimicrobials were not prescribed).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Systemic Antimicrobial Therapy not Prescribed
CPT II 4132F: Systemic antimicrobial therapy not prescribed

OR

Systemic Antimicrobial Therapy Prescribed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4131F to report documented circumstances that appropriately exclude patients from the denominator
4131F *with* 1P: Documentation of medical reason(s) for prescribing systemic antimicrobial therapy (eg, coexisting diabetes, immune deficiency)

OR

Systemic Antimicrobial Therapy Prescribed
CPT II 4131F: Systemic antimicrobial therapy prescribed

RATIONALE:
Despite their limited utility, many patients with AOE receive systemic antimicrobial therapy, often in addition to topical therapy. “There are no data on the efficacy of systemic therapy with the use of appropriate antibacterials and stratified by severity of the infection. Moreover, orally administered antibiotics have significant adverse effects that include rashes, vomiting, diarrhea, allergic reactions, altered nasopharyngeal flora, and development of bacterial resistance.” The use of systemic antimicrobial therapy to treat AOE should be limited only to those clinical situations in which it is indicated.

CLINICAL RECOMMENDATION STATEMENTS:
Systemic antimicrobial therapy should not be used unless there is extension outside the ear canal or the presence of specific host factors that would indicate a need for systemic therapy. (Recommendation based on randomized controlled trials with minor limitations and a preponderance of benefit over harm. [Aggregate evidence quality – Grade B]) (AAO-HNSF, 2006)

€ Measure #99 (NQF 0391): Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes), and the histologic grade

INSTRUCTIONS:
This measure is to be reported each time a breast cancer resection surgical pathology examination is performed during the reporting period for breast cancer patients. Each unique CPT Category I code submitted on the claim will be counted for denominator inclusion. It is anticipated that clinicians who examine breast tissue specimens following resection in a laboratory or institution will submit this measure. Independent laboratories (ILs) and independent diagnostic testing facilities (IDTFs), using indicator Place of Service 81, are not included in PQRS. If the specimen is not primary breast tissue (eg, liver, lung), report only CPT II code 3250F.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All breast cancer resection pathology reports (excluding biopsies)

Denominator Criteria (Eligible Cases):
Diagnosis for breast cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for breast cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND
Patient encounter during the reporting period (CPT): 88307, 88309

NUMERATOR:

Reports that include the pT category, the pN category and the histologic grade

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
pT Category, pN Category and Histologic Grade Documented
CPT II 3260F: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons
Append a modifier (1P) to CPT Category II code 3260F to report documented circumstances that appropriately exclude patients from the denominator.
3260F *with* 1P: Documentation of medical reason(s) for not including the pT category, the pN category, or the histologic grade in the pathology report (eg, re-excision without residual tumor, non-carcinomas)

OR

If patient is not eligible for this measure because the specimen is not primary breast tissue (eg, liver, lung) report:
CPT II 3250F: Specimen site other than anatomic location of primary tumor

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3260F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3260F *with* 8P: pT category, pN category, and histologic grade were not documented in pathology report, reason not otherwise specified

RATIONALE:
Therapeutic decisions for breast cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP recently conducted a structured audit of breast cancer pathology report adequacy at 86 institutions. Overall, 35% of eligible reports were missing at least one of the ten CAP-recommended breast cancer elements. Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 25% of breast cancer pathology reports did not include all of the information required by the CAP standards. While the exact percentage of breast cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown, these are essential elements in breast cancer treatment decisions and should be included in every pathology report when possible.

The CAP recently conducted a structured audit of breast cancer pathology report adequacy at 86 institutions. Overall, 32% of eligible reports were missing at least one of the ten CAP-recommended breast cancer elements (Idowu MO, et al).

CLINICAL RECOMMENDATION STATEMENTS:
All invasive breast carcinomas, with the exception of medullary carcinoma should be graded. The grading system used must be specified in the report; the Nottingham combined histologic grade (Elston-Ellis modification of Scarff-

Bloom-Richardson grading system) is recommended. Within each stage grouping there is a relation between histologic grade and outcome. (CAP, 2010)

All patients with breast cancer should be assigned a clinical stage of disease, and if appropriate evaluation is available, a pathologic stage of disease. The routine use of staging allows for efficient identification of local treatment options, assists in identifying systemic treatment options, allows the comparison of outcomes results across institutions and clinical trials, and provides baseline prognostic information. (NCCN, 2012)

€ Measure #100 (NQF 0392): Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade

INSTRUCTIONS:
This measure is to be reported each time a colorectal cancer resection surgical pathology examination is performed during the reporting period for colorectal cancer patients. Each unique CPT Category I code submitted on the claim will be counted for denominator inclusion. It is anticipated that clinicians who examine colorectal tissue specimens following resection in a laboratory or institution will submit this measure. Independent Laboratories (ILs) and Independent Diagnostic Testing Facilities (IDTFs), using indicator Place of Service 81, are not included in PQRS. If the specimen is not primary colorectal tissue (eg, liver, lung), report only G8723.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All colon and rectum cancer resection pathology reports

Denominator Criteria (Eligible Cases):
Diagnosis for colon or rectum cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8
Diagnosis for colon or rectum cancer (ICD-10-CM) [for use 10/1/2014-12/31/2014]: C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.2, C21.8
AND
Patient encounter during the reporting period (CPT): 88309

NUMERATOR:
Reports that include the pT category, the pN category and the histologic grade

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
pT Category, pN Category and Histologic Grade Documented

G8721: pT category (primary tumor), pN category (regional lymph nodes), and histologic grade were documented in pathology report

OR

pT Category, pN Category and Histologic Grade not Documented for Medical Reasons:
G8722: Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade in the pathology report (eg, re-excision without residual tumor; non-carcinomas, anal canal)

OR

If patient is not eligible for this measure because the specimen is not primary colorectal tissue (eg, liver, lung) report:
G8723: Specimen site is other than anatomic location of primary tumor

OR

pT Category, pN Category and Histologic Grade not Documented, Reason not Given
G8724: pT category, pN category and histologic grade were not documented in the pathology report, reason not given

RATIONALE:
Therapeutic decisions for colorectal cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete cancer resection pathology reports may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists (CAP) has produced evidence-based checklists of essential pathologic parameters that are recommended to be included in cancer resection pathology reports. These checklists have been endorsed as a voluntary standard by National Quality Forum (NQF) and are considered the reporting standard by the Commission on Cancer (CoC) of the American College of Surgeons (ACS).

The CAP conducted a structured audit of colorectal cancer pathology report adequacy at 86 institutions. Overall, 21% of eligible reports were missing at least one of the ten CAP-recommended colorectal cancer elements. (Idowu MO, et al, 2010) Cancer Care Ontario (CCO) conducted a similar study in 2005 and found that 31% of colorectal cancer pathology reports did not include all of the information required by the CAP standards.

While the exact percentage of colorectal cancer resection pathology reports that are missing the pT category, the pN category and the histologic grade is unknown, these are essential elements in colorectal cancer treatment decisions and should be included in every pathology report when possible.

CLINICAL RECOMMENDATION STATEMENTS:
Surgical resection remains the most effective therapy for colorectal carcinoma, and the best estimation of prognosis is derived from the pathologic findings on the resection specimen. The anatomic extent of disease is by far the most important prognostic factor in colorectal cancer. The protocol recommends the TNM staging system of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC)1 but does not preclude the use of other staging systems. By AJCC/UICC convention, the designation “T” refers to a primary tumor that has not been previously treated. The symbol “p” refers to the pathologic classification of the TNM, as opposed to the clinical classification, and is based on gross and microscopic examination. pT entails a resection of the primary tumor or biopsy adequate to evaluate the highest pT category, pN entails removal or biopsy of nodes adequate to validate lymph node metastasis, and pM implies microscopic examination of distant lesions. (CAP, 2011)

Colorectal cancers are usually staged after surgical exploration of the abdomen and pathologic examination of the surgical specimen. Some of the criteria that should be included in the report of the pathologic evaluation include the following: grade of the cancer; depth of penetration and extension to adjacent structures (T); number of regional lymph nodes evaluated; number of positive regional lymph nodes (N); an assessment of the presence of distant metastasis to other organs, the peritoneum of an abdominal structure, or in non-regional lymph nodes (M); the status

of proximal, distal and radial margins; lymphovascular invasion, perineurial invasion and extra-nodal tumor deposits. (NCCN, 2012)

▲Measure #102 (NQF 0389): Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer

INSTRUCTIONS:
This measure is to be reported once per episode of treatment (ie, interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) for all male patients with prostate cancer who receive interstitial prostate brachytherapy, external beam radiotherapy to the prostate, radical prostatectomy, or cryotherapy during the reporting period. 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 PQRS quality-data code needs to be submitted only once during the episode of radiation therapy (eg, 8 weeks of therapy). It is anticipated that clinicians who perform the listed procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis 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: 1P- medical reasons, 3P- system reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

DENOMINATOR NOTE: Only male patients with prostate cancer with low risk of recurrence will be counted in the performance denominator of this measure.

Denominator Criteria (Eligible Cases):
Any male patient, regardless of age
AND
Diagnosis for prostate cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 185
Diagnosis for prostate cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C61
AND

Patient encounter during the reporting period (CPT): 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 55875, 55876, 77427, 77776, 77777, 77778, 77787

NUMERATOR:
Patients who did *not* have a bone scan performed at any time since diagnosis of prostate cancer

Numerator Instructions: A higher score indicates appropriate treatment of patients with prostate cancer at low risk of recurrence.

Definitions:
Risk Strata: Low, Intermediate, or High –

Low Risk – PSA ≤ 10 ng/mL; AND Gleason score 6 or less; AND clinical stage T1c or T2a. (AUA, 2007)

Intermediate Risk – PSA > 10 to 20 ng/mL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk. (AUA, 2007)

High Risk – PSA > 20 ng/mL; OR Gleason score 8 to 10; OR clinically localized stage T3a. (NCCN, 2011)

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Bone Scan not Performed
(Two CPT II codes [3270F & 3271F] are required on the claim form to submit this numerator option)
CPT II 3270F: Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer
AND
CPT II 3271F: Low risk of recurrence, prostate cancer

OR

Bone Scan Performed for Medical or System Reasons
(Two CPT II codes [3269F-xP & 3271F] are required on the claim form to submit this numerator option)
Append a modifier (1P or 3P) to CPT Category II code 3269F to report documented circumstances that appropriately exclude patients from the denominator.
3269F *with* 1P: Documentation of medical reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons)
3269F *with* 3P: Documentation of system reason(s) for performing a bone scan (including bone scan ordered by someone other than reporting physician)
AND
CPT II 3271F: Low risk of recurrence, prostate cancer

OR

If patient is not eligible for this measure because the risk of recurrence is intermediate, high or not determined, report:
(One CPT II code [327xF] is required on the claim form to submit this numerator option)
Intermediate Risk of Recurrence
CPT II 3272F: Intermediate risk of recurrence, prostate cancer
OR
High Risk of Recurrence
CPT II 3273F: High risk of recurrence, prostate cancer

OR

Risk of Recurrence not Determined

CPT II 3274F: Prostate cancer risk of recurrence not determined or neither low, intermediate nor high

OR

Bone Scan Performed

(Two CPT II codes [3269F & 3271F] are required on the claim form to submit this numerator option)

CPT II 3269F: Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer

AND

CPT II 3271F: Low risk of recurrence, prostate cancer

RATIONALE:

A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.

CLINICAL RECOMMENDATION STATEMENTS:

Routine use of a bone scan is not required for staging asymptomatic men with clinically localized prostate cancer when their PSA is equal to or less than 20.0 ng/mL. (AUA, 2009)

For symptomatic patients and/or those with a life expectancy of greater than 5 years, a bone scan is appropriate for patients with any of the following: 1) T1 disease with PSA over 20 ng/mL or T2 disease with PSA over 10 ng/mL; 2) a Gleason score of 8 or higher; 3) T3 to T4 tumors or symptomatic disease. (Category 2A) (NCCN, 2011)

▲Measure #104 (NQF 0390): Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

INSTRUCTIONS:
This measure is to be reported once per episode of radiation therapy for all male 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 PQRS quality-data code needs to be submitted only once during the episode of radiation therapy (eg, 8 weeks of therapy). It is anticipated that clinicians who perform external beam radiotherapy to the prostate will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis code, CPT code, and the appropriate CPT Category II code AND/OR quality-data code OR the CPT Category II code with the modifier AND quality-data code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate

> *DENOMINATOR NOTE: Only male patients with prostate cancer with high risk of recurrence will be counted in the performance denominator of this measure.*
>
> Denominator Criteria (Eligible Cases):
> Any male patient, regardless of age
> AND
> Diagnosis for prostate cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 185
> Diagnosis for prostate cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C61
> AND
> Patient encounter during the reporting period (CPT): 77427

NUMERATOR:
Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

Definitions:
Risk Strata: Low, Intermediate, or High –
Low Risk – PSA ≤ 10 ng/mL; AND Gleason score 6 or less; AND clinical stage T1c or T2a. (AUA, 2007)
Intermediate Risk – PSA > 10 to 20 ng/mL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk. (AUA, 2007)
High Risk – PSA > 20 ng/mL; OR Gleason score 8 to 10; OR clinically localized stage T3a. (NCCN, 2011)
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 quality-data 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
AND
G8465: High risk of recurrence of prostate cancer

OR

Adjuvant Hormonal Therapy not Prescribed/Administered for Medical or Patient Reasons
(One CPT II code & one quality-data 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
AND
G8465: High risk of recurrence of prostate cancer

OR

If patient is not eligible for this measure because the risk of recurrence is low, intermediate or not determined, report:
(One quality-data code [G8464] is required on the claim form to submit this numerator option)
G8464: Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; Low or intermediate risk of recurrence OR risk of recurrence not determined

OR

Adjuvant Hormonal Therapy not Prescribed/Administered, Reason not Otherwise Specified
*(One CPT II code & one quality-data code [*4164F-8P & G8465*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 4164F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4164F *with* 8P: Patients who were not prescribed/administered adjuvant hormonal therapy, reason not otherwise specified

AND
G8465: High risk of recurrence of prostate cancer

RATIONALE:
If receiving external beam radiotherapy as primary therapy, prostate cancer patients with a high risk of recurrence should also be prescribed hormonal therapy, which has been shown to increase the effectiveness of the radiotherapy.

CLINICAL RECOMMENDATION STATEMENTS:
When counseling patients regarding treatment options, physicians should consider the following:
Based on results of two randomized controlled clinical trials, the use of adjuvant and concurrent hormonal therapy may prolong survival in the patient who has opted for radiotherapy. (AUA, 2007)

High risk patients who are considering specific treatment options should be informed of findings of recent high quality clinical trials, including that:
For those considering external beam radiotherapy, use of hormonal therapy combined with conventional radiotherapy may prolong survival. (Standard) (AUA, 2007)

There are several treatment options for patients with high-risk disease. The preferred treatment is 3D-CRT/IMRT with daily IGRT in conjunction with long-term ADT; ADT alone is insufficient. In particular, patients with low volume, high grade tumor warrant aggressive local radiation combined with typically 2-3 years of ADT. (Category 1) (NCCN, 2011)

▲Measure #106 (NQF 0103): Adult Major Depressive Disorder (MDD): Comprehensive Depression Evaluation: Diagnosis and Severity

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD) with evidence that they met the Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with an active diagnosis of major depressive disorder seen during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code(s). There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a new diagnosis or recurrent episode of major depressive disorder (MDD)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
Diagnosis for MDD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
AND
Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

NUMERATOR:
Patients with evidence that they met the DSM-5 criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified

Definitions:
MDD diagnosis (DSM-5) - For a diagnosis of MDD a patient must endorse five of nine symptoms, with one of those five being either 1) depressed mood or 2) loss of interest or pleasure. The other symptoms include significant weight loss or gain, or decrease or increase in appetite nearly every day; fatigue or loss of energy nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; feelings of worthlessness or guilt nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day; and recurrent thoughts of death or suicidal ideation.

These symptoms must be present for a duration of 2 weeks or longer, represent a change from previous functioning, and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

These symptoms must:

- Not be due to the physiological effects of a substanceor to another general medical condition
- Not be better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- Never have been accompanied by a manic or hypomanic episode

Note: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in the DSM-5 criteria, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

Severity – According to DSM-IV-TR (2000), severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. See the Rationale and Clinical Recommendation Statements Sections for Supporting Guidelines and Other References for additional information on defining severity levels. *(Note: DSM-5 does not address severity. As such, DSM-IV-TR is the most up to date resource to use for assessment of severity.)*

NUMERATOR NOTES:
For clinicians who use the term relapse, generally that refers to an episode of MDD that occurs within 6 months after either response or remission, which may be a variation on the initial episode. This measure is intended to capture either an initial or recurrent episode.

This measure is intended for use by clinicians who are qualified to diagnose and treat depression.

It can be helpful to use screening tools such as the PHQ-9 in order to substantiate the need for further evaluation and accurate diagnosis of MDD; however, simply using a tool alone would not constitute making a successful MDD diagnosis. A validated depression screening tool may include the PHQ-9, which is based on the DSM criteria for MDD. Other validated tools based on the DSM criteria may be available; this list is not intended to be all-inclusive.

Please refer to the most recent version of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) (version 5 as of 2013) for more information regarding diagnosing Major Depressive Disorder.

It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.

FOR PATIENTS WHOSE EPISODE OF MDD BEGAN PRIOR TO THE CURRENT REPORTING PERIOD: The clinician should report that DSM-5 criteria and depression severity was assessed during the visit in which the new diagnosis or recurrent episode was identified.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
DSM-5 Criteria for Major Depressive Disorder Documented
*(One CPT II code & one quality data code [*1040F & G8930*] are required on the claim form to submit this numerator option)*
1040F: DSM-5 criteria for major depressive disorder documented at the initial evaluation
AND
G8930: Assessment of depression severity at the initial evaluation

OR

DSM-5 Criteria for Major Depressive Disorder not Documented, Reason not Otherwise Specified
*(One CPT II code [1040F-8P] or one quality data code [*G8931*] is required on the claim form to submit this numerator option)*
1040F *with* 8P: DSM-5 criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified
OR
G8931: Assessment of depression severity not documented, reason not given

RATIONALE:
Chronic depression often goes unrecognized and untreated. The recognition and appropriate treatment of MDD is dependent on a thorough diagnostic assessment and an evaluation of the degree of severity of the disorder. A diagnostic assessment can help clinicians tailor a patient's treatment to their needs. It can help clinicians rule-out general medical conditions or other psychiatric conditions which may be contributing to depressive symptomology. An assessment of severity can also help clinicians tailor a patient's treatment. As noted in clinical guidelines, treatment methods should vary by the severity of depression. A diagnostic evaluation should be instituted for all patients with major depressive disorder to determine whether a diagnosis of depression is warranted and to reveal the presence of other conditions that may have an impact on treatment.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Patients should receive a thorough diagnostic assessment in order to establish the diagnosis of major depressive disorder, identify other psychiatric or general medical conditions that may require attention, and develop a comprehensive plan for treatment [I]. (APA, 2010)

Criteria for Major Depressive Episode
A. Five (or more) 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 attributable to another medical condition
1. Depressed mood most of the day, nearly every day as indicated by either subjective report (eg, feels sad, empty, hopeless) or observation made by others (eg, appears tearful)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation)
3. Significant weight loss when not dieting or weight gain (eg, a change of more than 5% body weight in a month), or decrease or increase in appetite nearly every day
4. Insomnia or hypersomnia nearly every day

5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or 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 as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning

C. The episode is not attributable to the physiological effects of a substance or to another medical condition

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (eg, bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

In distinguishing grief from a major depressive episode (MDE), it is useful to consider that in grief the predominant affect is feelings of emptiness and loss, while in MDE it is persistent depressed mood and the inability to anticipate happiness or pleasure. The dysphoria in grief is likely to decrease in intensity over days to weeks and occurs in waves, the so-called pangs of grief. These waves tend to be associated with thoughts or reminders of the deceased. The depressed mood of MDE is more persistent and not tied to specific thoughts or preoccupations. The pain of grief may be accompanied by positive emotions and humor that are uncharacteristic of the pervasive unhappiness and misery characteristic of MDE. The thought content associated with grief generally features a preoccupation with thoughts and memories of the deceased, rather than the self-critical or pessimistic ruminations seen in MDE. In grief, self esteem is generally preserved whereas in MDE feelings of worthlessness and self loathing are common. If self derogatory ideation is present in grief, it typically involves perceived failings vis-a-vis the deceased (e.g., not visiting frequently enough, not telling the deceased how much he or she was loved). If a bereaved individual thinks about death and dying, such thoughts are generally focused on the deceased and possibly about "joining" the deceased, whereas in MDE such thoughts are focused on ending one's own life because of feeling worthless, undeserving of life, or unable to cope with the pain of depression.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance induced or are attributable to the physiological effects of another medical condition. (DSM-5, 2013)

Major depressive disorder can alter functioning in numerous spheres of life including work, school, family, social relationships, leisure activities, or maintenance of health and hygiene. The psychiatrist (clinician) should evaluate the patient's activity in each of these domains and determine the presence, type, severity, and chronicity of any dysfunction [I]. (APA, 2010)

In developing a treatment plan, interventions should be aimed at maximizing the patient's level of functioning as well as helping the patient to set specific goals appropriate to his or her functional impairments and symptom severity [I]. (APA, 2010)

If criteria are currently met for the major depressive episode, it can be classified as Mild, Moderate, Severe Without Psychotic Features, or Severe with Psychotic Features. [The fifth digit (in the diagnostic codes for Major Depressive Disorder) indicates the severity as follows: 1 for mild severity, 2 for moderate severity, 3 for severe without psychotic features, and 4 for severe with psychotic features.] (DSM-IV-TR, 2000)

Severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress. (DSM-IV-TR, 2000)

- Mild episodes are characterized by the presence of only five or six depressive symptoms and either mild disability or the capacity to function normally but with substantial and unusual effort.
- Episodes that are Severe Without Psychotic Features are characterized by the presence of most of the criteria symptoms and clear-cut, observable disability (eg, inability to work or care for children).
- Moderate episodes have a severity that is intermediate between mild and severe.
- [Severe With Psychotic Features] indicates the presence of either delusions or hallucinations (typically auditory). The clinician can indicate the nature of the psychotic features by specifying With Mood-Congruent Features [ie, content of the delusions or hallucinations are consistent with the depressive themes] or With Mood-Incongruent Features (ie, content of the delusions or hallucinations has no apparent relationship to depressive themes).

▲ Measure #107 (NQF 0104): Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

INSTRUCTIONS:
This measure is to be reported a minimum of once during the reporting period for all patients with an active diagnosis of major depressive disorder (MDD) seen individually during the reporting period, including episodes of MDD that began prior to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
Diagnosis for MDD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
AND
Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285

NUMERATOR:
Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

Definition:
Suicide risk assessment - Must include questions about the following:

1) Suicidal ideation
2) Patient's intent of initiating a suicide attempt
AND, if either is present,
3) Patient plans for a suicide attempt
4) Whether the patient has means for completing suicide

NUMERATOR NOTE: It is expected that an initial evaluation will occur during the visit in which a new diagnosis or recurrent episode was identified.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Suicide Risk Assessed
G8932: Suicide risk assessed at the initial evaluation

OR

Suicide Risk not Assessed, Reason not Given
G8933: Suicide risk not assessed at the initial evaluation, reason not given

RATIONALE:
Research has shown that more than 90% of people who kill themselves have depression or another diagnosable mental or substance abuse disorder. Depression is the cause of over two-thirds of the reported suicides in the U.S. each year. The intent of this measure is for a clinician to assess suicide risk at initial intake or at the visit in which depression was diagnosed. As the guidelines state, it is important to assess for additional factors which may increase or decrease suicide risk, such as presence of additional symptoms (eg, psychosis, severe anxiety, hopelessness, severe chronic pain); presence of substance abuse, history and seriousness of previous attempts, particularly, recent suicidal behavior, current stressors and potential protective factors (eg, positive reasons for living, strong social support), family history of suicide or mental illness or recent exposure to suicide, impulsivity and potential for risk to others, including history of violence or violent or homicidal ideas, plans, or intentions, and putting one's affairs in order (eg, giving away possessions, writing a will). In addition, although the measure focuses on the initial visit, it is critical that suicide risk be monitored especially for the 90 days following the initial visit and throughout MDD treatment.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

A careful and ongoing evaluation of suicide risk is necessary for all patients with major depressive disorder [I]. (APA, 2010)

Such an assessment includes specific inquiry about suicidal thoughts, intent, plans, means, and behaviors; identification of specific psychiatric symptoms (eg, psychosis, severe anxiety, substance use) or general medical conditions that may increase the likelihood of acting on suicidal ideas; assessment of past and, particularly, recent suicidal behavior; delineation of current stressors and potential protective factors (eg, positive reasons for living, strong social support); and identification of any family history of suicide or mental illness [I]. (APA, 2010)
As part of the assessment process, impulsivity and potential for risk to others should also be evaluated, including any history of violence or violent or homicidal ideas, plans, or intentions [I]. (APA, 2010)

The patient's risk of harm to him- or herself and to others should also be monitored as treatment proceeds [I]. (APA, 2010)
Guidelines for Selecting a Treatment Setting for Patients at Risk for Suicide or Suicidal Behaviors (from APA's Practice Guideline for Assessment and Treatment of Patients With Suicidal Behaviors-2010, Downloaded from http://psychiatryonline.org/ on 6/25/12):

Admission generally indicated

After a suicide attempt or aborted suicide attempt if:

- Patient is psychotic
- Attempt was violent, near-lethal, or premeditated
- Precautions were taken to avoid rescue or discovery
- Persistent plan and/or intent is present
- Distress is increased or patient regrets surviving
- Patient is male, older than age 45 years, especially with new onset of psychiatric illness or suicidal thinking
- Patient has limited family and/or social support, including lack of stable living situation
- Current impulsive behavior, severe agitation, poor judgment, or refusal of help is evident
- Patient has change in mental status with a metabolic, toxic, infectious, or other etiology requiring further workup in a structured setting

In the presence of suicidal ideation with:

- Specific plan with high lethality
- High suicidal intent

Admission may be necessary

[In addition to the list above, these additional circumstances may warrant admission]
After a suicide attempt or aborted suicide attempt

In the presence of suicidal ideation with:

- Psychosis
- Major psychiatric disorder
- Past attempts, particularly if medically serious
- Possibly contributing medical condition (eg, acute neurological disorder, cancer, infection)
- Lack of response to or inability to cooperate with partial hospital or outpatient treatment
- Need for supervised setting for medication trial or ECT
- Need for skilled observation, clinical tests, or diagnostic assessments that require a structured setting
- Limited family and/or social support, including lack of stable living situation
- Lack of an ongoing clinician-patient relationship or lack of access to timely outpatient follow-up
- Evidence of putting one's affairs in order (eg, giving away possessions, writing a will)

In the absence of suicide attempts or reported suicidal ideation/plan/intent but evidence from the psychiatric evaluation and/or history from others suggests a high level of suicide risk and a recent acute increase in risk.

Release from emergency department with follow-up recommendations may be possible

After a suicide attempt or in the presence of suicidal ideation/plan when:

- Suicidality is a reaction to precipitating events (eg, exam failure, relationship difficulties), particularly if the patient's view of situation has changed since coming to emergency department
- Plan/method and intent have low lethality
- Patient has stable and supportive living situation
- Patient is able to cooperate with recommendations for follow-up, with treater contacted, if possible, if patient is currently in treatment

Outpatient treatment may be more beneficial than hospitalization

Patient has chronic suicidal ideation and/or self-injury without prior medically serious attempts, if a safe and supportive living situation is available and outpatient psychiatric care is ongoing.

♦ Measure #108 (NQF 0054): Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older who were diagnosed with RA and were prescribed, dispensed, or administered at least one ambulatory prescription for a DMARD

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for RA patients seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes can be used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier codes allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) and a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412,

M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:

Patients who were prescribed, dispensed, or administered at least one disease modifying anti-rheumatic drug (DMARD)

Definition:

Prescribed – May include prescription given to the patient for DMARD therapy at one or more visits in the 12-month period OR patient already taking DMARD therapy as documented in current medication list.

The DMARDs listed below are considered DMARDs for the purposes of this measure:

Description	Prescription			J Codes
5-Aminosalicylates	Sulfasalazine			N/A
Alkylating agents	Cyclophosphamide			N/A
Aminoquinolines	Hydroxychloroquine			N/A
Anti-rheumatics	Auranofin Gold sodium thiomalate	Leflunomide Methotrexate	Penicillamine	J1600, J9250, J9260
Immunomodulators	Abatacept Adalimumab Anakinra Certolizumab	Certolizumab pegol Etanercept Golimumab	Infliximab Rituximab Tocilizumab	J0129, J0135, J0718, J1438, J1745, J3262, J9310
Immunosuppressive agents	Azathioprine	Cyclosporine	Mycophenolate	J7502, J7515, J7516, J7517, J7518
Janus kinase (JAK) Inhibitor	Tofacitinib			N/A
Tetracyclines	Minocycline			N/A

Note: J codes should only be used to identify if the appropriate DMARD therapy was prescribed to the patient. CPT II codes are used when reporting this measure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
DMARD Prescribed, Dispensed, or Administered
CPT II 4187F: Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered

OR

DMARD not Prescribed, Dispensed, or Administered for Medical Reasons
Append a modifier (1P) to CPT Category II code 4187F to report documented circumstances that appropriately exclude patients from the denominator.
4187F *with* 1P: Documentation of medical reason(s) for not prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy (ie, patients with a diagnosis of HIV or pregnancy).

OR

DMARD not Prescribed, Dispensed, or Administered, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4187F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4187F *with* 8P: Disease modifying anti-rheumatic drug therapy was not prescribed, dispensed, or administered, reason not otherwise specified

RATIONALE:
Early diagnosis and management of RA presents an important opportunity to alter the course of this progressive disease. Treatment in the first few months after disease onset takes advantage of a window of opportunity to effectively limit structural damage to joints and improves health outcomes. American College of Rheumatology (ACR) guidelines underscore early DMARD therapy.

CLINICAL RECOMMENDATION STATEMENTS:
The American College of Rheumatology (ACR) recommends targeting either low disease activity or remission in all patients with early RA (level of evidence C) and established RA (level of evidence C) receiving any DMARD or biologic agent.

In patients with early RA, the ACR recommends the use of DMARD monotherapy both for low disease activity and for moderate or high disease activity with the absence of poor prognostic features (level of evidence A–C). In patients with early RA, the ACR recommends the use of DMARD combination therapy (including double and triple therapy) in patients with moderate or high disease activity plus poor prognostic features (level of evidence A–C). In patients with early RA, the ACR also recommends the use of an anti-TNF biologic with or without methotrexate in patients who have high disease activity with poor prognostic features (level of evidence A and B). Infliximab is the only exception and the recommendation is to use it in combination with methotrexate, but not as monotherapy.

▲Measure #109 (NQF 0050): Osteoarthritis (OA): Function and Pain Assessment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with osteoarthritis seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits for patients aged 21 years and older with a diagnosis of OA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 21 years on date of encounter
AND
Diagnosis for osteoarthritis (OA) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
Diagnosis for osteoarthritis (OA) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.10, M16.11, M16.12, M16.2, M16.30, M16.31, M16.32, M16.4, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.10, M18.11, M18.12, M18.2, M18.30, M18.31, M18.32, M18.4, M18.50, M18.51, M18.52, M18.9, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.111, M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142, M19.149, M19.171, M19.172, M19.179, M19.211, M19.212, M19.219, M19.221, M19.222, M19.229, M19.231, M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.90, M19.91, M19.92, M19.93

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patient visits with assessment for level of function and pain documented

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Osteoarthritis Symptoms and Functional Status Assessed

CPT II 1006F: Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as the SF-36, AAOS Hip & Knee Questionnaire)

OR

Osteoarthritis Symptoms and Functional Status not Assessed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1006F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1006F *with* 8P: Osteoarthritis symptoms and functional status not assessed, reason not otherwise specified

RATIONALE:

Osteoarthritis can be a debilitating condition. An assessment of patient symptoms and functional status is important as it serves as the basis for making treatment modifications, which in turn, assists in improving the patient's quality of life.

CLINICAL RECOMMENDATION STATEMENTS:

Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem. (AGA; IIA Recommendation)

Control of pain and maintenance of activity correlate well with satisfactory quality of life. If the patient is not satisfied with the outcome due to continued pain and limitation of activity, more aggressive intervention may be warranted. (AAOS, 2003)

▲Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

INSTRUCTIONS:
This measure is to be reported a minimum of once for visits for patients seen between January and March for the 2013-2014 influenza season AND a minimum of once for visits for patients seen between October and December for the 2014-2015 influenza season. This measure is intended to determine whether or not all patients aged 6 months and older received (either from the reporting physician or from an alternate care provider) or had an order for influenza immunization during the flu season. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

- If reporting this measure between January 1, 2014 and March 31, 2014, quality-data code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of August, September, October, November, and December of 2013 or January, February, and March of 2014 for the flu season ending March 31, 2014.
- If reporting this measure between October 1, 2014 and December 31, 2014, quality-data code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of August, September, October, November, and December of 2014 for the flu season ending March 31, 2015.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2013-2014 flu season OR 2014-2015 flu season) can be reported when a visit occurs during the flu season (October1 - March 31). In these cases, G8482 should be reported.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 6 months and older seen for a visit between October 1 and March 31

Denominator Criteria (Eligible Cases):
Patients aged ≥ 6 months seen for a visit between October 1 and March 31
AND
Patient encounter during the reporting period (CPT or HCPCS): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967,

90968, 90969, 90970, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439

NUMERATOR:
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

Definition:
Previous Receipt – Receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Influenza Immunization Administered
G8482: Influenza immunization administered or previously received

OR

Influenza Immunization not Administered for Documented Reasons
G8483: Influenza immunization was not ordered or administered for reasons documented by clinician (e.g., patient allergy or other medical reason, patient declined or other patient reasons, or other system reasons)
OR
Influenza Immunization Ordered or Recommended, but not Administered
G0919: Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit

OR

Influenza Immunization not Administered, Reason not Given
G8484: Influenza immunization was not ordered or administered, reason not given

RATIONALE:
Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months. To permit time for production of protective antibody levels, vaccination should optimally occur before onset of influenza activity in the community, and providers should offer vaccination as soon as vaccine is available. Vaccination also should continue to be offered throughout the influenza season. (CDC/ACIP, 2011)

♦ Measure #111 (NQF 0043): Pneumonia Vaccination Status for Older Adults

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The 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 claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients 65 years of age and older with a visit during the measurement period

> *DENOMINATOR NOTE: Pneumococcal vaccination is expected once ever for patients 65 years of age or older.*
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99356, 99357, G0402

NUMERATOR:
Patients who have ever received a pneumococcal vaccination

> Numerator Quality-Data Coding Options for Reporting Satisfactorily:
> Pneumococcal Vaccination Administered or Previously Received
> CPT II 4040F: Pneumococcal vaccine administered or previously received

OR

Pneumococcal Vaccination not Administered or Previously Received, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 4040F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4040F *with* 8P: Pneumococcal vaccine was not administered or previously received, reason not otherwise specified

RATIONALE:

Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease (NHLBI, 2011). In 1998, an estimated 3,400 adults aged > 65 years died as a result of invasive pneumococcal disease (IPD) (CDC, 2003).

Among the 91.5 million US adults aged > 50 years, 29,500 cases of IPD, 502,600 cases of nonbacteremic pneumococcal pneumonia and 25,400 pneumococcal-related deaths are estimated to occur yearly; annual direct and indirect costs are estimated to total $3.7 billion and $1.8 billion, respectively. Pneumococcal disease remains a substantial burden among older US adults, despite increased coverage with 23-valent pneumococcal polysaccharide vaccine, (PPV23) and indirect benefits afforded by PCV7 vaccination of young children (Weycker, et al., 2011).

Vaccination has been found to be effective against bacteremic cases (OR: 0.34; 95% CI: 0.27–0.66) as well as nonbacteremic cases (OR: 0.58; 95% CI: 0.39–0.86). Vaccine effectiveness was highest against bacteremic infections caused by vaccine types (OR: 0.24; 95% CI: 0.09–0.66) (Vila-Corcoles, et al., 2009).

CLINICAL RECOMMENDATION STATEMENTS:

The Advisory Committee on Immunization Practices' (ACIP) Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but a second dose is appropriate for those who received PPV23 before age 65 years for any indication if at least 5 years have passed since their previous dose (USPSTF, 1989; ACIP, 2010).

The major updates for the 2010 update are: 1) the indications for which PPSV23 vaccination is recommended now include smoking and asthma, and 2) routine use of PPSV23 is no longer recommended for Alaska Natives or American Indians aged <65 years unless they have medical or other indications for PPV23.

♦ Measure #112: Breast Cancer Screening

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of women 50 through 74 years of age who had a mammogram to screen for breast cancer within 27 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for female patients seen during the reporting period. There is no diagnosis associated with this measure. The patient should either be screened for breast cancer on the date of service OR there should be documentation that the patient was screened for breast cancer at least once within 27 months prior to the date of service. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Women 50 through 74 years of age with a visit during the measurement period

> *DENOMINATOR NOTE: The measure's 27-month look back period applies to women ages 52-74 (the numerator looks for a mammogram any time on or between October 1, 27 months prior to the measurement period, and December 31 of the measurement period in order to capture women who have had a mammogram every 24 months per clinical guidelines, with a 3-month grace period). Therefore, women ages 50-52 are included in the measure if they had a visit and a mammogram since age 50, but the look back only applies to patients age 52-74.*
>
> Denominator Criteria (Eligible Cases):
> Patients 50 through 74 years of age on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Patients who had one or more mammograms any time on or between October 1, 27 months prior to December 31 of the measurement period, not to precede the patient's 50th birthday

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Mammogram Performed
CPT II 3014F: Screening mammography results documented and reviewed

OR

Mammogram not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 3014F to report documented circumstances that appropriately exclude patients from the denominator.
3014F *with* 1P: Documentation of medical reason(s) for not performing a mammogram (ie, women who had a bilateral mastectomy or two unilateral mastectomies).

OR

Mammogram not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3014F *with* 8P: Screening mammography results were not documented and reviewed, reason not otherwise specified

RATIONALE:
Breast cancer ranks as the second leading cause of cancer-related death in women, accounting for nearly 40,000 estimated deaths in 2011 (American Cancer Society, 2011). Deaths from breast cancer have decreased over the years, in part due to early detection using mammography. About 85 percent of breast cancers occur in women who have no family history of breast cancer. Mammography is particularly valuable to the patients, detecting on average about 80-90 percent of breast cancers in women with no symptoms. (BreastCancer.Org, 2012)

CLINICAL RECOMMENDATION STATEMENTS:
The U.S. Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women aged 50-74 years (B recommendation). The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms (C recommendation). (USPSTF, 2009) The Task Force concludes the evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years and older (I statement).

U.S. Preventive Services Task Force (2009)
Grade: B recommendation. The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.
Grade: C recommendation. The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.
Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.
Grade: D recommendation. The USPSTF recommends against teaching breast self-examination (BSE).
Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.
Grade: I Statement. The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.

♦ Measure #113 (NQF 0034): Colorectal Cancer Screening

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 50 through 75 years of age who had appropriate screening for colorectal cancer

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients 51 through 75 years of age with a visit during the measurement period

> *DENOMINATOR NOTE: The age ranges for the description (50 – 75), and the denominator (51 – 75) are different due to the clinical guidelines supporting the three different screening approaches that state adults 50 years and older should be screened. The measure has a denominator of 51 to capture all adults at least 50 years of age and older who may have had a screening. For example, a patient who turns 51 in July of the measurement period was 50 when they had the appropriate screening in February; therefore, those patients who are 50 are included in the description.*
>
> Denominator Criteria (Eligible Cases):
> Patients 51 through 75 years of age on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, G0402

NUMERATOR:
Patients who had at least one or more screenings for colorectal cancer during or prior to the measurement period. Appropriate screenings are defined by any one of the following criteria below:
- Fecal occult blood test (FOBT) during the measurement period
- Flexible sigmoidoscopy during the measurement period or the four years prior to the measurement period

- Colonoscopy during the measurement period or the nine years prior to the measurement period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Colorectal Cancer Screening
CPT II 3017F: Colorectal cancer screening results documented and reviewed

OR

Colorectal Cancer Screening not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 3017F to report documented circumstances that appropriately exclude patients from the denominator.
3017F *with* 1P: Documentation of medical reason(s) for not performing a colorectal cancer screening (ie, diagnosis of colorectal cancer or total colectomy)

OR

Colorectal Cancer Screening not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3017F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3017F *with* 8P: Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

RATIONALE:
An estimated 142,570 men and women were diagnosed with colon cancer in 2010. In the same year, 51,370 were estimated to have died from the disease, making colorectal cancer the third leading cause of cancer death in the United States (American Cancer Society 2010).

Screening for colorectal cancer is extremely important as there are no signs or symptoms of the cancer in the early stages. If the disease is caught in its earliest stages, it has a five-year survival rate of 91%; however, the disease is often not caught this early. While screening is extremely effective in detecting colorectal cancer, it remains underutilized (American Cancer Society 2010).11

Fecal occult blood tests, colonoscopy, and flexible sigmoidoscopy are shown to be effective screening methods (United States Preventive Services Task Force, 2008). Colorectal screening of individuals with no symptoms can identify polyps whose removal can prevent more than 90% of colorectal cancers (Rozen, 2004).

Studies have shown that the cost-effectiveness of colorectal cancer screening is $40,000 per life year gained, which is similar to the cost-effectiveness of mammography for breast cancer screening (Hawk and Levin 2005).

CLINICAL RECOMMENDATION STATEMENTS:
The United States Preventive Services Task Force (2008):
[1] The USPSTF recommends screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy in adults, beginning at age 50 years and continuing until age 75 years (A recommendation).

[2] The USPSTF concludes that the evidence is insufficient to assess the benefits and harms of computed tomographic (CT) colonography and fecal DNA testing as screening modalities for colorectal cancer (I statement).

The American Cancer Society, The American College of Radiology, and the U.S. Multi-Society Task Force on Colorectal Cancer (Levin et al. 2008):

Tests that Detect Adenomatous Polyps and Cancer
[1] Colonoscopy (every 10 yrs)
[2] Flexible sigmoidoscopy (every 5 yrs)
[3] fecal occult blood tests (fecal occult blood test (FOBT))
[4] Double contrast barium enema (DCBE) (every 5 yrs)
[5] Computed tomographic colonography (CTC) (every 5 years)

Tests that Primarily Detect Cancer:
[1] guaiac fecal occult blood test (gFOBT) with high sensitivity for cancer (annually)
[2] fecal immunochemical test (FIT) with high sensitivity for cancer (annually)
[3] stool DNA (sDNA) with high sensitivity for cancer (interval uncertain)

Modalities not approved:
[1] Single digital rectal examination fecal occult blood test (FOBT) has a poor sensitivity for CRC and should not be performed as a primary screening method
[2] Studies evaluating virtual colonoscopy and fecal DNA testing for CRC screening have yielded conflicting results and therefore cannot be recommended

♦ Measure #116 (NQF 0058): Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of adults 18 through 64 years of age with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription on or 3 days after the episode

INSTRUCTIONS:
This measure is to be reported at each occurrence of acute bronchitis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 through 64 years of age with an outpatient or emergency department (ED) visit with a diagnosis of acute bronchitis during the measurement period

DENOMINATOR NOTE: To determine eligibility, look for any of the listed antibiotic drugs below in the 30 days prior to the visit with the acute bronchitis diagnosis. As long as there are no prescriptions for the listed antibiotics during this time period, the patient is eligible for denominator inclusion.

Denominator Criteria (Eligible Cases):
Patients 18 through 64 years of age on date of encounter
AND
Diagnosis for acute bronchitis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 466.0
Diagnosis for acute bronchitis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J20.0, J20.1, J20.2, J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99281, 99282, 99283, 99284, 99285, G0402

Antibiotic Medications

Description	Prescription		
Aminoglycosides	Amikacin Gentamicin	Kanamycin Streptomycin	Tobramycin
Aminopenicillins	Amoxicillin	Ampicillin	
Antipseudomonal penicillins	Piperacillin		
Beta-lactamase inhibitors	Amoxicillin-clavulanate Ampicillin-sulbactam	Piperacillin-tazobactam	Ticarcillin-clavulanate
First-generation cephalosporins	Cefadroxil	Cefazolin	Cephalexin

Fourth-generation cephalosporins	Cefepime		
Ketolides	Telithromycin		
Lincomycin derivatives	Clindamycin	Lincomycin	
Macrolides	Azithromycin Clarithromycin	Erythromycin Erythromycin ethylsuccinate	Erythromycin lactobionate Erythromycin stearate
Miscellaneous antibiotics	Aztreonam Chloramphenicol Dalfopristin-quinupristin	Daptomycin Erythromycin-sulfisoxazole Linezolid	Metronidazole Vancomycin
Natural penicillins	Penicillin G benzathine-procaine Penicillin G potassium	Penicillin G procaine Penicillin G sodium	Penicillin V potassium Penicillin G benzathine
Penicillinase resistant penicillins	Dicloxacillin	Nafcillin	Oxacillin
Quinolones	Ciprofloxacin Gemifloxacin	Levofloxacin Moxifloxacin	Norfloxacin Ofloxacin
Rifamycin derivatives	Rifampin		
Second generation cephalosporin	Cefaclor Cefotetan	Cefoxitin Cefprozil	Cefuroxime
Sulfonamides	Sulfadiazine	Sulfisoxazole	Sulfamethoxazole-trimethoprim
Tetracyclines	Doxycycline	Minocycline	Tetracycline
Third generation cephalosporins	Cefdinir Cefditoren Cefixime	Cefotaxime Cefpodoxime Ceftazidime	Ceftibuten Ceftriaxone
Urinary anti-infectives	Fosfomycin Nitrofurantoin Nitrofurantoin macrocrystals	Nitrofurantoin macrocrystals-monohydrate Trimethoprim	

NUMERATOR:
Patients who were not prescribed or dispensed antibiotics on or within 3 days of the initial date of service

Numerator Instructions: For performance, the measure will be calculated as the number of patient encounters where antibiotics were neither prescribed nor dispensed on or within 3 days of the episode for acute bronchitis over the total number of encounters in the denominator (patients aged 18 through 64 years with an outpatient or ED visit for acute bronchitis). A higher score indicates appropriate treatment of patients with acute bronchitis (e.g., the proportion for whom antibiotics *were not* prescribed or dispensed on or three days after the encounter).

Numerator Options:
Antibiotic neither prescribed nor dispensed (4124F)

OR

Documentation of medical reason(s) for prescribing or dispensing antibiotic (eg intestinal infection, pertussis, bacterial infection, Lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis/ mastoiditis/bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia, gonococcal infections/venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis/UTI, acne, HIV disease/asymptomatic HIV, cystic fibrosis, disorders of the immune system, malignancy neoplasms, chronic bronchitis, emphysema, bronchiectasis, extrinsic allergic alveolitis, chronic

airway obstruction, chronic obstructive asthma, pneumoconiosis and other lung disease due to external agents, other diseases of the respiratory system, and tuberculosis) (4120F *with* 1P)

OR

Antibiotic prescribed or dispensed (4120F)

RATIONALE:

Antibiotics are commonly misused and overused for a number of viral respiratory conditions where antibiotic treatment is not clinically indicated. (Scott J.G., D. Cohen, B. Dicicco-Bloom, 2001) About 80 percent of antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines. In adults, antibiotics are most often (65–80 percent) prescribed for acute bronchitis, despite its viral origin. The misuse and overuse of antibiotics contributes to antibiotic drug resistance, which is of public health concern due to the diminished efficacy of antibiotics against bacterial infections, particularly in sick patients and the elderly. (Austin D.J., K.G. Kristinsson, R.M. Anderson, 1999, Patterson, JE, 2001, Cohen ML, 1992, Lipsitch M, 2001)

A HEDIS measure that highlights inappropriate antibiotic prescribing in adults for a common respiratory condition will help to raise awareness among clinicians and patients about inappropriate antibiotic use. Antibiotics are most often inappropriately prescribed in adults with acute bronchitis. This measure builds on an existing HEDIS measure targeting inappropriate antibiotic prescribing for children with upper respiratory infection (common cold), where antibiotics are also most often inappropriately prescribed. (Chandran R., 2001, Gonzales R., J.F. Steiner, et al, 1999)

CLINICAL RECOMMENDATION STATEMENTS:

Clinical guidelines do not support antibiotic treatment of otherwise healthy adults with acute bronchitis due to the viral origin of acute bronchitis. Patients with chronic bronchitis, COPD or other chronic comorbidity may be treated with antibiotics and are therefore excluded from the measure denominator. (Gonzales R., D.C. Malone, J.H. Maselli, et al, 2001)

♦ Measure #117 (NQF 0055): Diabetes: Eye Exam

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
77Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329,

E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

AND

Patient encounter during the reporting period (CPT or HCPCS): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439

NUMERATOR:

Patients who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement period. For retinal or dilated eye exams performed 12 months prior to the measurement period, an automated result must be available.

Definition:

Automated Result – Electronic system-based data that includes results generated from test or procedures. For administrative data collection automated/electronic results are necessary in order to show that the exam during the 12 months prior was negative for retinopathy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Retinal or Dilated Eye Exam Performed by an Eye Care Professional

CPT II 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed

OR

CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed

OR

CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

OR

CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)*

*Note: This code can only be used if the claim/encounter was during the measurement period because it indicates that the patient had “no evidence of retinopathy in the prior year”. This code definition indicates results were negative; therefore an automated result is not required.

OR

Retinal or Dilated Eye Exam not Performed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 2022F or 2024F or 2026F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

CPT II 2022F or 2024F or 2026F *with* 8P: Dilated eye exam was not performed, reason not otherwise specified

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including glaucoma and blindness. Diabetic retinopathy is the most common

diabetic eye disease and causes 21,000–24,000 new cases of blindness annually. The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilated and comprehensive eye exam soon after diagnosis. Guidelines also recommend consultation with an ophthalmologist for treatment options if a patient has any level of macular edema or diabetic retinopathy (proliferative and nonproliferative). (American Diabetes Association 2009)

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (ADA) (2009):

• Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B recommendation)
• Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B recommendation)
• Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2–3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B recommendation)
• Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. (B recommendation)
• Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B recommendation)
• Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A recommendation)
• Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A recommendation)
• The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A recommendation)

American Geriatric Society (AGS) (Brown et al. 2003): The older adult who has new-onset DM should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training. (Level I, Grade B)

➤ Measure #118 (NQF 0066): Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic Dysfunction (LVEF < 40%)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for **all** patients with CAD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding. Only patients who had at least two denominator eligible visits during the reporting period will be counted for Reporting Criteria 1 and 2 of this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, quality-data code (Reporting Criteria 1), and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. It is expected that a single performance rate will be calculated for this measure.

There are two reporting criteria for this measure:
(1) Patients who are 18 years and older with a diagnosis of CAD with LVEF < 40%

OR

(2) Patients who are 18 years and older with a diagnosis of CAD who have diabetes

> The eligible professional should submit data on one of the reporting criteria, depending on the clinical findings. If the patient has CAD and LVSD (without a diagnosis of Diabetes), use Denominator Reporting Criteria 1. If the patient has CAD and Diabetes, use Denominator Reporting Criteria 2. If the patient has both diabetes and LVSD, the eligible professional may report quality data for Reporting Criteria 2 and this will count as appropriate reporting for this patient.

REPORTING CRITERIA 1: All patients with a diagnosis of CAD with LVEF < 40% (without a diagnosis of diabetes)

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a current or prior LVEF < 40%

> *DENOMINATOR NOTE: LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction.*
>
> Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease(ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.3, I21.4, I22.0, I22.1, I22.2, I21.29, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits
AND
Left Ventricular Ejection Fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function: G8934

NUMERATOR (REPORTING CRITERIA 1):
Patients who were prescribed ACE inhibitor or ARB therapy

Definition:
Prescribed – May include prescription given to the patient for ACE inhibitor or ARB therapy at one or more visits in the measurement period OR patient already taking ACE inhibitor or ARB therapy as documented in current medication list.

Numerator Options:
Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (G8935)

OR

Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (G8936)

OR

Clinician did not prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not given (G8937)

OR

REPORTING CRITERIA 2: All patients with a diagnosis of CAD who have diabetes

DENOMINATOR (REPORTING CRITERIA 2):
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes

DENOMINATOR NOTE: If a patient has both diabetes and LVSD, reporting criteria #2 will count as appropriate reporting for this patient.

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82

Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

AND

Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

AND

Two Denominator Eligible Visits

NUMERATOR (REPORTING CRITERIA 2):

Patients who were prescribed ACE inhibitor or ARB therapy

Definition:

Prescribed – May include prescription given to the patient for ACE inhibitor or ARB therapy at one or more visits in the measurement period OR patient already taking ACE inhibitor or ARB therapy as documented in current medication list.

Numerator Options:

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed (G8473)

OR

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed for reasons documented by the clinician (G8474)

OR

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy not prescribed, reason not given (G8475)

RATIONALE:
Nonadherence to cardioprotective medications is prevalent among outpatients with coronary artery disease and can be associated with a broad range of adverse outcomes, including all-cause and cardiovascular mortality, cardiovascular hospitalizations, and the need for revascularization procedures.

In the absence of contraindications, ACE inhibitors or ARBs are recommended for all patients with a diagnosis of coronary artery disease and diabetes or reduced left ventricular systolic function. ACE inhibitors remain the first choice, but ARBs can now be considered a reasonable alternative. Both pharmacologic agents have been shown to decrease the risk of death, myocardial infarction, and stroke. Additional benefits of ACE inhibitors include the reduction of diabetic symptoms and complications for patients with diabetes.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

ACE inhibitors should be started and continued indefinitely in all patients with left ventricular ejection fraction less than or equal to 40% and in those with hypertension, diabetes, or chronic kidney disease, unless contraindicated. (Class I Recommendation, Level A Evidence). (ACC/AHA, 2007)

Angiotensin receptor blockers are recommended for patients who have hypertension, have indicators for but are intolerant of ACE inhibitors, have heart failure, or have had a myocardial infarction with left ventricular ejection fraction less than or equal to 40% (Class I Recommendation, Level A Evidence). (ACC/AHA, 2007)

♦ Measure #119 (NQF 0062): Diabetes: Medical Attention for Nephropathy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with diabetes mellitus seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR quality-data code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged 18 years through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 01/01/2014-09/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630,

E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211,99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439

NUMERATOR:

Patients with a screening for nephropathy or evidence of nephropathy during the measurement period

Numerator Instructions: This measure is looking for a nephropathy screening test or evidence of nephropathy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Nephropathy Screening Performed

CPT II 3060F: Positive microalbuminuria test result documented and reviewed

OR

CPT II 3061F: Negative microalbuminuria test result documented and reviewed

OR

CPT II 3062F: Positive macroalbuminuria test result documented and reviewed

OR

CPT II 3066F: Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)

OR

G8506: Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

OR

Nephropathy Screening not Performed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 3060F or 3061F or 3062F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3060F or 3061F or 3062F *with* 8P: Nephropathy screening was not performed, reason not otherwise specified

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin (National Institute of Diabetes and Digestive and Kidney Diseases 2011). It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death (National Institute of Diabetes and Digestive and Kidney Diseases 2011). Diabetes may cause life-threatening, life-ending or life-altering complications, including end-stage kidney disease. Diabetes is the primary cause of kidney failure, accounting for 44 percent of newly diagnosed cases in 2005 (National Institute of Diabetes and Digestive and Kidney Diseases 2011). Clinical guidelines recommend regular testing to evaluate urine albumin excretions and serum creatinine and the estimated glomerular filtration rate derived from serum creatinine, in addition to comparing measurements when screening for chronic kidney disease (American Diabetes Association 2009; American Association of Clinical Endocrinologists 2007).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2009):

- Perform an annual test to assess urine albumin excretion in type 1 diabetic patients with diabetes duration of >=5 years and in all type 2 diabetic patients, starting at diagnosis. (Level of Evidence E)
- Measure serum creatinine at least annually in all adults with diabetes regardless of the degree of urine albumin excretion. The serum creatinine should be used to estimate GFR and stage the level of chronic kidney disease (CKD), if present. (Level of Evidence E)
- In the treatment of the nonpregnant patient with micro- or macroalbuminuria, either ACE inhibitors or ARBs should be used. (Level of Evidence A)

American Association of Clinical Endocrinologists (2007): Screen all patients with diabetes mellitus for chronic kidney disease annually; screening should begin 5 years after diagnosis in patients with Type 1 diabetes mellitus (T1DM) and at the time of diagnosis in patients with Type 2 diabetes mellitus (T2DM). Testing includes:
- Measurement of albumin-to-creatinine ratio in a spot urine specimen and measurement of the estimated glomerular filtration rate derived from serum creatinine
- The following are diagnostic criteria for chronic kidney disease:
. Estimated glomerular filtration rate <60 mL/min/1.73 m2 or albumin-to-creatinine ratio >=30 mg albumin/g creatinine
. Microalbuminuria >=30 mg albumin/g creatinine
. Macroalbuminuria >=300 mg albumin/g creatinine (Grade A)
. Prescribe an angiotensin-converting enzyme inhibitor or an angiotensin receptor blocker in the antihypertensive regimen in the absence of contraindications. (Grade A)

California Healthcare Foundation/American Geriatrics Society (2003): A test for the presence of microalbumin should be performed at diagnosis in patients with type 2 diabetes mellitus. After the initial screening and in the absence of previously demonstrated macro- or microalbuminuria, a test for the presence of microalbumin should be performed annually. (Level III, Grade A)

▲Measure #121 (NQF 1668): Adult Kidney Disease: Laboratory Testing (Lipid Profile)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) who had a fasting lipid profile performed at least once within a 12-month period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving RRT) seen during the reporting period. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of CKD (stage 3, 4, or 5, not receiving RRT)

Definition:
RRT (Renal Replacement Therapy) - For the purposes of this measure, RRT includes hemodialysis, peritoneal dialysis, and kidney transplantation.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 3, 4, or 5 CKD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.3, 585.4, 585.5
Diagnosis for stage 3, 4, or 5 CKD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.3, N18.4, N18.5
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who had a fasting lipid profile performed at least once within a 12-month period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Fasting Lipid Profile Performed
G8725: Fasting lipid profile performed (Triglycerides, LDL-C, HDL-C, and Total Cholesterol)

OR

Fasting Lipid Profile not Performed, for Documented Reason
G8726: Clinician has documented reason for not performing fasting lipid profile (e.g., patient declined, other patient reasons)

OR

Fasting Lipid Profile not Performed, Reason not Given
G8728: Fasting lipid profile not performed, reason not given

RATIONALE:
The principal reason to evaluate dyslipidemias in patients with CKD is to detect abnormalities that may be treated to reduce the incidence of ACVD. A number of observational studies have reported that various dyslipidemias are associated with decreased kidney function in the general population and in patients with CKD. (KDOQI)

Many factors influence the prevalence of dyslipidemias in CKD. Changes in proteinuria, GFR, and treatment of CKD may alter lipoprotein levels. Therefore, it is prudent to evaluate dyslipidemias more often than is recommended in the general population. (KDOQI)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.
Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

All adults and adolescents with CKD should be evaluated for dyslipidemias. (Grade B) (KDOQI, 2003)

For adults and adolescents with CKD, the assessment of dyslipidemias should include a complete fasting lipid profile with total cholesterol, LDL, HDL, and triglycerides. (Grade B) (KDOQI, 2003)

If a patient has GFR ≤ 30 ml/min/1.73m2, then s/he should be monitored for dyslipidemias; measurements should include triglycerides, LDL, HDL, and total cholesterol. (B) (RPA, 2002)

▲Measure #122: Adult Kidney Disease: Blood Pressure Management

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving Renal Replacement Therapy [RRT]) and proteinuria with a blood pressure < 130/80 mmHg OR ≥ 130/80 mmHg with a documented plan of care

INSTRUCTIONS:
This measure is to be reported at each visit, indicated within the denominator, for patients with a diagnosis of chronic kidney disease (CKD) (stage 3, 4, or 5, not receiving RRT) seen during the reporting period. It is anticipated that clinicians providing care for patients with CKD will submit this measure.

This measure will be calculated with 3 performance rates:

1) Percentage of patient visits with blood pressure results < 130/80 mmHg
2) Percentage of patient visits with blood pressure results ≥ 130/80 mmHg and plan of care
3) Overall percentage of patient visits with blood pressure results < 130/80 mmHg and ≥ 130/80 mmHg with a documented plan of care

Eligible professionals should continue to report the measure as specified, with no additional steps needed to account for multiple performance rates.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes 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/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code AND/OR CPT Category II code OR the CPT Category II code with the modifier AND quality-data code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of CKD (stage 3, 4, or 5, not receiving RRT) and proteinuria

Definitions:
Proteinuria - > 300 mg of albumin in the urine per 24 hours OR albumin creatinine ratio (ACR) > 300 mcg/mg creatinine OR protein to creatinine ratio > 0.3 mg/mg creatinine.

RRT (Renal Replacement Therapy) - For the purposes of this measure, RRT includes hemodialysis, peritoneal dialysis, and kidney transplantation.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 3, 4, or 5 CKD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.3, 585.4, 585.5
Diagnosis for stage 3, 4, or 5 CKD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.3, N18.4, N18.5
AND
Diagnosis for proteinuria (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 791.0
Diagnosis for proteinuria (ICD-10-CM) [for use 10/01/2014-12/31/2014]: R80.1, R80.8, R80.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patient 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:
Plan of Care - A documented plan of care should include one or more of the following: recheck blood pressure within 90 days; initiate or alter pharmacologic therapy for blood pressure control; initiate or alter non-pharmacologic therapy (lifestyle changes) for blood pressure control; documented review of patient's home blood pressure log which indicates that patient's blood pressure is or is not well controlled.

NUMERATOR 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 quality-data code [G8476] is required on the claim form to submit this numerator option)
G8476: Most recent blood pressure has a systolic measurement of < 130 mmHg and a diastolic measurement of < 80 mmHg

OR

Blood Pressure Plan of Care Documented for Patient Visits with Systolic Blood Pressure ≥ 130 mmHg and/or Diastolic Blood Pressure ≥ 80 mmHg (If either systolic blood pressure is ≥ 130 mmHg OR diastolic blood pressure is ≥ 80 mmHg, patient requires a plan of care):
(One quality-data code & one CPT II code [G8477 & 0513F] are required on the claim form to submit this numerator option)
G8477: Most recent blood pressure has a systolic measurement of ≥ 130 mmHg and/or a diastolic measurement of ≥ 80 mmHg
AND
CPT II 0513F: Elevated blood pressure plan of care documented

OR

Blood Pressure Measurement not Performed, Reason not Given
(One quality-data code [G8478] is required on the claim form to submit this numerator option)

G8478: Blood pressure measurement not performed or documented, reason not given

OR

Elevated Blood Pressure Plan of Care not Documented for Patient Visits with Systolic Blood **Pressure ≥ 130 mmHg and/or Diastolic Blood Pressure ≥ 80 mmHg, Reason not Otherwise Specified**
*(One CPT II code & one quality-data code [*0513F-8P & G8477*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 0513F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0513F *with* 8P: No documentation of elevated blood pressure plan of care, reason not otherwise specified
AND
G8477: Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥ 80 mmHg

RATIONALE:
Accurate measurement in CKD is especially important, because hypertension is more common in CKD, and because JNC 7 identifies CKD as a "compelling indication" for more aggressive antihypertensive therapy because of the higher risk of CVD in CKD than in the general population. (KDOQI)

Target blood pressure in nondiabetic kidney disease should be < 130 < 80 mmHg. (KDOQI)

The requirement for proteinuria in the denominator for these measures is based on growing controversy regarding the appropriateness of prior recommendations for a BP < 130/80 and for the use of ACE inhibition/angiotensin receptor blockade in non-proteinuric kidney disease. (Chang et al, 2010 and Agarwal, 2011)

CLINICAL RECOMMENDATION STATEMENTS:
Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

Blood pressure should be measured at each health encounter (Grade A). (KDOQI, 2004)

If a patient has GFR ≤ 30 ml/min/1.73m^2, then his/her blood pressure should be checked with every clinic visit (Grade A). (RPA, 2002)

If a patient has a GFR ≤ 30 ml/min/1.73m², and if blood pressure is determined to be elevated (systolic > 130 mmHg OR diastolic > 80 mmHg), then s/he should receive intensified antihypertensive therapy (Grade B). (RPA, 2002)

Patients with CKD should be considered in the “highest-risk” group for CVD for implementing recommendations for pharmacological therapy, irrespective of cause of CKD (Grade A). (KDOQI, 2004)

Target blood pressure for CVD risk reduction in CKD and diabetic/nondiabetic kidney disease should be < 130/80 mmHg (Grade B). (KDOQI, 2004)

All antihypertensive agents can be used to lower blood pressure in CKD. Multidrug regimens will be necessary in most patients with CKD to achieve therapeutic goals. Patients with specific causes of kidney disease and CVD will benefit from specific classes of agents. (KDOQI, 2004)

All classes of antihypertensive agents are effective in lowering blood pressure in CKD. Antihypertensive agents should be prescribed as follows, when possible: Preferred agents for CKD should be used first (Grade A); Diuretics should be included in the antihypertensive regimen in most patients (Grade A); Choose additional agents based on cardiovascular disease-specific indications to achieve therapeutic and preventive targets and to avoid side-effects and interactions (Grade B). (KDOQI, 2004)

Lifestyle modifications recommended for CVD risk reduction should be recommended as part of the treatment regimen (Grade B). (KDOQI, 2004)

Elevated blood pressure must be confirmed on repeated visits before characterizing an individual as having hypertension. Blood pressure can be determined by resting blood pressure measurement in the health-care provider's office (casual blood pressure [CBP]), self-measured blood pressure (SMBP), or ambulatory blood pressure monitoring (ABPM). Blood pressure should be measured according to the recommendations for indirect measurement of arterial blood pressure of the American Heart Association and Seventh Report of the Joint National Committee on the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) (Grade A); Patients should be taught to measure and record their blood pressure, whenever possible (Grade C). (KDOQI, 2004)

High blood pressure is both a cause and a complication of chronic kidney disease. As a complication, high blood pressure may develop early during the course of chronic kidney disease and is associated with adverse outcomes—in particular, faster loss of kidney function and development of cardiovascular disease.

- Blood pressure should be closely monitored in all patients with chronic kidney disease.
- Treatment of high blood pressure in chronic kidney disease should include specification of target blood pressure levels, nonpharmacologic therapy, and specific antihypertensive agents for the prevention of progression of kidney disease (Guideline 13) and development of cardiovascular disease (Guideline 15). (KDOQI, 2002)
- Interventions to slow the progression of kidney disease should be considered in all patients with chronic kidney disease.
- Interventions that have been proven to be effective include:
    (1) Strict glucose control in diabetes;
    (2) Strict blood pressure control;
    (3) Angiotensin-converting enzyme inhibition or angiotensin-2 receptor blockade. (KDOQI, 2002)

▲Measure #123 (NQF 1666): Adult Kidney Disease: Patients On Erythropoiesis-Stimulating Agent (ESA) - Hemoglobin Level > 12.0 g/dL

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which a hemoglobin level is measured for patients aged 18 years and older with a diagnosis of advanced chronic kidney disease (CKD) (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]) or End Stage Renal Disease (ESRD) (who are on hemodialysis or peritoneal dialysis) who are also receiving erythropoiesis-stimulating agent (ESA) therapy AND have a hemoglobin level > 12.0 g/dL

INSTRUCTIONS:
This measure is to be reported each calendar month patients are seen with a diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) or ESRD (who are on hemodialysis or peritoneal dialysis) during the reporting period. The most recent quality-data code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with advanced CKD or ESRD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All calendar months during which a hemoglobin level is measured for patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving RRT) or ESRD (who are on hemodialysis or peritoneal dialysis) who are also receiving ESA therapy

Definition:
RRT (Renal Replacement Therapy) - For the purposes of this measure, RRT includes hemodialysis, peritoneal dialysis, and kidney transplantation.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for stage 4 or 5 CKD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.4, 585.5
Diagnosis for stage 4 or 5 CKD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.4, N18.5
OR
Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.6

Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.6
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Calendar months during which patients have a hemoglobin level > 12.0 g/dL

Numerator Instructions: The hemoglobin values used for this measure should be a most recent (last) hemoglobin value recorded for each calendar month.

A lower calculated performance rate for this measure indicates better clinical care or control.

NUMERATOR 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:
Most Recent Hemoglobin level > 12.0 g/dL
(One quality-data code & one CPT II code [G0908 & 4171F] are required on the claim form to submit this numerator option)
G0908: Most recent Hemoglobin (Hgb) level > 12.0 g/dL
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

OR

Hemoglobin Level Measurement not Performed, Reason not Given
(One quality-data code & one CPT II code [G0909 & 4171F] are required on the claim form to submit this numerator option)
G0909: Hemoglobin level measurement not documented, reason not given
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy

OR

Documented Clinical Reason Patient is not Receiving Erythropoiesis-Stimulating Agent (ESA) Therapy, Patient is not Eligible
(One CPT II code [4172F] is required on the claim form to submit this numerator option)
CPT II 4172F: Patient not receiving Erythropoiesis-Stimulating Agents (ESA) therapy

OR

Most Recent Hemoglobin Level ≤ 12.0 g/dL
(One quality-data code & one CPT II code [G0910 & 4171F] are required on the claim form to submit this numerator option)
G0910: Most Recent Hemoglobin Level ≤ 12.0 g/dL
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agents (ESA) therapy11

RATIONALE:
Anemia is a common complication of chronic kidney disease (CKD). The prevalence of anemia varies with the degree of renal impairment in predialysis patients with CKD, but once end-stage kidney failure occurs, all patients are eventually affected. Anemia develops once renal function decreases to < 50% because of a deficiency in endogenous erythropoietin (EPO) production by the kidney, decreased red cell survival, blood losses, and increased

red blood cell destruction once the patient begins dialysis treatment, particularly hemodialysis. Anemia reduces physical capacity, well-being, neurocognitive function, and energy level and worsens quality of life both in predialysis and dialysis patients. Anemia also induces adaptive cardiovascular mechanisms to maintain tissue oxygen supply. This leads to left ventricular hypertrophy, left ventricular dilation, and myocardial ischemia, which are risk factors for cardiovascular disease and death. It is plausible that reversing anemia may reduce this risk. (Strippoli et al, 2004)

In clinical practice for CKD patients, determination of the frequency and size of sequential ESA dose adjustments in relationship to a threshold Hgb or target Hgb level; and an interpretation of previous therapeutic trends and responsiveness to ESA therapy is critical. (KDOQI, 2007)

Improvement in quality of life and avoidance of transfusion are treatment benefits from determining the appropriate hemoglobin level, and there is potential for harm when aiming for high Hgb targets. The potential harms are based on evidence from RCTs suggesting that assignment to Hgb targets greater than 13.0 g/dL may increase the risk of life threatening adverse events. (KDOQI, 2007)

CLINICAL RECOMMENDATION STATEMENTS:
Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

In the opinion of the [KDOQI] Work Group, in dialysis and nondialysis patients with CKD receiving ESA therapy, the selected Hgb target should generally be in the range of 11.0 to 12.0 g/dL. (Clinical Practice RECOMMENDATION) (KDOQI, 2007)

In dialysis and nondialysis patient with CKD receiving ESA therapy, the Hgb target should not be greater than 13.0 g/dL. (Clinical Practice GUIDELINE—MODERATELY STRONG EVIDENCE) (KDOQI, 2007)

♪ Measure #126 (NQF 0417): Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur. Risk catagorization and follow up treatment plan should be done according to the following table:

Risk Categorization System:

Category	Risk Profile	Evaluation Frequency
0	Normal	Annual
1	Peripheral Neuropathy (LOPS)	Semi-annual
2	Neuropathy, deformity, and/or PAD	Quarterly
3	Previous ulcer or amputation	Monthly to quarterly

This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,

E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

AND

Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:

Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities and may include: reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. The components listed are consistent with the neurological assessment recommended by the Task Force of the Foot Care Interest Group of the American Diabetes Association. They generally recommend at least two of the listed tests be performed when evaluating for loss of protective sensation; however the clinician should perform all necessary tests to make the proper evaluation.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Lower Extremity Neurological Exam Performed

G8404: Lower extremity neurological exam performed and documented

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons

G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure

OR

Lower Extremity Neurological Exam not Performed

G8405: Lower extremity neurological exam not performed

RATIONALE:

Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. Other forms of neuropathy may also play a role in foot ulcerations. Motor neuropathy resulting in anterior crural muscle atrophy or intrinsic muscle wasting can lead to foot deformities such as foot drop, equinus, and hammertoes. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:

Recognizing important risk factors and making a logical, treatment-oriented assessment of the diabetic foot requires a consistent and thorough diagnostic approach using a common language. Without such a method, the practitioner is more likely to overlook vital information and to pay inordinate attention to less critical points in the evaluation. A

useful examination will involve identification of key risk factors and assignment into appropriate risk category. Only then can an effective treatment plan be designed and implemented. (ACFAS/ACFAOM Clinical Practice Guidelines)

♪ Measure #127 (NQF 0416): Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9
AND
Patient encounter during the reporting period (CPT): 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97597, 97598, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who were evaluated for proper footwear and sizing at least once within 12 months

Definition:

Evaluation for Proper Footwear – Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device, and counseling on appropriate footwear should be based on risk categorization.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Footwear Evaluation Performed

G8410: Footwear evaluation performed and documented

OR

Footwear Evaluation not Performed for Documented Reasons

G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure

OR

Footwear Evaluation not Performed

G8415: Footwear evaluation was not performed

RATIONALE:
Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Shoe trauma, in concert with loss of protective sensation and concomitant foot deformity, is the leading event precipitating foot ulceration in persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of non-diabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:
The multifactorial etiology of diabetic foot ulcers is evidenced by the numerous pathophysiologic pathways that can potentially lead to this disorder. Among these are two common mechanisms by which foot deformity and neuropathy may induce skin breakdown in persons with diabetes. The first mechanism of injury refers to prolonged low pressure over a bony prominence (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. The other common mechanism of ulceration involves prolonged repetitive moderate stress. (ACFAS/ACFAOM Clinical Practice Guidelines)

♠ Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30
Age 18 – 64 years BMI ≥ 18.5 and < 25

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. *The most recent quality code submitted will be used for performance calculation.* There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided at the time of the qualifying visit and the measure-specific denominator coding. The BMI documented in the medical record may be reported if done in the provider's office/facility or if a BMI is documented within the previous six months in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented within six months of the abnormal BMI. The documented follow-up interventions must be related to the BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters".

Measure Reporting via Claims:
CPT codes or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged >18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447

NUMERATOR:

Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters

Numerator Instructions: An eligible professional or their staff is required to measure both height and weight. Both the height and the weight must be measured within the same six months. Self-reported values cannot be used. The documentation of a follow-up plan must be based on the most recent documented BMI within the previous six months

Definitions:
BMI – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H2) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))

OR

English Units: BMI = Weight (lb) / (Height (in) x Height (in)) x 703

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up may include but is not limited to: documentation education, a referral (e.g., a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.
Not Eligible for BMI Calculation or Follow-Up Plan – A patient is not eligible if one or more of the following reasons are documented:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan 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 Documentedas Normal, No Follow-Up Plan Required
*(One quality-data code [*G8417, G8418 or G8420*] is required on the claim form to submit this numerator option)*
G8420: BMI is documented within normal parameters and no follow-up plan is required
OR
BMI Documented as Above Normal Parameters, AND Follow-Up Documented
G8417: BMI is documented above normal parameters and a follow-up plan is documented
OR
BMI Documented as Below Normal Parameters, AND Follow-Up Documented
G8418: BMI is documented below normal parameters and a follow-up plan is documented

OR

BMI not Documented, Patient not Eligible
*(One quality-data code [*G8422 or G8938*] is required on the claim form to submit this numerator option)*
G8422: BMI not documented, documentation the patient is not eligible for BMI calculation

OR

BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible

G8938: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

OR

BMI not Documented, Reason not Given
(One quality-data code [G8419 or G8421] is required on the claim form to submit this numerator option)
G8421: BMI not documented and no reason is given
OR
BMI Documented Outside of Normal Parameters, Follow-Up Plan not Documented, Reason not Given
G8419: BMI documented outside normal parameters, no follow-up plan documented, no reason given

RATIONALE:

BMI Above Upper Parameters

Obesity continues to be a costly public health concern in the United States. The Centers for Disease Control and Prevention (CDC) reported that in 2009, no state met the Healthy People 2010 obesity target of 15 percent and the self reported overall prevalence of obesity among adults had increased 1.1 percentage points in 2007 to 26.7 percent (2010). Flegal, Carroll, Kit and Ogden (2012) reported the prevalence of BMI-defined obesity in adults is high and continues to exceed 30% in most sex-age groups. In addition to the continued high prevalence rate for adults in general, there has been a significant increase for men and for non-Hispanic black and Mexican American women over the 12-year period from 1999 through 2010 (2012). Moyer (2012) reported: Obesity is associated with such health problems as an increased risk for coronary artery disease, type 2 diabetes, various types of cancer, gallstones and disability. These comorbid medical conditions are associated with higher use of health care services and costs among obese patients (p. 373).

Obesity is also associated with an increased risk of death, particularly in adults younger than age 65 years and has been shown to reduce life expectancy by 6 to 20 years depending on age and race (LeBlanc et al., 2011).

Finkelstein, Trogdon, Cohen and Dietz (2009) found that in 2006, across all payers, per capita medical spending for the obese is $1,429 higher per year, (42 percent) than for someone of normal weight. Using 2008 dollars, this was estimated to be equivalent to $147 billion dollars in medical care costs related to obesity.

In addition to a high prevalence rate of obesity, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012).

BMI Below Normal Parameters

In the National Center for Health Statistics Health E-Stat, Fryer and Ogden reported that poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2010 National Health and Nutrition Examination Survey (NHANE), using measured heights and weights, indicate an estimated 1.7% of U.S. adults are underweight with women more likely to be underweight than men (2012).

Ranhoff, Gjoen and Mowe (2005) recommended using BMI < 23 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

CLINICAL RECOMMENDATION STATEMENTS:

Although multiple clinical recommendations addressing obesity have been developed by professional organizations, societies and associations, two recommendations have been identified which exemplify the intent of the measure and address the numerator and denominator.

The US Preventive Health Services Task Force (USPSTF) recommends screening all adults (aged 18 years and older) for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions. This is a B recommendation (Moyer, 2012)

As cited in Wilkinson et al. (2012), Institute for Clinical Systems Improvement (ICSI) *Preventive Services for Adults, Obesity Screening* (Level II) Recommendation provides the following guidance:

- Record height, weight and calculate body mass index at least annually
- A BMI greater or equal to 30 is defined as obese
- A BMI of 25-29 is defined as overweight
- Intensive intervention for obese individuals, based on BMI, is recommended by the U.S. Preventive Services to help control weight.

♠ Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list ***must*** include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosage, frequency and route of administration

INSTRUCTIONS:
This measure is to be reported each visit during the 12 month reporting period. Eligible professionals meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97110, 97140, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:
Eligible professional attests to documenting, updating or reviewing a patient's current medications using all immediate resources available on the date of encounter. This list ***must*** include ALL prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosages, frequency and route of administration

Definitions:
Current Medications - Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.
Route - Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)
Not Eligible - A patient is not eligible if the following reason is documented:

- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Current Medications Documented
G8427: Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

OR

Current Medications not Documented, Patient not Eligible
G8430: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional

OR

Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given
G8428: Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given

RATIONALE:
In the American Medical Association's (AMA) *Physician's Role in Medication Reconciliation* (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to The Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs of $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million VADEs in 2001 might have been prevented with improved systems of care and better patient education,

yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

In the Institute for Safe Medication Practices, *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists* (2007), the American Pharmaceutical Association identified that Americans spend more than $75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated $20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of $8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005 in the United States, 701,547 patients were treated for ADEs in emergency departments, and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs (AMA, 2007).

The Agency for Healthcare Quality's (AHRQ) The National Healthcare Disparities Report (2008) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows: older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the all the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

CLINICAL RECOMMENDATION STATEMENTS:

The Joint Commission's 2011 National Patient Safety Goals guides providers to maintain and communicate accurate patient medication information guiding elements of performance to obtain and/or update information on the medications the patient is currently taking. The National Quality Forum's 2010 update of the *Safe Practices for Better Healthcare*, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA's published report, *The Physician's Role in Medication Reconciliation*, identified the best practice medication reconciliation team as one that is multidisciplinary and--in all settings of care--will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team's variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as

possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

♠ Measure #131 (NQF 0420): Pain Assessment and Follow-Up

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

INSTRUCTIONS:
This measure is to be reported each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow up plan must be related to the presence of pain, example: "Patient referred to pain management specialist for back pain" or "Return in two weeks for re-assessment of pain".

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439

NUMERATOR:
Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

> *Numerator Note: The standardized tool used to assess the patient's pain must be documented in the medical record (exception; A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity)*
>
> Definitions:

Pain Assessment - Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.
Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).
Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.
Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pain Assessment Documented as Positive AND Follow-Up Plan Documented
*(One quality-data code [*G8730 or G8731*] is required on the claim form to submit this numerator option)*
G8730: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented
OR
Pain Assessment Documented as Negative, No Follow-Up Plan Required
G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required

OR

Pain Assessment NOT Documented Patient not Eligible
*(One quality-data code [*G8442 or G8939*] is required on the claim form to submit this numerator option)*
G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool
OR
Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible
G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible

OR

Pain Assessment not Documented, Reason not Given
*(One quality-data code [*G8732 or G8509*] is required on the claim form to submit this numerator option)*
G8732: No documentation of pain assessment, reason not given
OR
Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given
G8509: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given

RATIONALE:
Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the Affordable Care Act (ACA) of 2010 to improve pain care. The legislation includes:

- Mandating an Institute of Medicine (IOM) conference on pain to address key medical and policy issues affecting the delivery of quality pain care

- Establishing a training program to improve the skills of health care professionals to assess and treat pain
- Enhancing the pain research agenda for the National Institute of Health (NIH)

The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- 76.5 million Americans suffering from pain.
- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at $100 billion annually in healthcare expenses, lost income, and lost productivity– extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings. Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine's (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc.)
- Increase in obesity which is associated with chronic conditions that have painful symptoms
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain
- Surgical patients are at risk for acute and chronic pain
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.

Persistent chronic pain costs $560 to $635 billion in the USA. Additional healthcare costs due to pain range from $261 to $300 billion. Lost productive time amounts to $299 to $334 billion. Productivity is affected by number of days missed, number of annual hours worked and hourly wages (Gaskin, 2012). Stewart et al. (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition: 5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

There are no current estimates of the total cost of poorly controlled pain in today's dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President's Council of Economic Advisors, 2009), the cost of health care due to pain is estimated to be between $261 to $300 billion. The value of lost productivity based on estimates of days of work missed is $11.6 to 12.7 billion, hours of work lost is $95.2 to $96.5 billion and lower wages is $190.6 to $226.3 billion. Total financial cost of pain to society, combining healthcare cost estimates and productivity estimates, ranges from $560 to $635 billion in 2010 dollars (Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research, Appendix C, 2011).

"Medical care, specifically specialty care, rather than primary care, chiropractic care, or physical therapy is responsible for the rising costs of ambulatory care for spine conditions" (Davis 2012).

Chronic pain is defined as persistent pain which can be either continuous or recurrent and of sufficient duration and intensity to adversely affect a patient's well-being, level of function, and quality of life. If the patient has not been previously evaluated, attempt to differentiate between untreated acute pain and ongoing chronic pain. If a patient's pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the course of the chronic pain is warranted. (ICSI, 2011).

Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (The Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003 , Chronic Pain Research Alliance 2011). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012).

CLINICAL RECOMMENDATION STATEMENTS:

Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.

A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors, spiritual and cultural issues are also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2011) *Assessment and Management of Chronic Pain Guideline, Fifth Edition* was chosen because it addresses the key factors of the plan of care, pain assessment, and outcomes. In addition, it is based on a very broad foundation of evidence, and addresses a wide range of clinical conditions.

The Institute for Clinical Systems Improvement (ICSI, 2012) Adult acute and sub-acute low back pain guideline: Provides guidelines for more expedient evaluation, treatment, use of outcome measures and collaboration among healthcare professionals to allow patients to make informed decisions.

Low Back Pain: Clinical Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (Delitto, 2012). Provides evidence to classify musculoskeletal conditions, specify interventions and identify appropriate outcome measures.

"Early physical therapy following a new primary care consultation can decrease risk of subsequent healthcare" (Fritz, 2012) and does not increase healthcare costs or utilization (Fritz, 2013).

♠ Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The follow up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening."

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 12 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 12 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 92557, 92567, 92568, 92625, 92626, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444

NUMERATOR:
Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

> Numerator Instructions: The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record

> Definitions:
> Screening – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.
Examples of depression screening tools include but are not limited to:

- Adolescent Screening Tools (12-17 years)
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- Adult Screening Tools (18 years and older)
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan – Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

Not Eligible – A patient is not eligible if one or more of the following conditions are documented:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Screening for Clinical Depression Documented as Positive, AND Follow-Up Plan Documented
*(One quality-data code [*G8431or G8510*] is required on the claim form to submit this numerator option)*
G8431: Screening for clinical depression is documented as being positive AND a follow-up plan is documented
OR
Screening for Clinical Depression Documented as Negative, Follow-Up Plan not Required
G8510: Screening for clinical depression is documented as negative, a follow-up plan is not required
OR
Screening for Clinical Depression not Documented, Patient not Eligible
*(One quality-data code [*G8433 or G8940*] is required on the claim form to submit this numerator option)*
G8433: Screening for clinical depression not documented, documentation stating the patient is not eligible
OR
Screening for Clinical Depression Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible
G8940: Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible
OR
Screening for Clinical Depression not Documented, Reason not Given
*(One quality-data code [*G8432 or G8511*] is required on the claim form to submit this numerator option)*
G8432: Clinical depression screening not documented, reason not given

OR
Screening for Clinical Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given
G8511: Screening for clinical depression documented as positive, follow-up plan not documented, reason not given

RATIONALE:
The World Health Organization (WHO), as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic black persons had higher rates of depression than non-Hispanic white persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, raters of depression did not vary significantly by poverty status. Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

15–20 percent of adults older than age 65 in the United States have experienced depression (Geriatric Mental Health Foundation, 2008). 7 million adults aged 65 years and older are affected by depression (Steinman, 2007). Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone (Unützer, 2009). People aged 65 years and older accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO) concluded that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. In 2011, Healthy People 2020 recommended routine screening for mental health problems as a part of primary care for both children and adults. (U.S. Department of Health and Human Services, 2011)

Major depressive disorder (MDD) is a debilitating condition that has been increasingly recognized among youth, particularly adolescents. The prevalence of current or recent depression among children is 3% and among adolescents is 6%. The lifetime prevalence of MDD among adolescents may be as high as 20%. Adolescent-onset MDD is associated with an increased risk of death by suicide, suicide attempts, and recurrence of major depression by young adulthood. MDD is also associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood (Williams et al., 2009). Every fifth adolescent may have a history of depression by age 18. The increase in the onset of depression occurs around puberty. According to Gil Zalsman et al., (2006) as reported in Borner et al. (2010), depression ranks among the most commonly reported mental health problems in adolescent girls.

The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include suffering, possible side effects from treatment, fees for mental health and medical visits and medications, time away from work and lost wages, transportation, and reduced quality of personal relationships. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care. In 2000, the United States spent an estimated $83.1 billion in direct and indirect costs of depression (USPSTF, 2009).

CLINICAL RECOMMENDATION STATEMENTS:

Adolescent Recommendation (12-18 years)

The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (AHRQ, 2010, p.141).

Level II Child Preventive Services should be assessed and offered to each patient; as such services have been shown to be effective. Such Level II services include: Screening adolescents ages 12-18 for major depressive disorder when systems are in place for accurate diagnosis, treatment, and follow-up (ICSI, 2010).

Adult Recommendation (18 years and older)

The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (AHRQ, 2010, p.136).

Routine depression screening should be performed for adult patients (including older adults) but only if the practice has staff-assisted "systems in place to ensure that positive results are followed by accurate diagnosis, effective treatment, and careful follow-up" (ICSI, 2010).

* Measure #137 (NQF 0650): Melanoma: Continuity of Care – Recall System

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical skin exam, AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma or a history of melanoma will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma or history of melanoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82
Diagnosis for melanoma or history of melanoma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients whose information is entered, at least once within a 12 month period, into a recall system that includes:

- A target date for the next complete physical exam AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Numerator Instructions: To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due, and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam.

Numerator Options:

Patient information entered into a recall system that includes: target date for the next exam specified AND a process to follow up with patients regarding missed or unscheduled appointments (7010F)

OR

Documentation of system reason(s) for not entering patient's information into a recall system (eg, melanoma being monitored by another physician provider) (7010F *with* 3P)

OR

Recall system not utilized, reason not otherwise specified (7010F *with* 8P)

RATIONALE:

Lack of follow-up with providers noted in the Institute of Medicine (IOM) report on patient errors. Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments in accordance with their individual needs.

CLINICAL RECOMMENDATION STATEMENTS:

Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0, in situ melanoma. Clinicians should educate all patients about post-treatment monthly self-exam of their skin and of their lymph nodes if they had stage 1A to IV melanoma. Specific signs or symptoms are indications for additional radiologic imaging. (NCCN, 2011)

No clear data regarding follow-up interval exists, but at least annual history and physical examination with attention to the skin and lymph nodes is recommended. (AAD, 2011)

Regular clinical follow-up and interval patient self-exam of skin and regional lymph nodes are the most important means of detecting recurrent disease or new primary melanoma; findings from history and physical exam should direct the need for further studies to detect local, regional, and distant metastasis. (AAD, 2011)

* Measure #138 : Melanoma: Coordination of Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patient visits, regardless of age, with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. It is expected that a single performance rate will be calculated for this measure.

There are two reporting criteria for this measure:

1) All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma during excision of malignant lesion

OR

2) All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma evaluated in an outpatient setting

REPORTING CRITERIA 1: All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma during excision of malignant lesion

DENOMINATOR (REPORTING CRITERIA 1)
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for melanoma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND
Patient encounter for excision of malignant melanoma (CPT): 11600, 11601, 11602, 11603, 11604, 11606, 11620, 11621, 11622, 11623, 11624, 11626, 11640, 11641, 11642, 11643, 11644, 11646, 14000, 14001, 14020, 14021, 14040, 14041, 14060, 14061, 14301, 17311, 17313

NUMERATOR (REPORTING CRITERIA 1):

Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Numerator Instructions: A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

Definition:
Communication – Communication may include: documentation in the medical record that the physician(s) treating the melanoma communicated (eg, verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Options:
Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis (5050F)

OR

Documentation of patient reason(s) for not communicating treatment plan to the Primary Care Physician(s) (PCP)(s) (eg, patient asks that treatment plan not be communicated to the physician(s) providing continuing care) (5050F *with* 2P)
OR
Documentation of system reason(s) for not communicating treatment plan to the PCP(s) (eg, patient does not have a primary care physician or referring physician) (5050F *with* 3P)

OR

Treatment plan not communicated, reason not otherwise specified (5050F *with* 8P)

OR

REPORTING CRITERIA 2: All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma evaluated in an outpatient setting

DENOMINATOR: (REPORTING CRITERIA 2)
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

Denominator Criteria (Eligible Cases):
Diagnosis for melanoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for melanoma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR (REPORTING CRITERIA 2):
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Numerator Instructions: A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

Definition:

Communication – Communication may include: documentation in the medical record that the physician(s) treating the melanoma communicated (eg, verbally, by letter, copy of treatment plan sent) with the physician(s) providing the continuing care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for melanoma.

Numerator Options:

Treatment plan communicated to provider(s) managing continuing care within 1 month of diagnosis (5050F)

OR

Documentation of patient reason(s) for not communicating treatment plan to the Primary Care Physician(s) (PCP)(s) (eg, patient asks that treatment plan not be communicated to the physician(s) providing continuing care) (5050F *with* 2P)

OR

Documentation of system reason(s) for not communicating treatment plan to the PCP(s) (eg, patient does not have a primary care physician or referring physician) (5050F *with* 3P)

OR

Treatment plan not communicated, reason not otherwise specified (5050F *with* 8P)

RATIONALE:

Perceived lack of follow-up with primary care providers which is reinforced in the Institute of Medicine (IOM) report on patient errors. The intention of this measure is to enable the primary care provider to support, facilitate, and coordinate the care of the patient.

CLINICAL RECOMMENDATION STATEMENTS:

Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and caregivers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and caregivers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.
- Collect data for network-wide audit. (NICE, 2006)

Communication and information exchange between the medical home and the receiving provider should occur in an amount of time that will allow the receiving provider to effectively treat the patient. This communication and information exchange should ideally occur whenever patients are at a transition of care; eg, at discharge from the inpatient setting. The timeliness of this communication should be consistent with the patient´s clinical presentation and, in the case of a patient being discharged, the urgency of the follow-up required. Communication and information exchange between the MD and other physicians may be in the form of a call, voicemail, fax or other secure, private, and accessible means including mutual access to an EHR.

The TOCCC proposed a minimal set of data elements that should always be part of the transition record and be part of any initial implementation of this standard. That list includes the following:

- Principle diagnosis and problem list
- Medication list (reconciliation) including over the counter/ herbals, allergies and drug interactions
- Clearly identifies the medical home/transferring coordinating physician/institution and their contact information
- Patient's cognitive status
- Test results/pending results

The TOCCC recommended the following additional elements that should be included in an "ideal transition record" in addition to the above:

- Emergency plan and contact number and person
- Treatment and diagnostic plan
- Prognosis and goals of care
- Advance directives, power of attorney, consent
- Planned interventions, durable medical equipment, wound care, etc.
- Assessment of caregiver status
- Patients and/or their family/caregivers must receive, understand and be encouraged to participate in the development of their transition record which should take into consideration the patient's health literacy, insurance status and be culturally sensitive. (ACP, SGIMSHM, AGS, ACEP, SAEM, 2009) (Consensus Policy Statement)

*Measure #140 (NQF 0566): Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for AMD patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with AMD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis code, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 50 years and older with a diagnosis of AMD

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 50 years on date of encounter
> AND
> Diagnosis for AMD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.50, 362.51, 362.52
> Diagnosis for AMD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: H35.30, H35.31, H35.32
> AND
> Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients with AMD or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD

> Definition:

Counseling – Documentation in the medical record should include a discussion of risk or benefits of the AREDS formulation. Counseling can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, patients who are smokers (beta-carotene can increase the risk for cancer in these patients) or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given the purported risks associated with antioxidant use, patients would be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate patients about overuse as well as appropriate use.

NUMERATOR NOTE: If patient is already receiving AREDS formulation, the assumption is that counseling about AREDS has already been performed.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
AREDS Counseling Performed
CPT II 4177F: Counseling about the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of age-related macular degeneration (AMD) provided to patient and/or caregiver(s)

OR

AREDS Counseling not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4177F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4177F *with* 8P: AREDS counseling not performed, reason not otherwise specified

RATIONALE:
1. Scientific basis for counseling regarding use of AREDS formulation for patients with AMD

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

At the same time, published meta-analyses have raised an issue as to the presence of an elevated mortality risk among patients taking elements similar to parts of the AREDS formulation (and elevated risk among smokers). As such, patients need to know of their individualized risk profile for taking the AREDS formula AND the potential benefits, so that they can make their OWN individual decision as to whether or not to take the AREDS formulation.

This indicator thus seeks to directly enhance the provider-patient relationship to apply the results of level 1 randomized controlled trials (RCTs) in a manner that accommodates the needs of each individual patient in a patient-centered manner, rather than a paternalistic approach of either recommending or withholding treatment.

2. Evidence of gap in care.

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

CLINICAL RECOMMENDATION STATEMENTS:
Patients with intermediate AMD or advanced AMD in one eye should be counseled on the use of antioxidant vitamin and mineral supplements as recommended in the Age-related Eye Disease Study (AREDS) reports. (A:I) (AAO, 2008)

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 (NQF 0563): Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for glaucoma patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with POAG will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis code, CPT codes, and the appropriate CPT Category II code(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 claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of POAG

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 365.10, 365.11, 365.12, 365.15
Diagnosis for primary open-angle glaucoma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.151, H40.152, H40.153, H40.159
AND

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months

Definitions:
Plan of Care – May include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist.
Plan to Recheck – In the event certain factors do not allow for the IOP to be measured (eg, patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported.
Glaucoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

NUMERATOR NOTE: *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Intraocular Pressure (IOP) Reduced Greater than or Equal to 15% Pre-Intervention Level
(One CPT II code [3284F] is required on the claim form to submit this numerator option)
CPT II 3284F: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Reduced Less than 15% Pre-Intervention Level with Plan of Care
(Two CPT II codes [0517F & 3285F] are required on the claim form to submit this numerator option)
CPT II 0517F: Glaucoma plan of care documented
AND
CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Glaucoma Plan of Care not Documented, Reason not Otherwise Specified
(Two CPT II codes [0517F-8P & 3285F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 0517F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0517F *with* 8P: Glaucoma plan of care not documented, reason not otherwise specified
AND
CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Measurement not Documented, Reason not Otherwise Specified
(One CPT II code [3284F-8P] is required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3284F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3284F *with* 8P: IOP measurement not documented, reason not otherwise specified

RATIONALE:

1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate)
Analyses of results of several randomized clinical trials all demonstrate that reduction of IOP of at least 18% (EMGT, CIGTS, AGIS, CNTGS) reduces the rate of worsening of visual fields by at least 40%. The various studies, however, achieved different levels of mean IOP lowering in realizing their benefit in patient outcomes, ranging from 18% in the "normal pressure" subpopulation of EMGT to 42% in the CIGTS study. (Level I studies) As such, an appropriate "failure" indicator is to NOT achieve at least a 15% IOP reduction. The rationales for a failure indicator are that 1) the results of different studies can lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) to minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary from 18 to 40+%.

In addition, "…several population based studies have demonstrated that the prevalence of POAG as well as the incidence of POAG, increases as the level of IOP increases. These studies provide strong evidence that IOP plays an important role in the neuropathy of POAG. Furthermore, studies have demonstrated that reduction in the level of IOP lessens the risk of visual field progression in open-angle glaucoma. In addition, treated eyes that have a greater IOP fluctuation are at increased risk of progression.

Intraocular pressure is the intermediate outcome of therapy used by the FDA for approval of new drugs and devices and, as noted above, has been shown to be directly related to ultimate patient outcomes of vision loss. As such, failure to achieve minimal pressure lowering, absent an appropriate plan of care to address the situation, would constitute performance whose improvement would directly benefit patients with POAG.

2. Evidence for gap in care
Based on studies in the literature reviewing documentation of IOP achieved under care, the gap could be as great as 50% or more in the community of ophthalmologists and optometrists treating patients with primary open-angle glaucoma. Based on loose criteria for control, IOP was controlled in 66% of follow-up visits for patients with mild glaucoma and 52% of visits for patients with moderate to severe glaucoma. Another study of a single comprehensive insurance plan suggested that a large proportion of individuals felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than expected from recommendations of published guidelines.

CLINICAL RECOMMENDATION STATEMENTS:

When initiating therapy, the ophthalmologist assumes that the measured pretreatment pressure range contributed to optic nerve damage and is likely to cause additional damage in the future. Lowering the pretreatment IOP by 25% or more has been shown to inhibit progression of POAG. (A:II) (AAO, 2010)

Choosing an even lower target IOP can be justified if there is more severe optic nerve damage, if the damage is progressing rapidly, or if other risk factors such as family history, age, or disc hemorrhages are present.

Please note that the American Optometric Association's (AOA) 2002 guideline on Open-angle Glaucoma was not reviewed during the development of this measure prior to the public comment period and therefore is not presented here verbatim. Review of the AOA guideline subsequent to initial measure development indicates that the recommendations in the AOA guideline are consistent with the intent of the measure. This also applies to the 2010 guidelines. As such, the intent of this measure is to have this indicator apply to both optometrists and ophthalmologists (and any other physician who provides glaucoma care); the use of "ophthalmologists" only in the preceding verbatim section reflects the wording in the American Academy of Ophthalmology Preferred Practice pattern.

▲Measure #142 (NQF 0051): Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for patients aged 21 years and older with a diagnosis of osteoarthritis (OA) with an assessment for use of anti-inflammatory or analgesic over-the-counter (OTC) medications

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for OA patients seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis code, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits for patients aged 21 years and older with a diagnosis of OA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 21 years on date of encounter
AND
Diagnosis for osteoarthritis (OA) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
Diagnosis for osteoarthritis (OA) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.10, M16.11, M16.12, M16.2, M16.30, M16.31, M16.32, M16.4, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.10, M18.11, M18.12, M18.2, M18.30, M18.31, M18.32, M18.4, M18.50, M18.51, M18.52, M18.9, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.111, M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142, M19.149, M19.171, M19.172, M19.179, M19.211, M19.212, M19.219, M19.221, M19.222, M19.229, M19.231,

M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.90, M19.91, M19.92, M19.93

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented

Definition:

Assessment - May include: documentation of current medications, continue same medications, change in medication dose, documentation indicating that the patient was asked about OTC medication use.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Assessment for Anti-Inflammatory or Analgesic OTC Medications Performed

CPT II 1007F: Use of anti-inflammatory or analgesic over-the-counter (OTC) medications for symptom relief assessed

OR

Assessment for Anti-Inflammatory or Analgesic OTC Medications not Performed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1007F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1007F *with* 8P: Use of anti-inflammatory or analgesic OTC medications not assessed, reason not otherwise specified

RATIONALE:

Treatment goals for OA are to reduce pain, maintain or improve joint mobility, and limit functional impairment. Use of anti-inflammatory and analgesics has a documented role in these goals. Assessment of current medication use is a precursor to appropriate pharmacologic therapy.

CLINICAL RECOMMENDATION STATEMENTS:

Initial treatment should include activity modification and trial of analgesic or non-steroidal anti-inflammatory medication (NSAID). (AAOS, A Recommendation)

Acetaminophen has been shown to be as effective a pain reliever as NSAIDs in patients with OA of the knee. (AAOS, A Recommendation)

▲Measure #143 (NQF0384): Oncology: Medical and Radiation – Pain Intensity Quantified

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

This is a two-part measure which is paired with Measure #144: Oncology: Medical and Radiation: Plan of Care for Pain. If pain is present, Measure #144 *should* also be reported.

DESCRIPTION:
Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the measurement period for patients with a diagnosis of cancer who are seen during the measurement period. It is anticipated that clinicians providing care for patients with cancer will submit this measure.

For patients receiving radiation therapy, pain intensity should be quantified at each radiation treatment management encounter. For patients receiving chemotherapy, pain intensity should be quantified at each face-to-face encounter with the physician while the patient is receiving treatment. For purposes of calculating this measure, eligible encounters for patients receiving chemotherapy will include those encounters where the patient has been administered chemotherapy within 30 days prior to the encounter and also been administered chemotherapy within 30 days after the date of the encounter. For example, at every visit for patients with a diagnosis of cancer who are also receiving chemotherapy or radiation therapy, the patient should have pain intensity quantified.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

Denominator Criteria (Eligible Cases):
Diagnosis for cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22,

173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

Diagnosis for cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6,

C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C44.30, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, 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C81.91, C81.92,

C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8 D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

AND:

Patient encounter during the reporting period (CPT) - Procedure codes: 77427, 77431, 77432, 77435, 77470

OR

Patient encounter during the reporting period (CPT) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Patient encounter during the reporting period (CPT) - Procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549

NUMERATOR:
Patient visits in which pain intensity is quantified

Numerator Instructions: Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale.

Numerator Options:
Pain severity quantified; pain present (1125F)
OR
Pain severity quantified; no pain present (1126F)
OR
Pain severity not documented, reason not otherwise specified (1125F *with* 8P)

RATIONALE:
Inadequate cancer pain management is widely prevalent, harmful to the patient and costly.

CLINICAL RECOMMENDATION STATEMENTS:
This algorithm begins with the premise that all patients with cancer should be screened for pain during the initial evaluation, at regular intervals, and whenever new therapy is initiated. If pain is present on a screening evaluation, the pain intensity must be quantified by the patient (whenever possible). Since pain is inherently subjective, patient's self report to pain is the current standard of care for assessment. Intensity of pain should be quantified using a 0-10 numerical rating scale, a categorical scale, or a pictorial scale (eg, The Faces Pain Rating Scale). The Faces Pain Rating Scale may be successful with patients who have difficulty with other scales, for example, children, the elderly, and patients with language or cultural differences or other communication barriers. (NCCN, 2011)

All patients should be routinely screened for pain, and when it is present, pain intensity should be recorded in highly visible ways that facilitate regular review by health care providers. A standard for pain assessment and documentation should be established in each setting to ensure that pain is recognized, documented, and treated promptly. (APS, 2005)

▲Measure #144 (NQF 0383): Oncology: Medical and Radiation – Plan of Care for Pain

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

This is a two-part measure which is paired with Measure #143: Oncology: Medical and Radiation: Pain Intensity Quantified. This measure *should* be reported if patient reports pain for Measure #143.

DESCRIPTION:
Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of cancer and in which pain is present who are seen during the reporting period. It is anticipated that clinicians providing care for patients with cancer will submit this measure.

Measure Reporting via Registry:
All eligible instances when patient reports pain for Measure #143 make up the denominator for this measure. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

Denominator Criteria (Eligible Cases):
All eligible instances when pain severity quantified; pain present (1125F) is reported in the numerator for Measure #143
AND
Diagnosis for cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8,

183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

Diagnosis for cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31,

C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C44.30, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40,

C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8, D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

AND:

Patient encounter during the reporting period (CPT) - Procedure codes: 77427, 77431, 77432, 77435, 77470

OR

Patient encounter during the reporting period (CPT) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

AND

Patient encounter during the reporting period (CPT) - Procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549

NUMERATOR:
Patient visits that included a documented plan of care to address pain

Numerator Instructions: A documented plan of care may include: use of opioids, non-opioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

Numerator Options:
Plan of care to address pain documented (0521F)

OR

Plan of care for pain not documented, reason not otherwise specified (0521F *with* 8P)

RATIONALE:
Inadequate cancer pain management is widely prevalent, harmful to the patient and costly.

CLINICAL RECOMMENDATION STATEMENTS:
If the Pain Rating Scale score is above 0, a comprehensive pain assessment is initiated. (NCCN, 2011)

For management of cancer related pain in adults, the algorithm distinguishes three levels of pain intensity, based on a 0-10 numerical value obtained using numerical or the pictorial rating scale (with 0 being no pain to 10 being the worst pain). The three levels of pain intensity listed in the algorithm are mild pain (1-3); moderate pain (4-6); and severe pain (7-10). (NCCN, 2011)

The [NCCN] guidelines acknowledge the range of complex decisions faced in caring for these patients. As a result, they provide dosing guidelines for opioids, non-opioid analgesics, and adjuvant analgesics. They also provide specific suggestions for titrating and rotating opioids, escalation of opioid dosage, management of opioid adverse effects, and when and how to proceed to other techniques/interventions for the management of cancer pain. (NCCN, 2011)

Treatment must be individualized based on clinical circumstances and patient wishes, with the goal of maximizing function and quality of life. (NCCN, 2011)

Clinicians must respond to pain reports in a manner appropriate to the type of pain (eg, acute vs. chronic) and setting (eg, inpatient vs. outpatient)… Appropriate responses may not always include more opioids but rather more detailed assessments, use of nonopioid analgesics or techniques, or non-pharmacologic interventions (eg, education, relaxation, and use of heat or cold). (APS, 2005)

❑ Measure #145 (NQF 0510): Radiology: Exposure Time Reported for Procedures Using Fluoroscopy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

INSTRUCTIONS:
This measure is to be reported each time fluoroscopy is performed in a hospital or outpatient setting during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians providing the services for procedures using fluoroscopy will submit this measure.

Measure Reporting via Claims:
CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P-reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for procedures using fluoroscopy

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT or HCPCS): 0075T, 0234T, 0235T, 0238T, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27235, 27244, 27245, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 36147, 36221, 36222, 36223, 36224, 36225, 36226, 36252, 36253, 36254, 36598, 37182, 37183, 37184, 37187, 37188, 37211, 37212, 37213, 37214, 37217, 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37234, 37235, 37236, 37238, 37241, 37242, 37243, 37244, 43260, 43261, 43262, 43263, 43264, 43265, 43275, 43276, 43277, 43278, 43752, 44500, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465, 50382, 50384, 50385, 50386, 50387, 50389, 50590, 61623, 62263, 62264, 62280, 62281, 62282, 63610, 64610, 64620, 70010, 70015, 70170, 70332, 70370, 70371, 70373, 70390, 71023, 71034, 72240, 72255, 72265, 72270, 72275, 72285, 72291, 72295, 73040, 73085, 73115, 73525, 73580, 73615, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74291, 74300, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74430, 74440, 74445, 74450, 74455, 74470, 74475, 74480, 74485, 74740, 74742, 75600, 75605, 75625, 75630, 75658, 75705, 75710, 75716, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75791, 75801, 75803, 75805, 75807, 75809, 75810, 75825, 75827, 75831, 75833, 75840, 75842, 75860, 75870, 75872, 75880, 75885, 75887, 75889, 75891, 75893, 75894, 75896, 75898, 75901, 75902, 75952, 75953, 75954, 75956, 75957, 75958,

75959, 75962, 75966, 75970, 75978, 75980, 75982, 75984, 76000, 76001, 76080, 76120, 76496, 77001, 77002, 77003, 92611, 93565, 93566, 93567, 93568, G0106, G0120, G0278

NUMERATOR:
Final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Radiation Exposure or Exposure Time Documented in Final Procedure Report
CPT II 6045F: Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented

OR

Radiation Exposure or Exposure Time not Documented in Final Procedure Report, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 6045F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
6045F *with* 8P: Final procedure report does not include documentation of radiation exposure or exposure time, reason not otherwise specified

RATIONALE:
Data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation, including procedures using fluoroscopy. (NCI, 2002) The BEIR report concluded that "the linear no-threshold model (LNT) provided the most reasonable description of the relation between low-dose exposure to ionizing radiation and the incidence of solid cancers that are induced by ionizing radiation." (NRC, 2006) In order to monitor these long-term effects, the exposure time or radiation dose that a patient receives as a result of the procedure should be measured and recorded in the patient's record.

CLINICAL RECOMMENDATION STATEMENTS:
It is desirable that radiation dose data be recorded for all fluoroscopy procedures. Direct patient care radiation dose-related information provided by dosimetry systems should be recorded in the patient's medical record. If cumulative air kerma or kerma-area-product data are not available, the fluoroscopic exposure time and the number of images acquired should be recorded in the patient's medical record. (ACR, 2008)

[ACR] should now encourage practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (eg, upper gastrointestinal, pediatric voiding cystourethrography, diagnostic angiography) should then be compared with benchmark figures. More complete patient radiation dose data should be recorded for all high-dose interventional procedures, such as embolizations, transjugular intrahepatic portosystemic shunts, and arterial angioplasty or stent placement anywhere in the abdomen and pelvis. (Amis et al., ACR, 2007)
Measure & record patient radiation dose:
Record fluoroscopy time
Record available measures – DAP (dose area product), cumulative dose, skin dose (NCI, 2005)

❑ Measure #146 (NQF 0508): Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for screening mammograms that are classified as "probably benign"

INSTRUCTIONS:
This measure is to be reported each time a screening mammogram is performed during the reporting period. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for screening mammograms will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.
When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II codes. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for screening mammograms

> Denominator Criteria (Eligible Cases):
> Diagnosis for screening mammogram (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V76.11, V76.12
> Diagnosis for screening mammogram (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z12.31
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 77057, G0202

NUMERATOR:
Final reports classified as "probably benign"

> Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.A lower percentage, with a definitional target approaching 0%, indicates appropriate assessment of screening mammograms. The mammogram assessment category (corresponding CPT Category II 33xxF code for "Other than Probably Benign") to be reported is the single overall final assessment for the mammographic study. Separate breast assessment categories should not be reported for this measure.
>
> Definition:
> "Probably Benign" Classification – Mammography Quality Standards Act (MQSA) assessment category of "probably benign"; BI-RADS® category 3; or Food and Drug Administration (FDA)-approved equivalent assessment category.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Mammogram Assessment Category of "Probably Benign" Documented
CPT II 3343F: Mammogram assessment category of "probably benign", documented

OR

Mammogram Assessment Category Other than "Probably Benign" Documented
(One CPT II code [33xxF] is required on the claim form to submit this numerator option)
CPT II 3340F: Mammogram assessment category of "incomplete: need additional imaging evaluation," documented
OR
CPT II 3341F: Mammogram assessment category of "negative", documented
OR
CPT II 3342F: Mammogram assessment category of "benign", documented
OR
CPT II 3344F: Mammogram assessment category of "suspicious", documented
OR
CPT II 3345F: Mammogram assessment category "highly suggestive of malignancy", documented
OR
CPT II 3350F: Mammogram assessment category of "known biopsy proven malignancy", documented

RATIONALE:
Although a mammogram assessment category of "probably benign" is not recommended for use in interpreting screening mammograms, it is associated with up to 11% of screening mammograms and accounts for over 40%–50% of abnormal screening mammograms. (Yasmeen et al., 2003) 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)

▲Measure #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.) that were performed

INSTRUCTIONS:
This measure is to be reported each time bone scintigraphy is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated clinicians performing the bone scintigraphy study will report on this measure.

Measure Reporting via Claims:
CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All final reports for patients, regardless of age, undergoing bone scintigraphy

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): 78300, 78305, 78306, 78315, 78320

NUMERATOR:
Final reports that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.)

Definition:
Relevant Imaging Studies – Relevant imaging studies are defined as studies that correspond to the same anatomical region in question.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Bone Scintigraphy Report Correlated with Existing Studies
CPT II 3570F: Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) corresponding to the same anatomical region in question

OR

Bone Scintigraphy Report not Correlated for System Reasons

Append a modifier (3P) to CPT Category II code 3570F to report documented circumstances that appropriately exclude patients from the denominator.

3570F *with* 3P: Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (eg, no existing relevant imaging study available, patient did not have a previous relevant imaging study)

Note: Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.

OR

Bone Scintigraphy Report not Correlated, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 3570F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3570F *with* 8P: Bone scintigraphy report not correlated, reason not otherwise specified

RATIONALE:

Radionuclide bone imaging plays an integral part in tumor staging and management; the majority of bone scans are performed in patients with a diagnosis of malignancy, especially carcinoma of the breast, prostate gland, and lung. This modality is extremely sensitive for detecting skeletal abnormalities, and numerous studies have confirmed that it is considerably more sensitive than conventional radiography for this purpose. However, the specificity of bone scan abnormalities can be low since many other conditions may mimic tumor; therefore, it is important that radionuclide bone scans are correlated with available, relevant imaging studies. Existing imaging studies that are available can help inform the diagnosis and treatment for the patient. Furthermore, correlation with existing radiographs is considered essential to insure that benign conditions are not interpreted as tumor. While there are no formal studies on variations in care in how often correlation with existing studies is not performed, there is significant anecdotal information from physicians practicing in the field that there is a gap in care and that correlation is not occurring frequently when images are available.

Literature suggests that as many as 30% of Radiology reports contain errors, regardless of the imaging modality, radiologists' experience, or time spent in interpretation. Evidence has also suggested that Radiology reports are largely non-standardized and commonly incomplete, vague, untimely, and error-prone and may not serve the needs of referring physicians. Therefore, it is imperative that existing imaging reports be correlated with the Nuclear Medicine bone scintigraphy procedure to ensure proper diagnosis and appropriate patient treatment.

CLINICAL RECOMMENDATION STATEMENTS:

Bone scintigraphic abnormalities should be correlated with appropriate physical examination and imaging studies to ascertain that osseous or soft-tissue abnormalities, which might cause cord or other nerve compression or pathologic fracture in an extremity, are not present. (SNM, 2003)

Interpretation criteria

Bone scans are very sensitive for disease, but specificity of findings is low and must be interpreted in light of other information

a. History
b. Physical exam
c. Other test results
d. Comparison with previous studies

(SNM, 2003)

Reporting

1. Description of technique
2. Description of abnormal tracer uptake
3. Correlation with other studies

4. Comparison with previous studies
5. Interpretation
(SNM, 2003)

Comparisons with previous examinations and reports, when possible, should be a part of the imaging consultation and report. Integrated PET/CT studies are more valuable when correlated with previous diagnostic CT, previous PET, previous PET/CT, previous MRI, and all appropriate imaging studies and clinical data that are relevant. (SNM, 2010)

* Measure #154 (NQF: 0101): Falls: Risk Assessment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 *should* also be reported.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older who have a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:
Patients who had a risk assessment for falls completed within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:
Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.
Risk Assessment – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Risk Assessment for Falls Completed
*(Two CPT II codes [*3288F & 1100F*] are required on the claim form to submit this numerator option)*
CPT II 3288F: Falls risk assessment documented
AND
CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

Risk Assessment for Falls not Completed for Medical Reasons
*(Two CPT II codes [*3288F-1P & 1100F*] are required on the claim form to submit this numerator option)*
Append a modifier (1P) to CPT Category II code 3288F to report documented circumstances that appropriately exclude patients from the denominator.
3288F *with* 1P: Documentation of medical reason(s) for not completing a risk assessment for falls (ie, reduced mobility, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair)
AND
CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

If patient is not eligible for this measure because patient has documentation of no falls or only one fall without injury the past year, report:
Patient not at Risk for Falls
*(One CPT II code [*1101F*] is required on the claim form to submit this numerator option)*
CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

OR

If patient is not eligible for this measure because falls status is not documented, report:
Falls Status not Documented
*(One CPT II code [*1101F-8P*] is required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 1101F to report circumstances when the patient is not eligible for the measure.
1101F *with* 8P: No documentation of falls status

OR

Risk Assessment for Falls not Completed, Reason not Otherwise Specified
*(Two CPT II codes [*3288F-8P & 1100F*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 3288F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3288F *with* 8P: Falls risk assessment not completed, reason not otherwise specified
AND
CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

RATIONALE:
Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.

CLINICAL RECOMMENDATION STATEMENTS:
Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C)
Multifactorial assessment may include the following:
- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review (NICE) (Grade C)

A falls risk assessment should be performed for older persons who present for medical attention because of a fall, report recurrent falls in the past year, report difficulties in walking or balance or fear of falling, or demonstrate unsteadiness or difficulty performing a gait and balance test.

The falls risk evaluation should be performed by a clinician with appropriate skills and experience. [C]

A falls risk assessment is a clinical evaluation that should include the following, but are not limited to:
- a history of fall circumstances
- review of all medications and doses
- evaluation of gait and balance, mobility levels and lower extremity joint function
- examination of vision
- examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function
- cognitive evaluation
- screening for depression
- assessment of postural blood pressure

- assessment of heart rate and rhythm
- assessment of heart rate and rhythm, and blood pressure responses to carotid sinus stimulation if appropriate
- assessment of home environment

The falls risks assessment should be followed by direct intervention on the identified risk. [A] (AGS)

*Measure #155 (NQF: 0101): Falls: Plan of Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment.
This measure *should* be reported if CPT II code 1100F "Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year" is submitted for Measure #154.

DESCRIPTION:
Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
All eligible instances when CPT II code 1100F (patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154 make up the denominator for this measure. CPT Category II codes are used to report the numerator of the measure.

When CPT II code 1100F is reported with Measure #154, add the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
All eligible instances when patient is reported in the numerator for Measure #154 as screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> All eligible instances when CPT II code 1100F (Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154.
> AND

Patient encounter during the reporting period (CPT or HCPCS): 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439

NUMERATOR:
Patients with a plan of care for falls documented within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:
Plan of Care – Must include: 1) consideration of vitamin D supplementation AND 2) balance, strength, and gait training.
Consideration of Vitamin D Supplementation – Documentation that vitamin D supplementation was advised or considered or documentation that patient was referred to his/her physician for vitamin D supplementation advice.
Balance, Strength, and Gait Training – Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait OR referral to physical therapy.
Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Plan of Care Documented
CPT II 0518F: Falls plan of care documented

OR

Plan of Care not Documented for Medical Reasons
Append a modifier (1P) to CPT Category II code 0518F to report documented circumstances that appropriately exclude patients from the denominator.
0518F *with* 1P: Documentation of medical reason(s) for no plan of care for falls

OR

Plan of Care not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 0518F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0518F *with* 8P: Plan of care not documented, reason not otherwise specified

RATIONALE:
Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
Grade: B Recommendation.

The AGS 2010 Clinical Practice Guidelines Recommend:

Multifactorial/Multicomponent Interventions to Address Identified Risk(s) and Prevent Falls

1. A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified.[A]
2. The components most commonly included in efficacious interventions were:
    a. Adaptation or modification of home environment [A]
    b. Withdrawal or minimization of psychoactive medications [B]
    c. Withdrawal or minimization of other medications [C]
    d. Management of postural hypotension [C]
    e. Management of foot problems and footwear [C]
    f. Exercise, particularly balance, strength, and gait training [A]
3. All older adults who are at risk of falling should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program. [A]
4. Multifactorial/multicomponent intervention should include an education component complementing and addressing issues specific to the intervention being provided, tailored to individual cognitive function and language. [C]
5. The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals. [A]

▲ Measure #156 (NQF 0382): Oncology: Radiation Dose Limits to Normal Tissues

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer receiving 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of cancer receiving 3D conformal radiation therapy seen during the reporting period. It is anticipated that clinicians providing radiation therapy for patients with cancer will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and a CPT code are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, a CPT code, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and a CPT code are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy

Denominator Criteria (Eligible Cases):
Diagnosis for pancreatic or lung cancer (ICD-9-CM) [for use 01/01/2014-09/30/2014]: 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9
Diagnosis for pancreatic or lung cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]:
C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92
AND NOT
Diagnosis for metastatic cancer (ICD-9-CM) [for use 01/01/2014-09/30/2014]: 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89
Diagnosis for metastatic cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]:
C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19,

C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9
AND
Patient encounter during the reporting period (CPT): 77295

NUMERATOR:
Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Radiation Dose Limits to Normal Tissues Established
CPT II 0520F: Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs

OR

Radiation Dose Limits to Normal Tissues not Established, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 0520F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0520F *with* 8P: Radiation dose limits to normal tissues not established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs, reason not otherwise specified

RATIONALE:
Identifying radiation dose limits to normal tissues is an important step in the process of care for patients receiving radiation therapy treatments. Although no specific data is available, in its practice accreditation reviews, the American College of Radiation Oncology has found that radiation dose limits to normal tissues are included in the patient chart less frequently than reviewers expected. While dose constraint specification is an integral part of IMRT, it is not required for 3D conformal radiation therapy. Patients treated with 3D conformal radiation therapy are often subjected to dose levels that exceed normal tissue tolerance, and precise specification of maximum doses to be received by normal tissues represent both an intellectual process for the physician during radiation treatment planning, and a fail-safe point for the treating therapists. In most circumstances where facilities require specification of radiation dose limits to normal tissues prior to initiation of therapy, policies and procedures exist that prohibit exceeding those limits in the absence of written physician approval.

CLINICAL RECOMMENDATION STATEMENTS:
Pancreatic Adenocarcinoma
It is imperative to evaluate the DVH [dose volume histogram] of the PTV [planning target volume] and critical normal structures such as liver, kidneys, spinal cord, liver and bowel. While these limits are empirical they differ based on dose per fraction, total dose delivered, and disease status (adjuvant vs. unresectable). Studies have shown that the tolerability of radiation is largely dependent on PTV size/elective nodal irradiation, types of concurrent systemic/ targeted therapy, and whether conformal (3-D, IMRT, SBRT) vs. conventional radiation is used. (NCCN, 2012)

Non-Small Cell Lung Cancer
It is essential to evaluate the dose volume histogram (DVH) of critical structures and to limit the doses to the spinal cord, lungs, heart, esophagus, and brachial plexus to minimize normal tissue toxicity. These limits are mainly empirical. For patients receiving postoperative RT, more strict DVH parameters should be considered for lung. (NCCN, 2012)

Small Cell Lung Cancer
Normal tissue doses will be dependent on tumor size and location. (NCCN, 2012)

Ω Measure #157 (NQF 0455): Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of surgical patients aged 18 years and older undergoing resection for lung or esophageal cancer who had clinical staging provided prior to surgery

INSTRUCTIONS:
This measure is to be reported each time a major cancer resection of the lung or esophagus is performed. This measure is intended to reflect the quality of services provided for patients undergoing resection for lung or esophageal cancer. The clinical staging of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. It is anticipated that clinicians who perform the listed surgical procedures with a diagnosis of lung or esophageal cancer will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure via claims submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing resection for lung or esophageal cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for lung or esophageal cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 150.3, 150.4, 150.5, 150.8, 151.0, 162.2, 162.3, 162.4, 162.5, 162.9
Diagnosis for lung or esophageal cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C15.3, C15.4, C15.5, C15.8, C16.0, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.90, C34.91, C34.92
AND

Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505, 32506, 32507, 32663, 32666, 32667, 32668, 32669, 32670, 32671, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124

NUMERATOR:
Patients undergoing resection for lung or esophageal cancer who had clinical staging provided prior to surgery

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Clinical Staging Provided
CPTII 3323F: Clinical tumor, node and metastases (TNM) staging documented and reviewed prior to surgery

OR

Clinical Staging not Provided, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3323F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3323F *with* 8P: Clinical tumor, node and metastases (TNM) staging not documented and reviewed prior to surgery, reason not otherwise specified

RATIONALE:
Evaluation of patients with suspected lung cancer and esophageal cancer includes both diagnosis of the primary tumor and evaluation of the extent of disease. The current system for staging lung and esophageal cancer is based on the AJCC TNM classification. The clinical staging of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. Review of the 8,133 patients who underwent surgery and met the inclusion criteria for the measures recorded in the current STS General Thoracic Database identified a significant gap with respect to recording of clinical stage; it was reported in 89% of patients undergoing resection for lung or esophageal 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: http://www.cancer.gov page 3, 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 #159 (NQF 0404): HIV/AIDS: CD4+ Cell Count or CD4+ Percentage Performed

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 6 months and older with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ cell percentage was performed at least once every 6 months

INSTRUCTIONS:
This measure is to be reported either once or twice per reporting period for patients with HIV/AIDS. If the patient is seen during both the first and second halves of the year, we would expect 2 QDCs: one during the first half of the year and one in the second half of the year. However, if the two visits both occurred in either the first or second half of the year, only 1 QDC needs to be reported. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 6 months and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 90 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 6 months on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Patients with CD4+ cell count or CD4+ cell percentage performed at least once every 6 months

Numerator Options:
CD4+ cell count or CD4+ cell percentage results documented (G9214)
OR
CD4+ cell count or percentage results not documented, reason not given (G9215)

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)

❑ Measure #160 (NQF 0405): HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis Jiroveci Pneumonia (PCP) prophylaxis

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 90 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

This measure will be calculated with 4 performance rates:
1) All patients aged 6 years and older with diagnosis of HIV/AIDS
2) All patients aged 1-5 years of age with a diagnosis of HIV/AIDS
3) All patients aged 6 weeks to 12 months with a diagnosis of HIV/AIDS
4) Overall total of all patients with diagnosis of HIV/AIDS

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

There are three reporting criterion reported for this measure:

1) All patients aged 6 years and older with a diagnosis of HIV/AIDS
2) All patients aged 1-5 years of age with a diagnosis of HIV/AIDS
3) All patients aged 6 weeks to 12 months with a diagnosis of HIV/AIDS

Note: Once all denominators and numerators are calculated, a total rate should be calculated using the sum of the three denominators and the sum of the three numerators.

REPORTING CRITERIA 1: All patients aged 6 years and older with diagnosis of HIV/AIDS

DENOMINATOR (REPORTING CRITERIA 1):
All patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4 count below 200 cells/mm3 who had at least two visits during the measurement year, with at least 90 days in between each visit

Denominator Criteria (Eligible Cases):
Patients aged 6 years of age on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM) [for use 01/1/2014-09/30/2014]: 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B20, Z21
AND

Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402
AND
CD4+ cell count < 200 cells/mm^3

NUMERATOR (REPORTING CRITERIA 1):
Patients who were prescribed pneumocystis jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 200 cells/mm3

Definition:
Prescribed – May include prescription given to the patient for PCP prophylaxis therapy at one or more visits in the 12-month period OR patient already taking PCP prophylaxis therapy as documented in current medication list.

Numerator Options:
Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count below 200 cells/mm3 (G9222)

OR

Pneumocystis jiroveci pneumonia prophylaxis not prescribed within 3 months of low CD4+ cell count below 200 cells/mm3 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) (G9219)

OR

PCP prophylaxis was not prescribed within 3 months of low CD4+ cell count below 200 cells/mm3, reason not given (G9217)

REPORTING CRITERIA 2: All patients aged 1 - 5 years of age with diagnosis of HIV/AIDS

DENOMINATOR (REPORTING CRITERIA 2):
All patients aged 1-5 years of age with a diagnosis of HIV/AIDS and a CD4 count below 500 cells/mm3 or a CD4 percentage below 15% who had at least two visits during the measurement year, with at least 90 days in between each visit

Denominator Criteria (Eligible Cases):
Patients aged 1- 5 years of age on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM) [for use 01/1/2014-09/30/2014]: 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402
AND
CD4+ cell count below 500 cells/mm^3 or a CD 4 percentage below 15%

NUMERATOR (REPORTING CRITERIA 2):
Patients who were prescribed pneumocystic jiroveci pneumonia (PCP) prophylaxis within 3 months of CD4 count below 500 cells/ mm3 or a CD4 percentage below 15%

Definition:
Prescribed – May include prescription given to the patient for PCP prophylaxis therapy at one or more visits in the 12-month period OR patient already taking PCP prophylaxis therapy as documented in current medication list.

Numerator Options:
Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count below 500 cells/mm3 or a CD4 percentage below 15% (G9223)

OR

Pneumocystis jiroveci pneumonia prophylaxis not prescribed within 3 months of low CD4+ cell count below 500 cells/mm3 or a CD4 percentage below 15% 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) (G9220)

OR

PCP prophylaxis was not prescribed within 3 months of low CD4+ cell count below 500 cells/mm3 or a CD4 percentage below 15%, reason not given (G9218)

REPORTING CRITERIA 3: All patients aged 6 weeks to 12 months of age with diagnosis of HIV/AIDS

DENOMINATOR (REPORTING CRITERIA 3):
All patients aged 6 weeks to 12 months with a diagnosis of HIV/AIDS who had at least two visits during the measurement year, with at least 90 days in between each visit

Denominator Criteria (Eligible Cases):
Patients aged 6 weeks to 12 months of age on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM) [for use 01/1/2014-09/30/2014]: 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR (REPORTING CRITERIA 3):
Patients who were prescribed Pneumocystic jiroveci pneumonia (PCP) prophylaxis at the time of diagnosis of HIV

Definition:
Prescribed – May include prescription given to the patient for PCP prophylaxis therapy at one or more visits in the 12-month period OR patient already taking PCP prophylaxis therapy as documented in current medication list.

Numerator Options:
Pneumocystis jiroveci pneumonia prophylaxis prescribed (G9221)

OR

PCP prophylaxis was not prescribed at time of diagnosis of HIV, reason not given (G9216)

RATIONALE:
Although advances in the management of HIV and AIDS diseases have been made, Pneumocystis carinii pneumonia (PCP) remains an important complication and cause of morbidity. Without PCP prophylaxis, patients with HIV/AIDS are at increased risk of developing PCP, especially when CD4 cell counts fall 200 cells/mm^3 to 250 cells/mm^3. (Kaplan, 1998; Phair, 1990) PCP prophylaxis is very effective and has been demonstrated to prolong life.

Data from Kaiser Permanente suggests that a gap exists between what is recommended for patients with HIV infection, and what is actually performed. According to 2005-2006 data from Kaiser Permanente California (both Northern and Southern), Georgia, and Oregon, only 71% of HIV-infected persons with a CD4<200mm3 received PCP prophylaxis (personal communication, 2007).

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 #163 (NQF 0056): Diabetes: Foot Exam

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 01/1/2014-09/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.8, E10.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.65, E11.69, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628,

E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439

NUMERATOR:

Patients who received a foot exam (i.e., visual inspection, sensory exam with monofilament AND pulse exam) during the measurement period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Foot Exam Performed

G9226: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when all of the 3 components are completed)

OR

Foot Exam not Performed for Medical Reason

G9224: Documentation of medical reason for not performing foot exam (e.g., patient with bilateral foot/leg amputation)

OR

Foot Exam not Performed, Reason not Given

G9225: Foot exam was not performed, reason not given

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life-ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage. The consensus among established clinical guidelines is that patients with diabetes should have a foot exam soon after diagnosis and annually thereafter. Comprehensive foot care programs can lower amputation rates by 45-85 percent (American Diabetes Association 2009).

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (2009) Guidelines/ Recommendations: Perform annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (10-g monofilament plus testing any one of: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold).

Ω Measure #164 (NQF 0129): Coronary Artery Bypass Graft (CABG): Prolonged Intubation

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require postoperative intubation > 24 hours

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

NUMERATOR:
Patients undergoing isolated CABG who require intubation > 24 hours following exit from the operating room

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
Prolonged postoperative intubation (> 24 hrs) required (G8569)
OR
Prolonged postoperative intubation (> 24 hrs) not required (G8570)

RATIONALE:
Based on the STS coronary artery bypass graft (CABG) study population, the morbidity rate associated with prolonged intubation following CABG is 5.96%. Also, prolonged ventilation (defined as > 24 hours) was an independent predictor for readmission to the ICU following CABG surgery (OR=10.53; CI: 6.18 to 17.91). Shorter ventilation times are linked to high quality of care (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 (NQF 0130): Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who, within 30 days postoperatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

NUMERATOR:
Patients who, within 30 days post operatively, develop deep sternal wound infection involving muscle, bone, and/or mediastinum requiring operative intervention. Patient must have ALL of the following conditions: 1. wound opened with excision of tissue (incision and drainage) or re-exploration of mediastinum, 2. positive culture unless patient on antibiotics at time of culture or no culture obtained, and 3. treatment with antibiotics beyond perioperative prophylaxis.

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Development of deep sternal wound infection within 30 days postoperatively (G8571)

OR

No deep sternal wound infection (G8572)

RATIONALE:

The most serious hospital-acquired infection associated with coronary artery bypass graft (CABG) surgery is deep sternal wound or deep surgical site infection. The most common bacteria involved are *S. aureus* including increasingly more common methicillin resistant *Staph* (MRS). For CABG only outcomes 1997-1999 the STS dataset reported 0.63% deep sternal wound infection rate in 503,478 records. A report from an academic hospital reported 1.9% deep surgical site infections (Centers for Disease Control and Prevention National Nosocomial Infection Surveillance [CDC NNIS] criteria) in 1,980 patients undergoing isolated CABG or CABG+ procedures from 1996-1999. The Northern New England Cardiovascular Disease Study Group reported an incidence rate for mediastinitis of 1.25% and noted a marked increase in mortality during the first year post-CABG and a threefold increase during a 4-year follow-up period.

CLINICAL RECOMMENDATION STATEMENTS:

Several risk factors for sternal wound infection have been identified that can be optimized with good care practices: prophylactic antibiotics within 1 hour before incision time (odds ratio 5.3) [see antibiotic timing process measure] and avoiding elevated blood glucose levels (odds ratio 10.2). Surveillance for surgical site infections is a critical hospital function to monitor infection control practices and direct improvement activity.

Ω Measure #166 (NQF 0131): Coronary Artery Bypass Graft (CABG): Stroke

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

NUMERATOR:
Patients who have a postoperative stroke (i.e., any confirmed neurological deficit of abrupt onset caused by a disturbance in blood supply to the brain) that did not resolve within 24 hours

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
Stroke following isolated CABG surgery (G8573)
OR

No stroke following isolated CABG surgery (G8574)

RATIONALE:
Stroke is a devastating complication after coronary bypass surgery. The 1999 American College of Cardiology/American Heart Association (ACC/AHA) guidelines indicate that adverse cerebral outcomes are observed in ~6% of patients after bypass surgery equally divided between 2 types:
1) associated with major, focal neurological defects, stupor or coma and 2) evidence of deterioration in intellectual function. Type 1 deficits occur in ~3% of patients and are responsible for 21% mortality.

Reports in the literature on postoperative stroke incidence are difficult to compare because the conditions included in the term "stroke" vary. A standardized definition of stoke will provide common language to compare stroke incidence and evaluate management strategies for reducing this devastating complication.

Reported rates of postoperative cerebral dysfunction range from 0.4% to 13.8% following coronary operations. Complications for patients undergoing emergent CABG or valve surgery were greater than the complication rate for patients undergoing elective CABG or valve surgery. As bypass times increased, so did the incidence of stroke. When bypass time was 90 to 113 minutes, OR =1.59, p=0.022 and when bypass time was > 114 minutes, the OR =2.59, $p < 0.001$. Outcomes are better when patient age is younger and with beating-heart surgery rather than on-pump surgery.

CLINICAL RECOMMENDATION STATEMENTS:
The 1999 ACC/AHA guidelines describe strategies for reducing the risk of postoperative stroke such as an aggressive approach to the management of patients with severely diseased ascending aortas identified by intraoperative echocardiographic imaging, prevention or aggressive management of postoperative atrial fibrillation, delay of bypass surgery in the case of a left ventricular mural thrombus or a recent, preoperative CVA and preoperative carotid screening. Patients should carefully be screened for cerebrovascular disease to help prevent stroke and its associated morbidities.

Use of beta-adrenergic antagonists was associated with a lower incidence of stroke in patients undergoing elective CABG (OR=0.45; 95% CI 0.23 to 0.83; p=0.016). Use of antiplatelet agents within 48 hours of surgery is associated with a decreased risk of stroke (OR=0.51, p=0.01). Increased use of beating-heart surgery without cardiopulmonary bypass may lead to a lower prevalence of stroke following cardiac surgery and thus improve patient outcomes.

Ω Measure #167 (NQF 0114): Coronary Artery Bypass Graft (CABG): Postoperative Renal Failure

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery (without pre-existing renal failure) who develop postoperative renal failure or require dialysis

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

WITHOUT
Documented history of renal failure or baseline serum creatinine ≥ 4.0 mg/dL

NUMERATOR:
Patients who develop postoperative renal failure or require dialysis; (Definition of renal failure/dialysis requirement - patient had acute renal failure or worsening renal function resulting in one of the following: 1) increase of serum creatinine to ≥ 4.0 mg/dL or 3x most recent preoperative creatinine level, or 2) a new requirement for dialysis postoperatively)

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
Developed postoperative renal failure or required dialysis (G8575)

OR

No postoperative renal failure/dialysis not required (G8576)

RATIONALE:
In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to $20 billion. Some degree of Acute Renal Dysfunction (ARD) occurs in about 8% of patients following CABG, and dialysis-dependent renal failure occurs in 0.7% to 3.5% of patients receiving CABG. The latter is associated with substantial increases in morbidity, length of stay, and mortality (odds ratios for mortality range from 15 to 27). ARD is associated with increased morbidity, mortality and length of stay in an ICU following surgery. In addition, Acute Renal Failure occurs in 1.5% of patients undergoing any type of cardiac surgery. There has been a substantial increase in postoperative morbidity, mortality, and cost associated with this relatively common complication, regardless of whether or not this incidence varies much between providers, and there are implications of even a modest decrease in its incidence.

CLINICAL RECOMMENDATION STATEMENTS:
Acute renal failure following CABG is an intermediate outcome measure for mortality since this complication is independently associated (OR=27) with early mortality following cardiac surgery, even after adjustment for co-morbidity and postoperative complications.

Ω Measure #168 (NQF 0115): Coronary Artery Bypass Graft (CABG): Surgical Re-Exploration

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require a return to the operating room (OR) during the current hospitalization for mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530

NUMERATOR:
Patients who require a return to the OR during the current hospitalization for mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
Re-exploration required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason (G8577)

OR

Re-exploration not required due to mediastinal bleeding with or without tamponade, graft occlusion, valve dysfunction, or other cardiac reason (G8578)

RATIONALE:

In 2000, coronary artery bypass graft (CABG) surgery was performed on more than 350,000 patients at a cost of close to $20 billion. Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. As one of several major complications of cardiac surgery, repeat surgery is particularly worrisome for consumers and is an inefficient use of resources.

CLINICAL RECOMMENDATION STATEMENTS:

Re-exploration after surgery is a serious complication that impacts length of stay, efficient use of resources, and increases risk for additional complications and death. This measure is currently in use by approximately 65% of providers in the United States who perform cardiac surgery and report data to the STS National Database.

Ω Measure #169 (NQF 0116): Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on antiplatelet medication

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530
AND
Patient not deceased prior to discharge

NUMERATOR:
Patients who were discharged on antiplatelet medication

Numerator Options:
Antiplatelet medication at discharge (G8579)
OR
Antiplatelet medication contraindicated (G8580)
OR
No antiplatelet medication at discharge (G8581)

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 acute myocardial infarction.

Ω Measure #170 (NQF 0117): Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on beta-blockers

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530
AND
Patient not deceased prior to discharge

NUMERATOR:
Patients who were discharged on beta-blockers

Numerator Options:
Beta-blocker at discharge (G8582)
OR
Beta-blocker contraindicated (G8583)
OR
No beta-blocker at discharge (G8584)

RATIONALE:
Upwards of 70% of patients who undergo revascularization procedures have had a myocardial infarction (MI). Cumulative evidence and randomized trials indicate that patients with a previous MI live longer if they are on beta blockers. For many years, patients were taken off beta-blocker medications in preparation for surgery. Evidence from the STS National Database demonstrated that beta blocker use is safe and effective in many CABG patients previously thought to be at high risk for adverse events of beta blocker therapy (women, elderly, diabetes, congestive heart failure). In addition, the use of post-operative b-blockers is now known to protect patients both at one year and long term (greater than 5 years) from death following cardiac surgery. This effect is associated with a 46 % risk reduction in death at one year and 35% risk reduction in mortality during long-term follow-up (Chan et al., 2012).

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 (NQF 0118): Coronary Artery Bypass Graft (CABG): Anti-Lipid Treatment at Discharge

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on a statin or other lipid-lowering regimen

INSTRUCTIONS:
This measure is to be reported each time an isolated CABG procedure is performed during the reporting period. It is anticipated that clinicians who provide services for isolated CABG will submit this measure. This measure is intended to reflect the quality of the surgical services provided for isolated CABG or isolated reoperation CABG patients. Isolated CABG refers to CABG using arterial and/or venous grafts only.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing isolated CABG surgery

Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

OR

Patient encounter during the reporting period (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536
AND
Patient encounter during the reporting period (CPT): 33530
AND
Patient not deceased prior to discharge

NUMERATOR:
Patients who were discharged on a statin or other lipid-lowering regimen

Numerator Options:
Anti-lipid treatment at discharge (G8585)
OR
Anti-lipid treatment contraindicated (G8586)
OR
No anti-lipid treatment at discharge (G8587)

RATIONALE:

Atherosclerosis is a chronic disease. Events such as acute myocardial infarction (AMI) and coronary artery bypass graft (CABG) surgery identify patients with the disease, but acute therapy is not sufficient for optimal long-term outcomes. In post-bypass patients, atherosclerosis continues to progress in the native circulation and develops at an accelerated rate in saphenous vein bypass grafts. Management of the chronic disease is critically important in patients with atherosclerosis, such as those undergoing CABG.

The advantages of adherence to the American College of Cardiology/American Heart Association "Get with the Guidelines" program are discussed in a recent article, which also demonstrates both variation in quality and opportunity for improvement (38% compliance with guidelines before program implementation, 98.4% compliance thereafter). The article also discusses educational and process measures used by a major medical center to achieve compliance.

CLINICAL RECOMMENDATION STATEMENTS:

Compliance rates for patients receiving personalized follow-up for lipid management over two years were significantly better than in the control group. Lipid lowering in coronary heart disease has been demonstrated distinctively through three trials (CLAS, post-CABG, and CARE) to delay the progression of atherosclerosis and/or reduce deaths, and non- fatal MI following bypass surgery. Aggressive (low-density lipoprotein [LDL]) cholesterol-lowering treatment (target < 85 mg/dL) was correlated to a slower rate of disease progression (31%) after 4-5 years in comparison to the control group, which was comprised of patients receiving moderate lipid- lowering treatment (target < 130 to 140 mg/dL).

✦ Measure #172 (NQF 0259): Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of advanced Chronic Kidney Disease (CKD) (stage 3, 4, or 5) or End Stage Renal Disease (ESRD) requiring hemodialysis vascular access documented by surgeon to have received autogenous AV fistula

INSTRUCTIONS:
This measure is to be reported each time a procedure for hemodialysis access is performed during the reporting period. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT code, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients with advanced CKD or ESRD who undergo open surgical placement of permanent hemodialysis access

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for stage 3, 4, or 5 CKD or ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.3, 585.4, 585.5, 585.6, 996.73
> Diagnosis for stage 3, 4, or 5 CKD or ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.3, N18.4, N18.5, N18.6, T82.818A, T82.828A, T82.838A, T82.848A, T82.858A, T82.868A, T82.898A
> AND
> Patient encounter during the reporting period (CPT): 36818, 36819, 36820, 36821, 36825, 36830

NUMERATOR:
Patients diagnosed with advanced CKD or ESRD requiring hemodialysis vascular access as documented by the surgeon

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Autogenous AV Fistula Performed
G8530: Autogenous AV fistula received

OR

Autogenous AV Fistula not Performed for Documented Reasons
G8531: Clinician documented that patient was not an eligible candidate for autogenous AV fistula

OR

Autogenous AV Fistula not Performed, Reason not Given
G8532: Clinician documented that patient received vascular access other than autogenous AV fistula, reason not given

RATIONALE:
AV access complications account for more than 15% of hospital admissions among hemodialysis patients. As the number of patients in need of chronic hemodialysis increases - estimated at 10% per year starting at a base population of 345,000 in 2000 - the cost to the health care system of dialysis access-related complications will increase proportionally.

CLINICAL RECOMMENDATION STATEMENTS:
For the surgeon, the most directly measurable performance parameter is the percentage of autogenous accesses placed as a proportion of the total number of accesses, (autogenous and prosthetic) placed by the particular surgeon.

▲ Measure #173: Preventive Care and Screening: Unhealthy Alcohol Use – Screening

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method**

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for 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 Registry:
CPT or quality-data codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 96150, 96151, 96152, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271, G0438, G0439

NUMERATOR:
Patients who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method

Definition:
Unhealthy Alcohol Use – Covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as > 7 standard drinks per week or > 3 drinks per occasion for women and persons > 65 years of age; > 14 standard drinks per week or > 4 drinks per occasion for men ≤ 65 years of age.
**Systematic Screening Method – A systematic method of assessing for unhealthy alcohol use should be utilized. Systemic screening methods include but are not limited to:

- AUDIT Screening Instrument
- CAGE Screening Instrument
- AUDIT-C Screening Instrument
- Single Item Screening Instrument

Alternative approaches may also include questions regarding quantity/frequency of consumption (ie, drinks per week or drinks per occasion).

Numerator Options:
Patient screened for unhealthy alcohol use using a systematic screening method (3016F)

OR

Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons) (3016F *with* 1P)

OR

Unhealthy alcohol use screening not performed, reason not otherwise specified (3016F *with* 8P)

RATIONALE:
Screening for unhealthy alcohol use can identify patients whose habits may put them at risk for adverse health outcomes due to their alcohol use. While this measure does not require counseling for those patients to be found at risk, brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use. It would be expected that if a provider found their patient to be at risk after screening that intervention would be provided.

A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods.

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF 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)

⌘ Measure #176: Rheumatoid Arthritis (RA): Tuberculosis Screening

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all RA patients who are being considered or prescribed a first course of biologic disease-modifying anti-rheumatic drug therapy. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of RA who are receiving a first course of therapy using a biologic DMARD

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.10, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729,

M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

Patients for whom a TB screening was performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic DMARD

Numerator Instructions: Patients are considered to be receiving a first course of therapy using a biologic DMARD only if they have never previously been prescribed or dispensed a biologic DMARD.

Definition:

Biologic DMARD Therapy – Includes Adalimunab, Etanercept, Infliximab, Abatacept, Anakinra (Rituximab is excluded).

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Tuberculosis Screening Performed and Results Interpreted

*(Two CPT II codes [*3455F & 4195F*] are required on the claim form to submit this numerator option*)

CPT II 3455F: TB screening performed and results interpreted within six months prior to initiation of first-time biologic disease modifying anti-rheumatic drug therapy for RA

AND

CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

TB Screening not Performed or Results not Interpreted for Medical Reasons

*(Two CPT II codes [*3455F-1P & 4195F*] are required on the claim form to submit this numerator option)*

Append a modifier (1P) to CPT Category II code 3455F to report documented circumstances that appropriately exclude patients from the denominator.

3455F *with* 1P: Documentation of medical reason for not screening for TB or interpreting results (ie, patient positive for TB and documentation of past treatment; patient has recently completed a course of anti-TB therapy)

AND

CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

If patient does not meet denominator inclusion because biologic DMARD prescription is Rituximab or this is not the first course of biologic DMARD therapy for RA, report:
(One CPT II code [4196F] is required on the claim form to submit this numerator option)
CPT II 4196F: Patient not receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

TB Screening not Performed or Results not Interpreted, Reason not Otherwise Specified
(Two CPT II codes [3455F-8P & 4195F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 3455F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3455F *with* 8P: TB screening not performed or results not interpreted, reason not otherwise specified
AND
CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

RATIONALE:
Before initiating biologic DMARDs for a patient with RA, it is essential to screen the patient for tuberculosis, as research has documented a higher incidence of TB after anti-TNFα therapy. All patients being considered for biologic DMARD should receive a tuberculin skin test, even if the patient has previously received the BCG vaccination. Test results, in addition to patient risk for TB and other tests, should be used to assess the patient's risk for latent TB infection. This is a patient safety measure.

CLINICAL RECOMMENDATION STATEMENTS:
The American College of Rheumatology recommends screening to identify latent TB infection (LTBI) in all RA patients being considered for therapy with biologic agents, regardless of the presence of risk factors for LTBI. (Level of Evidence: C) (ACR, 2012)

⌘ Measure #177: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (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 Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of RA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.10, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729,

M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

Patient encounter during the reporting period (CPTor HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

Patients with disease activity assessed by a standardized descriptive or numeric scale or composite index and classified into one of the following categories: low, moderate, or high, at least once within 12 months

Definition:

Assessment and Classification of Disease Activity – Assesses if physicians are utilizing a standardized, systematic approach for evaluating the level of disease activity. The scales/instruments listed are examples of how to define activity level and cut-off points can differ by scale. Standardized descriptive or numeric scales and/or composite indexes could include but are not limited to: DAS28, SDAI, CDAI, RADAI, RAPID.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Disease Activity Assessed and Classified

CPT II 3470F: Rheumatoid arthritis (RA) disease activity, low

OR

CPT II 3471F: Rheumatoid arthritis (RA) disease activity, moderate

OR

CPT II 3472F: Rheumatoid arthritis (RA) disease activity, high

OR

Disease Activity not Assessed and Classified, Reason not Otherwise 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.

CPT II 3470F *with* 8P: Disease activity not assessed and classified, reason not otherwise specified

RATIONALE:

After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the patient's disease activity at the time of the treatment decisions.

CLINICAL RECOMMENDATION STATEMENTS:

Several indices to measure RA disease activity have been developed each of which has advantages and disadvantages. Evidence-based guidelines require clear definitions of disease activity to make rational therapeutic choices, but it is not possible or appropriate to mandate use of a single disease activity score for the individual physician, and different studies have used different definitions. Therefore, the TFP was asked to consider a combined estimation of disease activity, which allowed reference to many past definitions. With these instruments as our guide, we rated RA disease activity in an ordinal manner as low, moderate, or high. (ACR, 2008)

⌘ Measure #178: Rheumatoid Arthritis (RA): Functional Status Assessment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of RA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.10, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821,

M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

Patients for whom a functional status assessment was performed at least once within 12 months

Definitions:

Functional Status Assessment – This measure assesses if physicians are using a standardized descriptive or numeric scale, standardized questionnaire, or notation of assessment of the impact of RA on patient activities of daily living. Examples of tools used to assess functional status include but are not limited to: Health Assessment Questionnaire (HAQ), Modified HAQ, HAQ-2; American College of Rheumatology's Classification of Functional Status in Rheumatoid Arthritis.

Activities of Daily Living – Could include a description of any of the following: dressing/grooming, rising from sitting, walking/running/ability to ambulate, stair climbing, reaching, gripping, shopping/running errands, house or yard work.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Functional Status Assessed

CPT II 1170F: Functional status assessed

OR

Functional Status not Assessed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1170F *with* 8P: Functional status not assessed, reason not otherwise specified

RATIONALE:

Functional limitations are a significant and disruptive complication for patients living with RA. Assessments of functional limitations are used to assess prognosis and guide treatment and therapy decisions. Functional status should be assessed at the baseline and each follow-up visit, using questionnaires such as the ACR's Classification of Functional Status in RA or the Health Assessment Questionnaire or an assessment of activities of daily living. Regardless of the assessment tool used, it should indicate whether a functional decline is due to inflammation, mechanical damage, or both, as treatment strategies will vary accordingly.

CLINICAL RECOMMENDATION STATEMENTS:

The management of RA is an iterative process, and patients should be periodically reassessed for evidence of disease or limitation of function with significant alteration of joint anatomy. Baseline evaluation of disease activity and damage in patients with rheumatoid arthritis through evaluation of functional status or quality of life assessments using standardized questionnaires, a physician's global assessment of disease activity, or patient's global assessment of disease activity. The initial evaluation of the patient with RA should document symptoms of active disease (ie, presence of joint pain, duration of morning stiffness, degree of fatigue), functional status, objective

evidence of disease activity (ie, synovitis, as assessed by tender and swollen joint counts, and the ESR or CRP level), and mechanical joint problems.

At each follow up visit, the physician must assess whether the disease is active or inactive. Symptoms of inflammatory (as contrasted with mechanical) joint disease, which include prolonged morning stiffness, duration of fatigue, and active synovitis on joint examination, indicate active disease and necessitate consideration of changing the treatment program. Occasionally, findings of the joint examination alone may not adequately reflect disease activity and structural damage; therefore, periodic measurements of the ESR or CRP level and functional status, as well as radiographic examinations of involved joints should be performed. It is important to determine whether a decline in function is the result of inflammation, mechanical damage, or both; treatment strategies will differ accordingly. (ACR, 2002)

⌘ Measure #179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of RA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.10, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761,

M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

Patients with at least one documented assessment and classification (good/poor) of disease prognosis utilizing clinical markers of poor prognosis 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 (eg, HAQ Disability Index), extraarticular disease (eg, vasculitis, Sjorgen's syndrome, RA lung disease, rheumatoid nodules), RF positivity, positive anti-CCP antibodies (both characterized dichotomously, per CEP recommendation), and/or bony erosions by radiography.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Disease Prognosis Assessed and Classified

CPT II 3475F: Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented

OR

CPT II 3476F: Disease prognosis for rheumatoid arthritis assessed, good prognosis documented

OR

Disease Prognosis not Assessed and Classified, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 3475F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3475F *with* 8P: Disease prognosis for rheumatoid arthritis not assessed and classified, reason not otherwise specified

RATIONALE:

After establishing a diagnosis of RA, risk assessment is crucial for guiding optimal treatment. For the purposes of selecting therapies, physicians should consider the presence of these prognostic factors at the time of the treatment decisions.

CLINICAL RECOMMENDATION STATEMENTS:

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) (ACR, 2008)

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) (ACR, 2008)

⌘ Measure #180: Rheumatoid Arthritis (RA): Glucocorticoid Management

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with RA seen during the reporting period. It is anticipated that clinicians who provide care for patients with a diagnosis of RA will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of RA

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 714.0, 714.1, 714.2, 714.81
Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.10, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352,

M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

NUMERATOR:

Patients who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of a glucocorticoid management plan within 12 months

Definitions:

Prolonged Dose – Doses > 6 months in duration.

Prednisone Equivalents – Determine using the following:

1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone.

Glucocorticoid Management Plan – Includes documentation of attempt to taper steroids OR documentation of a new prescription for a non-glucocorticoid disease-modifying anti-rheumatic drug (DMARD) OR increase in dose of non-glucocorticoid DMARD dose for persistent RA disease activity at current or reduced dose.

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Glucocorticoid Use Assessed

(One CPT II code [419xF] is required on the claim form to submit this numerator option)

CPT II 4192F: Patient not receiving glucocorticoid therapy

OR

CPT II 4193F: Patient receiving < 10 mg daily prednisone (or equivalent), or RA disease activity is worsening, or glucocorticoid use is for less than 6 months

OR

Glucocorticoid Use Assessed and Management Plan Documented
(Two CPT II codes [4194F & 0540F] are required on the claim form to submit this numerator option)
CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity
AND
CPT II 0540F: Glucocorticoid Management Plan documented

OR

Glucocorticoid Plan not Documented for Medical Reasons
(Two CPT II codes [0540F-1P & 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 (ie, glucocorticoid prescription is for a medical condition other than RA)
AND
CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

OR

Glucocorticoid Dose not Documented, Reason not Otherwise 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 Otherwise Specified
(Two CPT II codes [0540F-8P & 4194F] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 0540F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0540F *with* 8P: Glucocorticoid plan not documented, reason not otherwise specified
AND
CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

RATIONALE:
Glucocorticoids are an important part of RA treatment as they inhibit inflammation and may control synovitis. However, long-term use of glucocorticoids, especially at high doses, should be avoided, due to the potential health complications. Monitoring length and dose of glucocorticoid treatment for patients with RA is integral to making other clinical decisions.

CLINICAL RECOMMENDATION STATEMENTS:
Low-dose oral glucocorticoids and local injections of glucocorticoids are highly effective for relieving symptoms in patients with active RA. 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. (ACR, 2002)

♠ Measure #181: Elder Maltreatment Screen and Follow-Up Plan

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of encounter AND a documented follow-up plan on the date of the positive screen

INSTRUCTIONS:
This measure is to be reported once during the reporting period for patients seen during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding at the time of the qualifying visit. The documented follow up plan must be related to positive elder maltreatment screening, example: "Patient referred for protective services due to positive elder maltreatment screening."

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 65 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 96116, 96150, 96151, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0270, G0402, G0438, G0439

NUMERATOR:
Patients with a documented elder maltreatment screen using an Elder Maltreatment Screening Tool on the date of the encounter and follow-up plan documented on the date of the positive screen

> Definitions:
> Screen for Elder Maltreatment – An elder maltreatment screen should include assessment and documentation of all of the following components: (1) physical abuse, (2) emotional or psychological abuse,

(3) neglect (active or passive), (4) sexual abuse, (5) abandonment, (6) financial or material exploitation and (7) unwarranted control.

Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.

Emotional or Psychological Abuse – Involves psychological abuse, verbal abuse, or mental injury and includes acts or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.

Neglect – Involves attitudes of others or actions caused by others-such as family members, friends, or institutional caregivers-that have an extremely detrimental effect upon well-being.

Active – Behavior that is willful or when the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts.

Passive – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources.

Sexual Abuse – The forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.

Elder Abandonment – Desertion of an elderly person by an individual who has assumedresponsibility for providing care for an elder, or by a person with physical custody of an elder.

Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit.

Unwarranted Control – Controlling a person's ability to make choices about living situations, household finances, and medical care.

Note: Self neglect is a prevalent form of abuse in the elderly population. Screening for self neglect and screening tools for self neglect are not included in this measure. Resources for suspected self neglect are listed below.

Follow-Up Plan – Must include a documented report to state or local Adult Protective Services (APS) agency. Note: APS does not have jurisdiction in all states to investigate maltreatment of patients in long-term care facilities. In those states where APS does not have jurisdiction, APS may refer the provider to another state agency -- such as the state facility licensure agency – for appropriate reporting. *Federal reporting: In addition to state requirements, some types of providers are required by federal law to report suspected maltreatment. For example, nursing facilities certified by Medicare and/or Medicaid are required to report suspected maltreatment to the applicable State Survey and Certification Agency.*

For state-specific information to report suspected elder maltreatment, including self neglect, the following resources are available:

1. National Adult Protective Services Association- http://www.napsa-now.org/get-help/help-in-your-area/
2. Eldercare Locater: 1-800-677-1116 www.eldercare.gov
3. National Center on Elder Abuse
http://www.ncea.aoa.gov/NCEAroot/Main_Site/Find_Help/State_Resources.aspx

Disclaimer: The follow-up plan recommendations set forth in this quality measure are not intended to supersede any mandatory state, local or federal reporting requirements.

Not Eligible – A patient is not eligible if one or more of the following reasons is documented:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: Documentation of an elder maltreatment screening must include identification of the tool used. Examples of screening tools for elder maltreatment include, but are not limited to: Elder Abuse Suspicion Index (EASI), Vulnerability to Abuse Screening Scale (VASS) and Hwalek-Sengstock Elder Abuse Screening Test (H-S/EAST).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Elder Maltreatment Screen Documented as Positive AND Follow-Up Plan Documented

(One quality-data code [G8733 or G8734] is required on the claim form to submit this numerator option)

G8733: Elder maltreatment screen documented as positive AND a follow-up plan is documented

OR

Elder Maltreatment Screen Documented as Negative, Follow-Up Plan not Required

G8734: Elder maltreatment screen documented as negative, follow-up is not required

OR

Elder Maltreatment Screen not Documented, Patient not Eligible

(One quality-data code [G8535 or G8941] is required on the claim form to submit this numerator option)

G8535: Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen

OR

Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible for Follow-Up Plan

G8941: Elder maltreatment screen documented as positive, follow-up plan not documented, documentation the patient is not eligible for follow-up plan

OR

Elder Maltreatment Screen not Documented, Reason not Given

(One quality-data code [G8536 or G8735] is required on the claim form to submit this numerator option)

G8536: No documentation of an elder maltreatment screen, reason not given

OR

Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Reason not Given

G8735: Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given

RATIONALE:

"Most cases of elder abuse go unidentified and unreported (Cohen, 2011, p.261). Elder maltreatment is prevalent and occurs predominantly in the community, not in nursing care facilities. One in ten seniors reported being abused, neglected or exploited in the past twelve months; 5.2% for financial abuse, 4.6% for emotional, 1.6% for physical abuse and 0.6% for sexual abuse. Financial exploitation by family members and by strangers was increased among the more physically disabled adults (Aceirno et al., 2010). Elder Abuse and Neglect: In Search of Solutions (2013), reports that every year an estimated 4 million older Americans are victims of physical, psychological, or other forms of abuse and neglect, and for every reported case there may be as many as 23 unreported. Although less prevalent, patients in nursing homes do experience maltreatment. In a 2010 study performed by Natan et al., more than half of nursing facility surveyed staff reported they identified abuse of elderly residents over the past year with approximately two- thirds reporting incidents of neglect.

There are many complex reasons for underreporting; minimal screening, a lack of knowledge and skills for interventions (Cohen, 2011) on the part of health care providers and failure of the abused patient to report due to fear of retaliation by the abuser (APA, 2010), inability of the victim to report due to a cognitive deficit or initiating family discord. This lack of identifying victims of elder abuse leads to increased rates of hospitalization (Dong & Simon, 2013), morbidity (Cohen, 2011), mortality (Dong, et al., 2009) and admission into a nursing home (Lachs et al., 2011). These outcomes are costly. As cited in Dong (2011), the Government Accounting Office reported spending $11.9 million dollars in 2009 for all activities related to elder abuse and this amount was not enough to provide basic

protection for older adults from abuse, neglect and exploitation. It is clear that additional screening, education of victims and health care providers and financial support is needed in order to unveil the depth of the problem and provide aid those who are being abused and neglected.

CLINICAL RECOMMENDATION STATEMENTS:

The United States Preventive Services Task Force (USPSTF) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement).

Though the USPSTF does not support elder maltreatment screening, it is important to remember that absence of hard evidence supporting screening is not evidence that it is not effective. There have been many qualitative reports that do support the benefits of screening. Expert consensus and public policy for mandatory reporting support the value of screening this vulnerable population.

♠ Measure #182: Functional Outcome Assessment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies

INSTRUCTIONS:
This measure is to be reported each visit for patients seen during the 12 month reporting period. The functional outcome assessment is required to be current as defined in the definition section. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT codes and patient demographics are used to identify patients that are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT): 97001, 97002, 97003, 97004, 98940, 98941, 98942

NUMERATOR:
Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies

> Numerator Instructions: Documentation of a current functional outcome assessment must include identification of the standardized tool used.
>
> Definitions:

Standardized Tool – A tool that has been normalized and validated Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), and Patient-Reported Outcomes Measurement Information System (PROMIS).
*Note: A functional outcome assessment is multi-dimensional and quantifies pain and neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does **not** meet the criteria of a functional outcome assessment standardized tool.*
Functional Outcome Assessment – Patient completed questionnaires designed to measure a patient's limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.
Current (Functional Outcome Assessment) – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days.
Functional Outcome Deficiencies – Impairment or loss of physical function related to neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.
Care Plan – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient's health care problems. Care plans may also be known as a treatment plan.
Not Eligible – A patient is not eligible if one or more of the following reasons(s) is documented:

- Patient refuses to participate
- Patient unable to complete questionnaire
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: The intent of this measure is for a functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code G8942 should be used for reporting purposes.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Functional Outcome Assessment Documented as Positive AND Care Plan Documented

(One quality-data code [G8539 or G8542 or G8942] is required on the claim form to submit this numerator option)

G8539: Functional outcome assessment documented as positive using a standardized tool AND a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required

G8542: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required

OR

Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated, Within the Previous 30 Days

G8942: Functional outcome assessment using a standardized tool is documented within the previous 30 days and care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented

OR

Functional Outcome Assessment not Documented, Patient not Eligible

*(One quality-data code [*G8540 or G9227*] is required on the claim form to submit this numerator option)*
G8540: Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool
OR
Functional Outcome Assessment Documented, Care Plan Not Documented, Patient Not Eligible
G9227: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan

OR

Functional Outcome Assessment not Documented, Reason not Given
*(One quality-data code [*G8541 or G8543*] is required on the claim form to submit this numerator option)*
G8541: Functional outcome assessment using a standardized tool not documented, reason not given
OR
Functional Outcome Assessment Documented as Positive, Care Plan not Documented, Reason not Given
G8543: Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented, reason not given

RATIONALE:
Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice. Despite the recognition of the importance of outcomes assessments, questionnaires and tools, recent evidence suggests their use in clinical practice is limited. Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by (1) identifying and quantifying body function and structure limitations; (2) formulating the evaluation, diagnosis, and prognosis; (3) informing the plan of care; and (4) helping to evaluate the success of physical therapy interventions (Potter et al., 2011).

CLINICAL RECOMMENDATION STATEMENTS:
As a category, functional outcome assessments of everyday tasks are very suitable for evaluating treatment of dysfunctions of the neuromusculoskeletal system. Many questionnaires could be used; choice should depend upon the validity, reliability, responsiveness, and practicality demonstrated in the scientific literature. Functional questionnaires seek to directly quantify symptoms, function and behavior, rather than draw inferences from relevant physiological tests. Clinicians contemplating the use of functional instruments should be aware of differences between questionnaires and choose the most appropriate assessment tool for the specific purpose (Haldeman et al., 2005) (Evidence Class: I, II, III, Consensus Level: 1).

Outcome measures/standardized assessments are used by physical therapists to evaluate patient response to therapeutic interventions. In a 2006 Centers for Medicare & Medicaid Services report, *Uniform Patient Assessment for Post-Acute Care,* the Division of Health Care Policy and Research recommended there is a role for uniform outcome assessments to determine long term function for patients leaving the acute care hospital.
Clinicians should use validated self-report questionnaires/tools that are useful for identifying a patient's baseline status relative to pain, function, and disability and for monitoring a change in a patient's status throughout the course of treatment. Tools such as the Oswestry Disability Index and the Roland-Morris Disability Questionnaire can be used. (Delitto et al., 2012)

The Council on Chiropractic Education (2012) recommended keeping appropriate records of the patient's evaluation and case management needs to aptly respond to changes in patient status, or failure of the patient to respond to care.

The Institute of Medicine's (2012) *Living Well with Chronic Illness: A Call for Public Health Action* stated the surveillance systems need to be improved to assess health-related quality of life and functional status of patients. Federal and state governments should expand surveillance systems which can be used to inform the planning,

development, implementation, and evaluation of public health policies, programs and interventions relevant to individuals with chronic illness.

▲ Measure #183 (NQF 0399): Hepatitis C: Hepatitis A Vaccination in Patients with Hepatitis C Virus (HCV)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and the appropriate CPT Category II codes OR the CPT Category II codes with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic hepatitis C

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic hepatitis C (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 070.54
Diagnosis for chronic hepatitis C (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B18.2
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:
Patients who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A

Definition:

Received - Includes at least one injection of hepatitis A vaccine during a current or prior visit, or previous receipt from another provider.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Hepatitis A Vaccine Injection Received or Patient Has Documented Immunity to Hepatitis A
CPT II 4148F: Hepatitis A vaccine injection administered or previously received
OR
CPT II 3215F: Patient has documented immunity to hepatitis A

OR

Hepatitis A Vaccine Injection not Received for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 4148F to report documented circumstances that appropriately exclude patients from the denominator.
4148F *with* 1P: Documentation of medical reason(s) for not administering at least one injection of hepatitis A vaccine (eg, allergy or intolerance to a known component of the vaccine, other medical reasons)
4148F *with* 2P: Documentation of patient reason(s) for not administering at least one injection of hepatitis A vaccine (eg, patient declined, insurance coverage, other patient reasons)

OR

Hepatitis A Vaccine Injection not Received, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4148F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4148F *with* 8P: Hepatitis A Vaccine not received, reason not otherwise specified

RATIONALE:
The hepatitis A vaccination decreases the potential for a patient acquiring hepatitis A which would contribute to further liver damage. A single report has suggested that superimposition of hepatitis A virus infection in persons with chronic liver disease, particularly those with hepatitis C, was associated with fulminant hepatitis. Therefore, it is recommended that persons with chronic HCV infection who lack evidence of preexisting antibody to hepatitis A be administered the hepatitis A vaccine. (AASLD, 2009)

CLINICAL RECOMMENDATION STATEMENTS:
All persons with chronic HCV infection who lack antibodies to hepatitis A and B should be offered vaccination against these two viral infections. (AASLD, 2009)

Patients with chronic hepatitis C should be vaccinated against HAV and HBV. (EASL, 2011)

⌘ Measure #185 (NQF 0659): Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings, who had an interval of 3 or more years since their last colonoscopy

INSTRUCTIONS:
This measure is to be reported each time a surveillance colonoscopy is performed during the reporting period. It is anticipated the clinician who performs the listed procedures, as specified in the denominator coding, will report on this measure. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73 or 74 will not qualify for inclusion into this measure.

Measure Reporting via Claims:
The ICD-9-CM/ICD-10-CM diagnosis code, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis code, CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
The ICD-9-CM/ICD-10-CM diagnosis code, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior adenomatous polyp(s) in previous colonoscopy findings

> Denominator Instructions: Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into this measure.
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for history of adenomatous (colonic) polyp(s) (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V12.72

Diagnosis for history of adenomatous (colonic) polyp(s) (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z86.010
AND
Patient encounter during the reporting period (CPT or HCPCS): 44388, 44389, 44392, 44393, 44394, 45355, 45378, 45380, 45381, 45383, 45384, 45385, G0105
WITHOUT
CPT Category I Modifiers: 52, 53, 73 or 74

NUMERATOR:
Patients who had an interval of 3 or more years since their last colonoscopy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Interval of Three or More Years Since Patient's Last Colonoscopy
CPT II 0529F: Interval of 3 or more years since patient's last colonoscopy, documented

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy for Medical or System Reasons
Append a modifier (1P or 3P) to CPT Category II code 0529F to report documented circumstances that appropriately exclude patients from the denominator.
0529F *with* 1P: Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (eg, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, last colonoscopy found greater than 10 adenomas, or patient at high risk for colon cancer [Crohn's disease, ulcerative colitis, lower gastrointestinal bleeding, personal or family history of colon cancer])
0529F *with* 3P: Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report, previous colonoscopy report was incomplete)

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 0529F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0529F *with* 8P: Interval of less than 3 years since patient's last colonoscopy, reason not otherwise specified

RATIONALE:
Colorectal cancer is the 2nd leading cause of cancer death in the United States. Colonoscopy is the recommended method of surveillance after the removal of adenomatous polyps because it has been shown to significantly reduce subsequent colorectal cancer incidence. The time interval for the development of malignant changes in adenomatous polyps is estimated at 5 to 25 years. (ICSI, 2006) Inappropriate interval recommendations can result in overuse of resources and can lead to significant patient harm. Performing colonoscopy too often not only increases patients' exposure to procedural harm, but also drains resources that could be more effectively used to adequately screen those in need. (Lieberman et al, 2009)

CLINICAL RECOMMENDATION STATEMENTS:
Patients with only 1 or 2 small (< 1 cm) tubular adenomas with only low-grade dysplasia should have their next follow-up colonoscopy in 5–10 years; the precise timing within this interval should be based on other clinical factors (such as prior colonoscopy findings, family history, and the preferences of the patient and judgment of the physician). Patients with 3 to 10 adenomas, or any adenoma ≥1 cm, or any adenoma with villous features, or high-grade dysplasia should have their next follow-up colonoscopy in 3 years providing that piecemeal removal has not been performed and the adenoma(s) are removed completely; if the follow-up colonoscopy is normal or

shows only 1 or 2 small tubular adenomas with low-grade dysplasia, then the interval for the subsequent examination should be 5 years. (Winawer, et al, 2006)

Measure #187: Stroke and Stroke Rehabilitation: Thrombolytic Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of acute ischemic stroke who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well

INSTRUCTIONS:
This measure is to be reported for each episode of acute ischemic stroke for patients who arrive at the hospital within two hours of time last known well and for whom IV t-PA was initiated within three hours of time last known well. It is anticipated that clinicians providing care for patients with acute ischemic stroke in the hospital setting will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute ischemic stroke whose time of arrival is within two hours (≤ 120 minutes) of time last known well

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter.
AND
Diagnosis for ischemic stroke (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 433.01, 433.10, 433.11, 433.21, 433.31, 433.81, 433.91, 434.00, 434.01, 434.11, 434.91, 436
Diagnosis for ischemic stroke (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I63.111, I63.112, I63.119, I63.139, I63.19, I63.20, I63.219, I63.22, I63.231, I63.232, I63.239, I63.30, I63.40, I63.50, I63.59, I65.29, I66.02, I66.03, I66.09, I66.19, I66.29
AND
Patient encounter during reporting period (CPT): 99221, 99222, 99223, 99291
AND
Time last known well to arrival in the emergency department less than or equal to two hours (**≤ 120** minutes)

NUMERATOR:
Patients for whom IV thrombolytic therapy was initiated at the hospital within three hours (≤ 180 minutes) of time last known well

Definition:
Last Known Well – The date and time prior to hospital arrival at which it was witnessed or reported that the patient was last known to be without the signs and symptoms of the current stroke or at his or her baseline state of health.

Numerator Options:

IV t-PA initiated within three hours (≤ 180 minutes) of time last known well (G8600)

OR

IV t-PA not initiated within three hours (≤ 180 minutes) of time last known well for reasons documented by clinician (e.g., patient enrolled in clinical trial for stroke, patient admitted for elective carotid intervention) (G8601)

OR

IV t-PA not initiated within three hours (≤ 180 minutes) of time last known well, reason not given (G8602)

RATIONALE:

The administration of thrombolytic agents to carefully screened, eligible patients with acute ischemic stroke has been shown to be beneficial in several clinical trials. These included two positive randomized controlled trials in the United States; The National Institute of Neurological Disorders and Stroke (NINDS) Studies, Part I and Part II. Based on the results of these studies, the Food and Drug Administration approved the use of intravenous recombinant tissue plasminogen activator (IV r-TPA or t-PA) for the treatment of acute ischemic stroke when given within 3 hours of stroke symptom onset. A large meta-analysis controlling for factors associated with stroke outcome confirmed the benefit of IV t-PA in patients treated within 3 hours of symptom onset. While controversy still exists among some specialists, the major society practice guidelines developed in the United States all recommend the use of IV t-PA for eligible patients. Physicians with experience and skill in stroke management and the interpretation of CT scans should supervise treatment.

CLINICAL RECOMMENDATION STATEMENTS:

Intravenous r-TPA (0.9 mg/kg, maximum dose 90 mg) is recommended for selected patients who may be treated within 3 hours of onset of ischemic stroke (Class 1, Level of Evidence A) (AHA/ASA).

For eligible patients (see inclusion and exclusion criteria listed below), we recommend administration of IV t-PA in a dose of 0.9 mg/kg (maximum of 90 mg), with 10% of the total dose given as an initial bolus and the remainder infused over 60 min, provided that treatment is initiated within 3 hours of clearly defined symptom onset (Class 1, Grade 1A) (ACP).

* Measure #191 (NQF 0565): Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery

INSTRUCTIONS:
This measure is to be calculated each time a procedure for uncomplicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated cataract surgery.

Note: This is an outcomes measure and can be calculated solely using registry data.

- *For patients who receive the cataract surgical procedures specified in the denominator coding, it should be reported whether or not the patient had best-corrected visual acuity of 20/40 or better achieved within 90 days following cataract surgery.*
- *Patients who have any of the listed significant ocular conditions [comorbid] in the exclusion criteria should be removed from the denominator; these patients have existing ocular conditions that could impact the outcome of surgery and are not included in the measure calculation for those patients who have best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.*
- *Include only procedures performed through September 30th of the reporting period. This will allow the post-operative period to occur within the reporting year.*

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to determine patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery

Denominator Instructions: Clinicians who indicate modifier 55, postoperative management only OR modifier 56, preoperative management only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
AND NOT

Any of the following significant ocular conditions that impact the visual outcome of surgery

(Patients with documentation of any of the following significant ocular conditions that impact the visual outcome of surgery prior to date of cataract surgery are excluded from the measure calculation)

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 1/1/2014-9/30/2014]
Acute and Subacute Iridocyclitis	364.00, 364.01, 364.02, 364.03, 364.04, 364.05
Amblyopia	368.01, 368.02, 368.03
Burn Confined to Eye and Adnexa	940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9
Cataract Secondary to Ocular Disorders	366.32, 366.33
Central Corneal Ulcer	370.03
Certain Types of Iridocyclitis	364.21, 364.22, 364.23, 364.24, 364.3
Choroidal Degenerations	363.43
Choroidal Detachment	363.72
Choroidal Hemorrhage and Rupture	363.61, 363.62, 363.63
Chorioretinal Scars	363.30, 363.31, 363.32, 363.33, 363.35
Chronic Iridocyclitis	364.10, 364.11
Cloudy Cornea	371.01, 371.02, 371.03, 371.04
Corneal Opacity and Other Disorders of Cornea	371.00, 371.03, 371.04
Corneal Edema	371.20, 371.21, 371.22, 371.23, 371.43, 371.44
Degeneration of Macula and Posterior Pole	362.50, 362.51, 362.52, 362.53, 362.54, 362.55, 362.56, 362.57
Degenerative Disorders of Globe	360.20, 360.21, 360.23, 360.24, 360.29
Diabetic Macular Edema	362.07
Diabetic Retinopathy	362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Disorders of Optic Chiasm	377.51, 377.52, 377.53, 377.54
Disorders of Visual Cortex	377.75
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	363.10, 363.11, 363.12, 363.13, 363.14, 363.15
Focal Chorioretinitis and Focal Retinochoroiditis	363.00, 363.01, 363.03, 363.04, 363.05, 363.06, 363.07, 363.08
Glaucoma	365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89
Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes	365.41, 365.42, 365.43, 365.44, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89, 365.9
Hereditary Choroidal Dystrophies	363.50, 363.51, 363.52, 363.53, 363.54, 363.55, 363.56, 363.57
Hereditary Corneal Dystrophies	371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58
Hereditary Retinal Dystrophies	362.70, 362.71, 362.72, 362.73, 362.74, 362.75, 362.76
Injury to Optic Nerve and Pathways	950.0, 950.1, 950.2, 950.3, 950.9

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 1/1/2014-9/30/2014]
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	369.10, 369.11, 369.12, 369.13, 369.14, 369.15, 369.16, 369.17, 369.18
Nystagmus and Other Irregular Eye Movements	379.51
Open Wound of Eyeball	871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3
Optic Atrophy	377.10, 377.11, 377.12, 377.13, 377.14, 377.15, 377.16
Optic Neuritis	377.30, 377.31, 377.32, 377.33, 377.34, 377.39
Other Background Retinopathy and Retinal Vascular Changes	362.12, 362.16, 362.18
Other Corneal Deformities	371.70, 371.71, 371.72, 371.73
Other Disorders of Optic Nerve	377.41
Other Disorders of Sclera	379.11, 379.12
Other Endophthalmitis	360.11, 360.12, 360.13, 360.14, 360.19
Other Proliferative Retinopathy	362.20, 362.21, 362.22, 362.23, 362.24, 362.25, 362.26, 362.27
Other Retinal Disorders	362.81, 362.82, 362.83, 362.84, 362.85, 362.89
Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis	363.20, 363.21, 363.22
Pathologic Myopia	360.20, 360.21
Prior Penetrating Keratoplasty	371.60, 371.61, 371.62
Profound Impairment, Both Eyes	369.00, 369.01, 369.02, 369.03, 369.04, 369.05, 369.06, 369.07, 369.08
Purulent Endophthalmitis	360.00, 360.01, 360.02, 360.03, 360.04
Retinal Detachment with Retinal Defect	361.00, 361.01, 361.02, 361.03, 361.04, 361.05, 361.06, 361.07
Retinal Vascular Occlusion	362.31, 362.32, 362.35, 362.36
Scleritis and Episcleritis	379.04, 379.05, 379.06, 379.07, 379.09
Separation of Retinal Layers	362.41, 362.42, 362.43
Uveitis	360.11, 360.12
Visual Field Defects	368.41

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2014-12/31/2014]
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.019, H20.021, H20.022, H20.023, H20.029, H20.031, H20.032, H20.033, H20.039, H20.041, H20.042, H20.043, H20.049, H20.051, H20.052, H20.053, H20.059
Amblyopia	H53.011, H53.012, H53.013, H53.019, H53.021, H53.022, H53.023, H53.029, H53.031, H53.032, H53.033, H53.039
Burn Confined to Eye and Adnexa	T26.00XA, T26.01XA, T26.02XA, T26.10XA, T26.11XA, T26.12XA, T26.20XA, T26.21XA, T26.22XA, T26.30XA, T26.31XA, T26.32XA, T26.40XA, T26.41XA, T26.42XA, T26.50XA, T26.51XA, T26.52XA, T26.60XA, T26.61XA, T26.62XA, T26.70XA, T26.71XA, T26.72XA, T26.80XA, T26.81XA, T26.82XA, T26.90XA, T26.91XA, T26.92XA

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2014-12/31/2014]
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.219, H26.221, H26.222, H26.223, H26.229
Central Corneal Ulcer	H16.011, H16.012, H16.013, H16.019
Certain Types of Iridocyclitis	H20.20, H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.819, H20.821, H20.822, H20.823, H20.829, H20.9, H40.40X0
Choroidal Degenerations	H35.33
Choroidal Detachment	H31.411, H31.412, H31.413, H31.419
Choroidal Hemorrhage and Rupture	H31.301, H31.302, H31.303, H31.309, H31.311, H31.312, H31.313, H31.319, H31.321, H31.322, H31.323, H31.329
Chorioretinal Scars	H31.001, H31.002, H31.003, H31.009, H31.011, H31.012, H31.013, H31.019, H31.021, H31.022, H31.023, H31.029, H31.091, H31.092, H31.093, H31.099
Chronic Iridocyclitis	A18.54, H20.10, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829
Corneal Opacity and Other Disorders of Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9
Corneal Edema	H18.10, H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.229, H18.231, H18.232, H18.233, H18.239, H18.421, H18.422, H18.423, H18.429, H18.43
Degeneration of Macula and Posterior Pole	H35.30, H35.31, H35.32, H35.341, H35.342, H35.343, H35.349, H35.351, H35.352, H35.353, H35.359, H35.361, H35.362, H35.363, H35.369, H35.371, H35.372, H35.373, H35.379, H35.381, H35.382, H35.383, H35.389
Degenerative Disorders of Globe	H44.20, H44.21, H44.22, H44.23, H44.311, H44.312, H44.313, H44.319, H44.321, H44.322, H44.323, H44.329, H44.391, H44.392, H44.393, H44.399
Diabetic Macular Edema	E08.311, E08.321, E08.331, E08.341, E08.351, E09.311, E09.321, E09.331, E09.341, E09.351, E10.311, E10.321, E10.331, E10.341, E10.351, E11.311, E11.321, E11.331, E11.341, E11.351, E13.311, E13.321, E13.331, E13.341, E13.351
Diabetic Retinopathy	E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
Disorders of Optic Chiasm	H47.41, H47.42, H47.43, H47.49
Disorders of Visual Cortex	H47.611, H47.612, H47.619

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2014-12/31/2014]
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	A18.53, H30.101, H30.102, H30.103, H30.109, H30.111, H30.112, H30.113, H30.119, H30.121, H30.122, H30.123, H30.129, H30.131, H30.132, H30.133, H30.139, H30.141, H30.142, H30.143, H30.149
Focal Chorioretinitis and Focal Retinochoroiditis	H30.001, H30.002, H30.003, H30.009, H30.011, H30.012, H30.013, H30.019, H30.021, H30.022, H30.023, H30.029, H30.031, H30.032, H30.033, H30.039, H30.041, H30.042, H30.043, H30.049
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1390, H40.1391, H40.1392, H40.1393, H40.1394, H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492, H40.1493, H40.1494, H40.151, H40.152, H40.153, H40.159, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.219, H40.2210, H40.2211, H40.2212, H40.2213, H40.2214, H40.2220, H40.2221, H40.2222, H40.2223, H40.2224, H40.2230, H40.2231, H40.2232, H40.2233, H40.2234, H40.2290, H40.2291, H40.2292, H40.2293, H40.2294, H40.231, H40.232, H40.233, H40.239, H40.241, H40.242, H40.243, H40.249, H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.60X0, H40.60X1, H40.60X2, H40.60X3, H40.60X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, Q15.0

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2014-12/31/2014]
Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes	H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, H40.9, H42
Hereditary Choroidal Dystrophies	H31.20, H31.21, H31.22, H31.23, H31.29
Hereditary Corneal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59
Hereditary Retinal Dystrophies	H35.50, H35.51, H35.52, H35.53, H35.54, H36
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.019A, S04.02XA, S04.031A, S04.032A, S04.039A, S04.041A, S04.042A, S04.049A
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	H54.10, H54.11, H54.12
Nystagmus and Other Irregular Eye Movements	H55.01
Open Wound of Eyeball	S05.10XA, S05.11XA, S05.12XA, S05.20XA, S05.21XA, S05.22XA, S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52XA, S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.8X9A, S05.90XA, S05.91XA, S05.92XA
Optic Atrophy	H47.20, H47.211, H47.212, H47.213, H47.219, H47.22, H47.231, H47.232, H47.233, H47.239, H47.291, H47.292, H47.293, H47.299
Optic Neuritis	H46.00, H46.01, H46.02, H46.03, H46.10, H46.11, H46.12, H46.13, H46.2, H46.3, H46.8, H46.9
Other Background Retinopathy and Retinal Vascular Changes	H35.021, H35.022, H35.023, H35.029, H35.051, H35.052, H35.053, H35.059, H35.061, H35.062, H35.063, H35.069
Other Corneal Deformities	H18.70, H18.711, H18.712, H18.713, H18.719, H18.721, H18.722, H18.723, H18.729, H18.731, H18.732, H18.733, H18.739, H18.791, H18.792, H18.793, H18.799
Other Disorders of Optic Nerve	H47.011, H47.012, H47.013, H47.019
Other Disorders of Sclera	H15.831, H15.832, H15.833, H15.839, H15.841, H15.842, H15.843, H15.849

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2014-12/31/2014]
Other Endophthalmitis	H16.241, H16.242, H16.243, H16.249, H21.331, H21.332, H21.333, H21.339, H33.121, H33.122, H33.123, H33.129, H44.111, H44.112, H44.113, H44.119, H44.121, H44.122, H44.123, H44.129, H44.131, H44.132, H44.133, H44.139, H44.19
Other Proliferative Retinopathy	H35.101, H35.102, H35.103, H35.109, H35.111, H35.112, H35.113, H35.119, H35.121, H35.122, H35.123, H35.129, H35.131, H35.132, H35.133, H35.139, H35.141, H35.142, H35.143, H35.149, H35.151, H35.152, H35.153, H35.159, H35.161, H35.162, H35.163, H35.169, H35.171, H35.172, H35.173, H35.179
Other Retinal Disorders	H35.60, H35.61, H35.62, H35.63, H35.81, H35.82, H35.89
Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis	H30.20, H30.21, H30.22, H30.23, H30.811, H30.812, H30.813, H30.819, H30.891, H30.892, H30.893, H30.899, H30.90, H30.91, H30.92, H30.93
Pathologic Myopia	H44.20, H44.21, H44.22, H44.23, H44.30
Prior Penetrating Keratoplasty	H18.601, H18.602, H18.603, H18.609, H18.611, H18.612, H18.613, H18.619, H18.621, H18.622, H18.623, H18.629
Profound Impairment, Both Eyes	H54.0, H54.10
Purulent Endophthalmitis	H44.001, H44.002, H44.003, H44.009, H44.011, H44.012, H44.013, H44.019, H44.021, H44.022, H44.023, H44.029
Retinal Detachment with Retinal Defect	H33.001, H33.002, H33.003, H33.009, H33.011, H33.012, H33.013, H33.019, H33.021, H33.022, H33.023, H33.029, H33.031, H33.032, H33.033, H33.039, H33.041, H33.042, H33.043, H33.049, H33.051, H33.052, H33.053, H33.059, H33.8
Retinal Vascular Occlusion	H34.10, H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, H34.239, H34.811, H34.812, H34.813, H34.819, H34.831, H34.832, H34.833, H34.839
Scleritis and Episcleritis	A18.51, H15.021, H15.022, H15.023, H15.029, H15.031, H15.032, H15.033, H15.039, H15.041, H15.042, H15.043, H15.049, H15.051, H15.052, H15.053, H15.059, H15.091, H15.092, H15.093, H15.099
Separation of Retinal Layers	H35.711, H35.712, H35.713, H35.719, H35.721, H35.722, H35.723, H35.729, H35.731, H35.732, H35.733, H35.739
Uveitis	H44.111, H44.112, H44.113, H44.119, H44.131, H44.132, H44.133, H44.139
Visual Field Defects	H53.411, H53.412, H53.413, H53.419

NUMERATOR:
Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery

Numerator Options:
Best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery (4175F)

OR

Best-corrected visual acuity of 20/40 or better (distance or near) not achieved within 90 days following cataract surgery, reason not otherwise specified (4175F *with* 8P)

RATIONALE:

1. Scientific basis for measuring visual acuity outcomes after cataract surgery

The only reason to perform cataract surgery (other than for a limited set of medical indications) is to improve a patient's vision and associated functioning. The use of a 20/40 visual acuity threshold is based on several considerations. First, it is the level for unrestricted operation of a motor vehicle in the US. Second, it has been consistently used by the FDA in its assessment for approval of intraocular lens (IOL) and other vision devices. Third, it is the literature standard to denote success in cataract surgery. Fourth, work by West et al in the Salisbury Eye Study suggests that 20/40 is a useful threshold for 50th percentile functioning for several vision-related tasks.

Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery in eyes without comorbid ocular conditions that would impact the success of the surgery would reflect care that should be assessed for opportunities for improvement.

The exclusion of patients with other ocular and systemic conditions known to increase the risk of an adverse outcome reflects the findings of the two published prediction rule papers for cataract surgery outcomes, by Mangione et al and Steinberg et al. In both papers, the presence of comorbid glaucoma and macular degeneration negatively impacted the likelihood of successful outcomes of surgery. Further, as noted in the prior indicator, exclusion of eyes with ocular conditions that could impact the success of the surgery would NOT eliminate the large majority of eyes undergoing surgery while also minimizing the potential adverse selection that might otherwise occur relative to those patients with the most complex situations who might benefit the most from having surgery to maximize their remaining vision.

2. Evidence of a gap in care

This is an outcome of surgery indicator of direct relevance to patients and referring providers. The available evidence suggests that cataract surgery achieves this in between 86 and 98% of surgeries in eyes without comorbid ocular conditions (this indicator). While small, the volume of cataract surgery in the US of over 2.8 million surgeries suggests that the impact could affect more than 100,000 patients per year. Because of the exclusion of comorbid ocular conditions, one would expect performance on this indicator to be as high as possible, with significantly lower rates suggestive of opportunities for improvement.

The ASCRS National Cataract Database reported that at 3 months postoperatively, 85.5% of all patients had a 20/40 or better best-corrected visual acuity, 57.2% of patients had 20/25 or better postoperative best-corrected visual acuity, and 74.6% of patients were within ± 1.0 D of target spherical equivalent. Based on 5,788 responses, the mean visual function index score at 3 months postoperatively was 70.3% compared with 55.0% preoperatively. (The score is based on a scale of 0 to 100, with 0 indicating an inability to perform any of the activities.) The European Cataract Outcome Study reported for 1999 that 89% of patients achieved a postoperative visual acuity of 0.5 or more (20/40 or better), the average induced astigmatism was 0.59 D, and 86% of patients had an induced astigmatism within ± 1.0 D.

The AAO National Eyecare Outcomes Network (NEON) database also found similar rates of success, with an improvement in visual acuity in 92.2% of patients and improvement in VF-14 in over 90% of patients. Best-corrected visual acuity (BCVA) of 20/40 was achieved by 89% of all NEON patients and 96% of NEON patients without preoperative ocular comorbid conditions. Seventy-eight percent of patients were within ± 1.0 D of target spherical equivalent. Ninety-five percent of patients reported being satisfied with the results of their surgery. Patients who were dissatisfied with the results of their surgery were slightly older and more likely to have ocular comorbidity.

In studies of phacoemulsification cataract surgery performed by ophthalmology residents, the reported range of patients with postoperative BCVA of 20/40 or better is 80% to 91%. If eyes with ocular comorbidities are excluded, the reported range of patients with postoperative BCVA of 20/40 or better is 86% to 98%. (AAO, 2011)

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcome measure. As such, there are no statements in the guideline specific to this measurement topic.

* Measure #192 (NQF 0564): Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence

INSTRUCTIONS:
This measure is to be calculated each time a procedure for non-complicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated cataract surgery.

Note: This is an outcome measure and can be calculated solely using registry data.

- *For patients who receive the cataract surgical procedures specified in the denominator coding, claims should be reviewed to determine if any of the procedure codes listed in the numerator were performed within 30 days of the date of cataract surgery.*
- *Patients who have any of the listed significant ocular conditions in the exclusion criteria should be removed from the denominator, and not considered as having a complication within 30 days following cataract surgery.*

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to determine patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant ocular conditions impacting the surgical complication rate

Denominator Instructions: Clinicians who indicate modifier 55, postoperative management only OR modifier 56, preoperative management only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
AND NOT
Any of the following significant ocular conditions that impact the visual outcome of surgery

(Patients with documentation of one or more of the following significant ocular conditions prior to date of cataract surgery are excluded from the measure calculation)

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 1/1/2014-9/30/2014]
Acute and Subacute Iridocyclitis	364.00, 364.01, 364.02, 364.03, 364.04, 364.05
Adhesions and Disruptions of Iris and Ciliary Body	364.70, 364.71, 364.72, 364.73, 364.74, 364.75, 364.76, 364.77, 364.81, 364.82, 364.89
Anomalies of Puillary Function	379.42
Aphakia and Other Disorders of Lens	379.32, 379.33, 379.34
Burn Confined to Eye and Adnexa	940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9
Cataract Secondary to Ocular Disorders	366.32, 366.33
Cataract, Congenital	743.30
Cataract, Mature or Hypermature	366.9
Cataract, Posterior Polar	743.31
Central Corneal Ulcer	370.03
Certain Types of Iridocyclitis	364.21, 364.22, 364.23, 364.24, 364.3
Chronic Iridocyclitis	364.10, 364.11
Cloudy Cornea	371.01, 371.02, 371.03, 371.04
Corneal Opacity and Other Disorders of Cornea	371.00, 371.03, 371.04
Corneal Edema	371.20, 371.21, 371.22, 371.23, 371.43, 371.44
Cysts of Iris, Ciliary Body, and Anterior Chamber	364.60, 364.61, 364.62, 364.63, 364.64
Enophthalmos	376.50, 376.51, 376.52
Glaucoma	365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89
Hereditary Corneal Dystrophies	371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58
High Hyperopia	367.0
Hypotony of Eye	360.30, 360.31, 360.32, 360.33, 360.34
Injury to Optic Nerve and Pathways	950.0, 950.1, 950.2, 950.3, 950.9
Open Wound of Eyeball	871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3
Pathologic Myopia	360.20, 360.21
Posterior Lenticonus	743.36
Prior Pars Plana Vitrectomy	67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure)
Pseudoexfoliation Syndrome	365.52
Retrolental Fibroplasias	362.21
Senile Cataract	366.11
Traumatic Cataract	366.20, 366.21, 366.22, 366.23
Use of Systemic Sympathetic Alpha-1a Antagonist Medication for Treatment of Prostatic Hypertrophy	Patient taking tamsulosin hydrochloride

Significant Ocular Condition	Corresponding ICD-9-CM Codes [for use 1/1/2014-9/30/2014]
Uveitis	360.11, 360.12
Vascular Disorders of Iris and Ciliary Body	364.42

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2014-12/31/2014]
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.019, H20.021, H20.022, H20.023, H20.029, H20.031, H20.032, H20.033, H20.039, H20.041, H20.042, H20.043, H20.049, H20.051, H20.052, H20.053, H20.059
Adhesions and Disruptions of Iris and Ciliary Body	H21.40, H21.41, H21.42, H21.43, H21.501, H21.502, H21.503, H21.509, H21.511, H21.512, H21.513, H21.519, H21.521, H21.522, H21.523, H21.529, H21.531, H21.532, H21.533, H21.539, H21.541, H21.542, H21.543, H21.549, H21.551, H21.552, H21.553, H21.559, H21.561, H21.562, H21.563, H21.569, H21.81, H21.82, H21.89, H22
Anomalies of Puillary Function	H57.03
Aphakia and Other Disorders of Lens	H27.10, H27.111, H27.112, H27.113, H27.119, H27.121, H27.122, H27.123, H27.129, H27.131, H27.132, H27.133, H27.139
Burn Confined to Eye and Adnexa	T26.00XA, T26.01XA, T26.02XA, T26.10XA, T26.11XA, T26.12XA, T26.20XA, T26.21XA, T26.22XA, T26.30XA, T26.31XA, T26.32XA, T26.40XA, T26.41XA, T26.42XA, T26.50XA, T26.51XA, T26.52XA, T26.60XA, T26.61XA, T26.62XA, T26.70XA, T26.71XA, T26.72XA, T26.80XA, T26.81XA, T26.82XA, T26.90XA, T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.219, H26.221, H26.222, H26.223, H26.229
Cataract, Congenital	Q12.0
Cataract, Mature or Hypermature	H26.9
Cataract, Posterior Polar	Q12.0
Central Corneal Ulcer	H16.011, H16.012, H16.013, H16.019
Certain Types of Iridocyclitis	H20.20, H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.819, H20.821, H20.822, H20.823, H20.829, H20.9, H40.40X0
Chronic Iridocyclitis	A18.54, H20.10, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829
Corneal Opacity and Other Disorders of Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9
Corneal Edema	H18.10, H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.229, H18.231, H18.232, H18.233, H18.239, H18.421, H18.422, H18.423, H18.429, H18.43

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2014-12/31/2014]
Cysts of Iris, Ciliary Body, and Anterior Chamber	H21.301, H21.302, H21.303, H21.309, H21.311, H21.312, H21.313, H21.319, H21.321, H21.322, H21.323, H21.329, H21.341, H21.342, H21.343, H21.349, H21.351, H21.352, H21.353, H21.359
Enophthalmos	H05.401, H05.402, H05.403, H05.409, H05.411, H05.412, H05.413, H05.419, H05.421, H05.422, H05.423, H05.429
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1390, H40.1391, H40.1392, H40.1393, H40.1394, H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492, H40.1493, H40.1494, H40.151, H40.152, H40.153, H40.159, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.219, H40.2210, H40.2211, H40.2212, H40.2213, H40.2214, H40.2220, H40.2221, H40.2222, H40.2223, H40.2224, H40.2230, H40.2231, H40.2232, H40.2233, H40.2234, H40.2290, H40.2291, H40.2292, H40.2293, H40.2294, H40.231, H40.232, H40.233, H40.239, H40.241, H40.242, H40.243, H40.249, H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.60X0, H40.60X1, H40.60X2, H40.60X3, H40.60X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, Q15.0

Significant Ocular Condition	Corresponding ICD-10-CM Codes [for use 10/01/2014-12/31/2014]
Hereditary Corneal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59
High Hyperopia	H52.00, H52.01, H52.02, H52.03
Hypotony of Eye	H44.40, H44.411, H44.412, H44.413, H44.419, H44.421, H44.422, H44.423, H44.429, H44.431, H44.432, H44.433, H44.439, H44.441, H44.442, H44.443, H44.449
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.019A, S04.02XA, S04.031A, S04.032A, S04.039A, S04.041A, S04.042A, S04.049A
Open Wound of Eyeball	S05.10XA, S05.11XA, S05.12XA, S05.20XA, S05.21XA, S05.22XA, S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52XA, S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.8X9A, S05.90XA, S05.91XA, S05.92XA
Pathologic Myopia	H44.20, H44.21, H44.22, H44.23, H44.30
Posterior Lenticonus	Q12.2, Q12.4, Q12.8
Prior Pars Plana Vitrectomy	67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure)
Pseudoexfoliation Syndrome	H40.1410, H40.1411, H40.1412, H40.1413, H40.1414, H40.1420, H40.1421, H40.1422, H40.1423, H40.1424, H40.1430, H40.1431, H40.1432, H40.1433, H40.1434, H40.1490, H40.1491, H40.1492, H40.1493, H40.1494
Retrolental Fibroplasias	H35.171, H35.172, H35.173, H35.179
Senile Cataract	H25.89
Traumatic Cataract	H26.101, H26.102, H26.103, H26.109, H26.111, H26.112, H26.113, H26.119, H26.121, H26.122, H26.123, H26.129, H26.131, H26.132, H26.133, H26.139
Use of Systemic Sympathetic Alpha-1a Antagonist Medication for Treatment of Prostatic Hypertrophy	Patient taking tamsulosin hydrochloride
Uveitis	H44.111, H44.112, H44.113, H44.119, H44.131, H44.132, H44.133, H44.139
Vascular Disorders of Iris and Ciliary Body	H21.1X1, H21.1X2, H21.1X3, H21.1X9

NUMERATOR:

Patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence

Numerator Instructions: Codes for major complications (eg, retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence): 65235, 65800, 65810, 65815, 65860, 65880, 65900, 65920, 65930, 66030, 66250, 66820, 66825, 66830, 66852, 66986, 67005, 67010, 67015, 67025, 67028, 67030, 67031, 67036, 67039, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67250, 67255

NUMERATOR NOTE: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Surgical procedure performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) (G8627)

OR

Surgical procedure not performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) (G8628)

RATIONALE:

1. Scientific basis for assessing short-term complications following cataract surgery.

Complications that may result in a permanent loss of vision following cataract surgery are uncommon. This short-term outcome of surgery indicator seeks to identify those complications from surgery that can reasonably be attributed to the surgery and surgeon and which reflect situations which - if untreated - generally result in significant avoidable vision loss that would negatively impact patient functioning. Further, it seeks to reduce surgeon burden and enhance accuracy in reporting by focusing on those significant complications that can be assessed from administrative data alone and which can be captured by the care of another physician or the provision of additional, separately coded, post-operative services. Finally, it focuses on patient safety and monitoring for events that, while hopefully uncommon, can signify important issues in the care being provided. For example, the need to reposition or exchange an intraocular lens (IOL) reflects in part "wrong power" IOL placement, a major patient safety issue.

In order to achieve these ends, the indicator excludes patients with other known, pre-operative ocular conditions that could impact the likelihood of developing a complication. Based on the results of the Cataract Appropriateness Project at RAND, other published studies, and one analysis performed on a national MCO data base, the exclusion codes would preserve over 2/3 of all cataract surgery cases for analysis. Thus, this provides a "clean" indicator that captures care for the large majority of patients undergoing cataract surgery.

2. Evidence for gap in care.

The advances in technology and surgical skills over the last 30 years have made cataract surgery much safer and more effective. An analysis of a single company's database (commercial age MCO) demonstrated that the rate of complications found for this indicator was approximately 1 to 2%. Nevertheless, as noted above, the occurrence of one of these events is associated with a significant potential for vision loss that is otherwise avoidable. Furthermore, with an annual volume of 2.8 million cataract surgeries in the US, a 2% rate would mean that over 36,000 surgeries are accompanied by these complications (2/3 of 56,000 surgeries).

A synthesis of the literature published prior to 1992 found weighted mean complication rates among all patients undergoing cataract surgery of 0.13% for endophthalmitis, 0.3% for bullous keratopathy, 1.4% clinically detectable CME, 3.5% for angiographically demonstrated CME, 0.7% for retinal detachment, and 1.1% for IOL dislocation. Bullous keratopathy and CME are not included in this indicator because they are conditions that are almost always temporary and resolve without additional intervention through additional procedures and associated care in this population of patients without prior known ocular conditions.

Additional studies similarly demonstrate the low occurrence of complications, including many that are temporary in nature and without a significant impact on patient outcomes. A national survey of over 100 hospitals from 1997 to 1998 found the following results on 18,454 patients 50 years old or older. Seventy-seven percent of these patients had surgery performed by phacoemulsification. Rates for events that occurred during surgery were 4.4% for posterior capsule rupture and vitreous loss, 1.0% for incomplete cortical cleanup, 1.0% for anterior chamber hemorrhage and or collapse, and 0.77% for iris damage. Short-term (within 48 hours) perioperative complications included corneal

edema (9.5%), increased IOP (7.9%), uveitis (5.6%), wound leak (1.2%), hyphema (1.1%), and retained lens material (1.1%).

A retrospective study from New Zealand of 1,793 consecutive patients undergoing phacoemulsification reported a rate of 1.8% for posterior capsule rupture and a rate of 1.2% for rhegmatogenous retinal detachment. (AAO, 2006)

CLINICAL RECOMMENDATION STATEMENTS:
This is an outcome measure. As such, there are no statements in the guideline specific to this measurement topic.

▲ Measure #193 (NQF 0454): Perioperative Temperature Management

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom *either* active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

INSTRUCTIONS:
This measure is to be reported each time a surgical or therapeutic procedure not involving cardiopulmonary bypass is performed under general or neuraxial anesthesia during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the listed anesthesia services as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT Procedure code and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- Medical reasons, 8P- reasons not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): Patient encounter during the reporting period (CPT): Anesthesia codes for surgical or therapeutic procedures under general or neuraxial anesthesia: 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00566, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914,

00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966, 01968, 01969

NUMERATOR:

Patients for whom *either:*

- Active warming was used intraoperatively for the purpose of maintaining normothermia OR
- At least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

Numerator Instructions: The anesthesia time used for this measure should be the time recorded in the anesthesia record.

NUMERATOR NOTE: If monitored anesthesia care (MAC) or peripheral nerve block (PNB) without the use of general anesthesia during an applicable procedure (regardless of duration of procedure), report 4250F-1P.

Definition:

Active Warming – For purposes of this measure, active warming is limited to over-the-body active warming (eg, forced air, warm-water garments, and resistive heating blankets).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Active Warming Used Intraoperatively OR At Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Recorded Within Designated Timeframe

(Two CPT II codes [4250F & 4255F] are required on the claim form to submit this numerator option)

CPT II 4250F: Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade not Achieved Within Designated Timeframe for one of the following Medical Reasons:

(Two CPT II codes [4250F-1P & 4255F] are required on the claim form to submit this numerator option)

Append a modifier (1P) to CPT Category II code 4250F to report one of the following documented circumstances that appropriately exclude patients from the denominator.

4250F *with* 1P: Intentional hypothermia OR active warming not indicated due to anesthetic technique: peripheral nerve block without general anesthesia, OR monitored anesthesia care

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

If patient does not meet denominator inclusion because anesthesia time as indicated on the anesthesia record is less than 60 minutes duration

(One CPT II code [4256F] is required on the claim form to submit this numerator option)

CPT II 4256F: Duration of general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Not Achieved Within Designated Timeframe, Reason Not Otherwise Specified

(Two CPT II codes [4250F-8P & 4255F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 4250F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4250F *with* 8P: Active warming not performed OR at least one body temperature equal to or greater than 36 degrees Centigrade not achieved within designated timeframe, reason not otherwise specified

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

RATIONALE:

Anesthetic-induced impairment of thermoregulatory control is the primary cause of perioperative hypothermia. Even mild hypothermia (1-2°C below normal) has been associated in randomized trials with a number of adverse consequences, including: increased susceptibility to infection, impaired coagulation and increased transfusion requirements, cardiovascular stress and cardiac complications, post-anesthetic shivering and thermal discomfort. Whether the benefits of avoiding hypothermia in patients undergoing cardiopulmonary bypass (CPB) outweigh potential harm is uncertain, because known complications of CPB include cerebral injury, which may be mitigated by mild hypothermia. Therefore, patients undergoing CPB are excluded from the denominator population for this measure. Several methods to maintain normothermia are available to the anesthesiologist in the perioperative period; various studies have demonstrated the superior efficacy of over-the-body active warming (eg, forced air, warm-water garments, and resistive heating blankets).

CLINICAL RECOMMENDATION STATEMENTS:

Preoperative patient management

Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Measure patient temperature on admission. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities).

Interventions: Institute preventive warming measures for patients who are normothermic (normothermia is defined as a core temperature range from 36°C-38°C [96.8°F-100.4°F]). A variety of measures may be used, unless contraindicated. Passive insulation may include warmed cotton blankets, socks, head covering, limited skin exposure, circulating water mattresses, and increase in ambient room temperature (minimum 68ºF- 75ºF). Institute active warming measures for patients who are hypothermic (defined as a core temperature less than 36°C). Active warming is the application of a forced air convection warming system. Apply appropriate passive insulation and increase the ambient room temperature (minimum 68ºF-75ºF). Consider warmed intravenous (IV) fluids. (ASPAN)

Intraoperative patient management

Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities). Monitor patient's temperature intraoperatively.

Intervention: Implement warming methods. (ASPAN)

Maintenance of body temperature in a normothermic range is recommended for most procedures other than during periods in which mild hypothermia is intended to provide organ protection (eg, during high aortic cross-clamping). (Class I Recommendation, Level of Evidence B) (ACC/AHA, 2007)

Measure #194 (NQF 0386): Oncology: Cancer Stage Documented

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have a baseline American Joint Committee on Cancer (AJCC) cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with cancer seen during the reporting period. This measure is limited to cancer diagnoses for which AJCC staging or equivalent is available. This measure is intended to reflect the quality of services provided for the primary management of patients with cancer who are seen in the ambulatory setting or receiving radiation treatment planning.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT Procedure code, ICD-9-CM/ICD-10-CM diagnosis codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P-reasons not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting

Denominator Criteria (Eligible Cases):
Diagnosis for cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 160.0, 160.2, 160.3, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6,

171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 184.0, 184.1, 184.2, 184.3,185, 186.0, 187.1, 187.2, 187.3, 187.5, 187.6, 187.7, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 190.1, 190.2, 190.3, 193, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36

Diagnosis for cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C30.0, C31.0, C31.1, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C47.0, C47.10, C47.11, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211,

C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C58, C60.0, C60.1, C60.2, C61, C62.00, C62.01, C62.02, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C69.00, C69.01, C69.02, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C73, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C88.4, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9

AND

Patient encounter during reporting period (CPT): 77261, 77262, 77263, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who have a baseline American Joint Committee on Cancer (AJCC)* cancer stage** or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period

Numerator Instructions:

* For certain malignancies, staging or classification systems included in the AJCC Staging Manual would also satisfy the requirements of this measure (eg, Ann Arbor).

**Cancer stage refers to stage at diagnosis. Documentation that the cancer is metastatic at diagnosis would also satisfy the requirements of the measure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Cancer Stage Documented and Reviewed
CPT II 3300F: American Joint Committee on Cancer (AJCC) stage documented and reviewed
OR
CPT II 3301F: Cancer stage documented in medical record as metastatic and reviewed

OR

Cancer Stage not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3301F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3301F *with* 8P: Cancer stage not documented, reason not otherwise specified

RATIONALE:
Cancer stage is a critical component in determining treatment options for patients with cancer. Though critically important, cancer stage is not always documented in the medical record. This measure is intended to be reported at least once per 12 month reporting period.

CLINICAL RECOMMENDATION STATEMENTS:
A simple classification scheme, which can be incorporated into a form for staging and can be universally applied, is the goal of the TNM system as proposed by the [American Joint Committee on Cancer (AJCC).] Thus, examination during the surgical procedure and histologic examination of the surgically removed tissues may identify significant additional indicators of the prognosis of the patient (T, N, and M) as different from what could be discerned clinically before therapy. Because this is that pathologic (pTNM) classification and stage grouping (based on examination of a surgically resected specimen with sufficient tissue to evaluate the highest T, N, or M classification), it is recorded in addition to the clinical classification. It does not replace the clinical classification. Both should be maintained in the patient's permanent medical record…It is intended to provide a means by which this information can readily be communicated to others, to assist in therapeutic decisions, and to help estimate prognosis. (American Joint Committee on Cancer, 2010)

The following represent a sample of guideline recommendation statements supporting the measure for a variety of cancers:

Breast Cancer
All patients with breast cancer should be assigned a clinical stage of disease, and if appropriate evaluation is available, a pathologic stage of disease. The routine use of staging allows for efficient identification of local treatment options, assists in identifying systemic treatment options, allows the comparison of outcome results across institutions and clinical trials, and provides baseline prognostic information….A central component of the treatment of breast cancer is full knowledge of extent of disease and biologic features. These factors contribute to the determination of the stage of disease, assist in the estimation of the risk that cancer will recur, and provide information that predicts response to therapy (e.g., hormone receptors and human epidermal growth factor receptor 2 [HER2]). (NCCN, 2011)

Colon Cancer
Some of the criteria that should be included in the report of the pathologic evaluation include the following: grade of the cancer; depth of penetration and extension to adjacent structures (T); number of regional lymph nodes evaluated; number of positive regional lymph nodes (N); an assessment of the presence of distant metastases to other organs, the peritoneum of an abdominal structure, or in non-regional lymph nodes (M); the status of proximal, distal, and radial margins; lymphovascular invasion; perineural invasion; and extra-nodal tumor deposits. (NCCN, 2012)

*Measure #195 (NQF 0507): Radiology: Stenosis Measurement in Carotid Imaging Reports

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of final reports for carotid imaging studies (neck magnetic resonance angiography [MRA], neck computed tomography angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

INSTRUCTIONS:
This measure is to be reported each time a carotid imaging study is performed during the reporting period for all patients, regardless of age. There is no diagnosis associated with this measure. Clinicians who provide the professional component of diagnostic imaging studies of the carotids will submit this measure.

Measure Reporting via Claims:
CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT procedure codes and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reporting on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed

> Denominator Criteria (Eligible Cases):
> Patient encounter during the reporting period (CPT): 36222, 70498, 70547, 70548, 70549, 93880, 93882

NUMERATOR:
Final carotid imaging study reports that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

> Numerator Instructions: This measure requires that the estimate of stenosis included in the report of the imaging study employ a method such as the North American Symptomatic Carotid Endarterectomy Trial (NASCET) method for calculating the degree of stenosis. The NASCET method calculates the degree of stenosis with reference to the lumen of the carotid artery distal to the stenosis.

For duplex imaging studies the reference is indirect, since the degree of stenosis is inferred from velocity parameters and cross referenced to published or self-generated correlations among velocity parameters and results of angiography or other imaging studies which serve as the gold standard. In Doppler ultrasound, the degree of stenosis can be estimated using Doppler parameter of the peak systolic velocity (PSV) of the internal carotid artery (ICA), with concordance of the degree of narrowing of the ICA lumen. Additional Doppler parameters of ICA-to-common carotid artery (CCA) PSV ratio and ICA end-diastolic velocity (EDV) can be used when degree of stenosis is uncertain from ICA PSV. (Grant et al, 2003)

A short note can be made in the final report, such as:

- *"Severe left ICA stenosis of 70-80% by NASCET criteria"* or
- *"Severe left ICA stenosis of 70-80% by criteria similar to NASCET"* or
- *"70% stenosis derived by comparing the narrowest segment with the distal luminal diameter as related to the reported measure of arterial narrowing"* or
- *"Severe stenosis of 70-80% - validated velocity measurements with angiographic measurements, velocity criteria are extrapolated from diameter data as defined by the Society of Radiologists in Ultrasound Consensus Conference Radiology 2003; 229;340-346."*

Definition:
"Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" – includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (eg, for duplex ultrasound studies, velocity parameters that correlate with anatomic measurements that use the distal internal carotid lumen as the denominator for stenosis measurement).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Reference to Measurements of Distal Internal Carotid Diameter as the Denominator for Stenosis Measurement Referenced
CPT II 3100F: Carotid imaging study report (includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement)

OR

Measurements of Distal Internal Carotid Diameter not Referenced, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3100F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3100F *with* 8P: Carotid imaging study report did not include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement, reason not otherwise specified

RATIONALE:
Since the clinical decision-making is based on randomized trial evidence and degree of stenosis is an important element of the decision for carotid intervention, characterization of the degree of stenosis needs to be standardized. Requiring that stenosis calculation be based on a denominator of distal internal carotid diameter or, in the case of duplex ultrasound, velocity measurements that have been correlated to angiographic stenosis calculation based on distal internal carotid diameter, makes the measure applicable to both imaging and duplex studies.

CLINICAL RECOMMENDATION STATEMENTS:
The panel recommended that the NASCET method of carotid stenosis measurement should be used when angiography is used to correlate the US findings. (USDSR, 2003)

When MRA techniques are used for determining carotid stenosis, the report should reflect the methodology and reference the criteria for percent stenosis outlined in the NASCET. Also, the percent stenosis must be calculated using the distal cervical ICA diameter, where the walls are parallel, for the denominator. Similar to CTA, MRA with

attention to the acquisition parameters and post-processing techniques can provide cross sectional measurements of stenosis that correlate with properly performed NASCET estimates of percent stenosis obtained with catheter angiography. In the setting of near occlusion, it may not be accurate to calculate percent stenosis ratios in the presence of post-stenotic arterial diameter decrease. Some MRA techniques may not be amenable to quantitative measurements, in which case qualitative assessment of stenosis should be provided. (ACR-ASNR-SNIS-SPR, 2010)

Measure #197 (NQF 0074): Coronary Artery Disease (CAD): Lipid Control

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result ≥ 100 mg/dL and have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with CAD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding. Only patients who had at least two denominator eligible visits during the reporting period will be counted into the denominator of this measure.

This measure will be calculated with 3 performance rates:

1) Percentage of patients with an LDL-C less than 100 mg/dL
2) Percentage of patients with an LDL-C greater than or equal to 100 mg/dL with a documented plan of care to achieve LDL-C less than 100 mg/dL, including at a minimum the prescription of a statin
3) Overall percentage of patients with an LDL-C less than 100 mg/dL and with an LDL-C greater than or equal to 100 mg/dL with a documented plan of care to achieve LDL-C less than 100 mg/dL, including at a minimum the prescription of a statin

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period

DENOMINATOR NOTE: In order for the patient to be included in the measure denominator, the patient must have two denominator eligible visits.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82
Diagnosis for coronary artery disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701,

I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.798, I25.790, I25.791, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits

NUMERATOR:
Patients who have a LDL-C result < 100 mg/dL OR patients who have a LDL-C result ≥ 100 mg/dL and have a documented plan of care to achieve LDL-C < 100 mg/dL, including at a minimum the prescription of a statin

Numerator Instructions: The first numerator option can be reported for patients who have a documented LDL-C < 100 mg/dL at any time during the measurement period (if more than one result, report most current). All patients that meet denominator criteria without an LDL-C result will NOT meet performance for the measure.

Definitions:
Documented plan of care - Includes the prescription of a statin and may also include: documentation of discussion of lifestyle modifications (diet, exercise) or scheduled re-assessment of LDL-C.
Prescribed - May include prescription given to the patient for a statin at one or more visits within the measurement period OR patient already taking a statin as documented in current medication list.

Numerator Options:
Most current LDL-C < 100 mg/dL (G8736)

OR

Most current LDL-C ≥ 100mg/dL (G8737)
AND
Statin therapy prescribed or currently being taken (4013F)
AND
Plan of care to achieve lipid control documented (0556F)

OR

Most current LDL-C ≥ 100mg/dL (G8737)
AND
Plan of care to achieve lipid control documented (0556F)
AND
Documentation of medical reason(s) for statin therapy not prescribed or currently being taken (eg, allergy, intolerance to statin medication(s), other medical reasons) (4013F *with* 1P)
OR
Documentation of patient reason(s) for statin therapy not prescribed or currently being taken (eg, patient declined, other patient reasons) (4013F *with* 2P)
OR
Documentation of system reason(s) for statin therapy not prescribed or currently being taken (eg, financial reasons, other system reasons) (4013F *with* 3P)

OR

Most current LDL-C ≥ 100mg/dL (G8737)
AND

Statin therapy not prescribed or currently being taken, reason not otherwise specified (4013F *with* 8P)

OR

Most current LDL-C ≥ 100mg/dL (G8737)
AND
Plan of care to achieve lipid control not documented (0556F *with* 8P)
OR
LDL-C result not present or not within 12 months prior (G8943)

RATIONALE:
Managing LDL-C to less than 100 mg/dL through use of statins reduces risk of cardiovascular events.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

Recommended lipid management includes assessment of a fasting lipid profile (Class I Recommendation, Level A Evidence). (ACC/AHA, 2007)

a. LDL-C should be less than 100 mg/dL (Class I Recommendation, Level A Evidence).
b. Reduction of LDL-C to less than 70 mg/dL or high-dose statin therapy is reasonable (Class IIa Recommendation, Level A Evidence).
c. If baseline LDL-C is greater than or equal to 100 mg/dL, LDL-lowering medications are used in high-risk or moderately high-risk persons, it is recommended that intensity of the therapy be sufficient to achieve a 30% to 40% reduction in LDL-C levels (Class I Recommendation, Level A Evidence).
d. If on-treatment LDL-C is greater than or equal to 100 mg/dL, LDL-lowering therapy should be intensified (Class I Recommendation, Level A Evidence).
e. If baseline LDL-C is 70 to 100 mg/dL, it is reasonable to treat LDL-C to less than 70 mg/dL (Class IIa Recommendation, Level B Evidence).

Statins should be considered as first-line drugs when LDL-lowering drugs are indicated to achieve LDL treatment goals. (The Third Report of the National Cholesterol Education Program [NCEP] Adult Treatment Panel III [ATPII], 2002)

➧ Measure #198 (NQF 0079): Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of heart failure for whom the quantitative or qualitative results of a recent or prior [any time in the past] LVEF assessment is documented within a 12 month period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with heart failure seen during the reporting period, regardless of when the evaluation of left ventricular function was performed. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure. This measure may be reported by clinicians who perform the quality actions described based on the services provided and the measure-specific denominator coding. Only patients who had at least two denominator eligible visits during the reporting period will be counted into the denominator of this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of heart failure

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
AND
Two Denominator Eligible Visits

NUMERATOR:
Patients for whom the quantitative or qualitative results of a recent or prior [any time in the past] LVEF assessment is documented within a 12 month period

NUMERATOR NOTE: LVEF < 40% corresponds to qualitative documentation of moderate dysfunction or severe dysfunction. The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely

Numerator Instructions: Documentation must include documentation in a progress note of the results of an LVEF assessment, regardless of when the evaluation of ejection fraction was performed.

Definition:
Qualitative Results Correspond to Numeric Equivalents as Follows:

- Hyperdynamic: corresponds to LVEF greater than 70%
- Normal: corresponds to LVEF 50% to 70% (midpoint 60%)
- Mild dysfunction: corresponds to LVEF 40% to 49% (midpoint 45%)
- Moderate dysfunction: corresponds to LVEF 30% to 39% (midpoint 35%)
- Severe dysfunction: corresponds to LVEF less than 30%

Numerator Options:
Left ventricular ejection fraction (LVEF) < 40% or documentation of severely or moderately depressed left ventricular systolic function (G8738)

OR

Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function (G8739)

OR

Left ventricular ejection fraction (LVEF) not performed or assessed, reason not given (G8740)

RATIONALE:
Evaluation of LVEF in patients with heart failure provides important information that is required to appropriately direct treatment. Several pharmacologic therapies have demonstrated efficacy in slowing disease progression and improving outcomes in patients with left ventricular systolic dysfunction. LVEF assessed during the initial evaluation of patients presenting with heart failure can be considered valid unless the patient has demonstrated a major change in clinical status, experienced or recovered from a clinical event, or received therapy that might have a significant effect on cardiac function.

A comprehensive 2-dimensional echocardiogram with Doppler flow studies has been identified as the single most useful diagnostic test in the evaluation of patients with heart failure.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

Two-dimensional echocardiography with Doppler should be performed during initial evaluation of patients presenting with HF to assess LVEF, LV size, wall thickness, and valve function. Radionuclide ventriculography can be performed to assess LVEF and volumes. Radionuclide ventriculography can be performed to assess LVEF and volumes. (Class I, Level of Evidence: C) (ACC/AHA, 2009)

Magnetic resonance imaging or computed tomography may be useful in evaluating chamber size and ventricular mass, detecting right ventricular dysplasia, or recognizing the presence of pericardial disease, as well as in assessing cardiac function and wall motion. (ACCF/AHA, 2009)

♦ Measure #204 (NQF 0068): Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with IVD seen during the reporting period. The performance period for this measure is 12 months from the date of service. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate quality-data code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 years of age and older with the diagnosis of ischemic vascular disease (IVD) during the measurement period, OR who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for Ischemic Vascular Disease (ICD-9-CM) [for use 01/1/2014-09/30/2014]: 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89
Diagnosis for Ischemic Vascular Disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.11, I21.19, I21.21, I21.29, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118,

I25.119, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.89, I25.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I70.1, I70.201, I70.202, I70.203, I70.208, I70.209, I70.211, I70.212, I70.213, I70.218, I70.219, I70.221, I70.222, I70.223, I70.228, I70.229, I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.261, I70.262, I70.263, I70.268, I70.269, I70.291, I70.292, I70.293, I70.298, I70.299, I70.92, I74.01, I74.09, I74.10, I74.11, I74.19, I74.2, I74.3, I74.4, I74.5, I74.8, I74.9, I75.011, I75.012, I75.013, I75.019, I75.021, I75.022, I75.023, I75.029, I75.81, I75.89

OR

Diagnosis for acute myocardial infarction (ICD-9-CM) [for use 01/1/2014-09/30/2014]: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

Diagnosis for acute myocardial infarction (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4

AND

Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

OR

Patient encounter during the reporting period (CPT) - Procedure: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943

NUMERATOR:

Patients who have documentation of use of aspirin or another antithrombotic therapy

Numerator Instructions: Oral antithrombotic therapy consists of aspirin, clopidogrel, combination of aspirin and extended release dipyridamole, prasugrel, ticagrelor or ticlopidine

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Aspirin or Another Antithrombotic Therapy Used

G8598: Aspirin or another antithrombotic therapy used

OR

Aspirin or Another Antithrombotic Therapy not Used, Reason not Given

G8599: Aspirin or another antithrombotic therapy not used, reason not given

RATIONALE:

Coronary heart disease (CHD) is a major cause of death in the United States – in 2004, it was an underlying or contributing cause of death for 451,300 people (1 of every 5 deaths). Acute myocardial infarction (AMI) was as an underlying or contributing cause of death for 156,000 people (American Heart Association 2008). In addition, nearly 16 million people (or 7.3 percent of the American population) had CHD in 2005 (American Heart Association 2008). The cost of cardiovascular diseases and stroke in the United States for 2008 was estimated at $448.5 billion

(American Heart Association 2008). This figure includes health expenditures (direct costs such as the cost of physicians and healthcare practitioners, hospital and nursing home services, medications, home health care and other medical durables) and lost productivity resulting from morbidity and mortality (indirect costs). AMI accounts for 18 percent of hospital discharges and 28 percent of deaths due to heart disease (National Heart, Lung, and Blood Institute 2000). Research has shown that costs associated with cardiovascular disease for hospitals are easily $156 billion (American Heart Association 2008).

Aspirin treatments reduce MI in men (127 events per 100,000 person-years) and women (17 events per 100,000 person-years) (Grieving et al. 2008). While studies have shown warfarin to be more effective, aspirin is a safer, more convenient, and less expensive form of therapy (Patrono et al. 2004). Aspirin therapy has been shown to directly reduce the odds of cardiovascular events among men by 14 percent and among women by 12 percent (Berger et al. 2006). Aspirin use has been shown to reduce the number of strokes by 20 percent, MI by 30 percent, and other vascular events by 30 percent (Weisman and Graham 2002).

CLINICAL RECOMMENDATION STATEMENTS:

U.S. Preventive Sevices Task Force (2009):
The U.S. Preventive Services Task Force (USPSTF) strongly recommends that clinicians discuss aspirin chemoprevention with adults who are at increased risk (5-year risk of greater than or equal to 3 percent) for coronary heart disease (CHD). Discussions with patients should address both the potential benefits and harms of aspirin therapy.

The USPSTF found good evidence that aspirin decreases the incidence of coronary heart disease in adults who are at increased risk for heart disease. They also found good evidence that aspirin increases the incidence of gastrointestinal bleeding and fair evidence that aspirin increases the incidence of hemorrhagic strokes. The USPSTF concluded that the balance of benefits and harms is most favorable in patients at high risk of CHD (5-year risk of greater than or equal to 3 percent) but is also influenced by patient preferences.

USPSTF encourages men age 45 to 79 years to use aspirin when the potential benefit of a reduction in myocardial infarctions outweighs the potential harm of an increase in gastrointestinal hemorrhage. They encourage women age 55 to 79 years to use aspirin when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

American Diabetes Association (2008):
Use aspirin therapy (75-162 mg/day) as a primary prevention strategy in those with type 1 or 2 diabetes at increased cardiovascular risk, including those who are 40 years of age or who have additional risk factors (family history of CVD, hypertension, smoking, dyslipidemia, or albuminuria).

American Heart Association/American Stroke Association (2006):
AHA/ASA: The use of aspirin is recommended for cardiovascular (including but not specific to stroke) prophylaxis among persons whose risk is sufficiently high for the benefits to outweigh the risks associated with treatment (a 10-year risk of cardiovascular events of 6% to 10%).

American College of Clinical Pharmacy (2004):
For long-term treatment after PCI, the guideline developers recommend aspirin, 75 to 162 mg/day. For long-term treatment after PCI in patients who receive antithrombotic agents such as clopidogrel or warfarin, the guideline developers recommend lower-dose aspirin, 75 to 100 mg/day. For patients with ischemic stroke who are not receiving thrombolysis, the guideline developers recommend early aspirin therapy, 160 to 325 mg/day.

❑ Measure #205 (NQF 0409): HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia, Gonorrhea, and Syphilis

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia, gonorrhea, and syphilis screenings were performed at least once since the diagnosis of HIV infection

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV/AIDS seen during the reporting period. Only patients who had at least two visits during the reporting period, with at least 90 days between each visit will be counted in the denominator for this measure. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV/AIDS.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 13 and older with a diagnosis of HIV/AIDS who had at least two medical visits during the measurement year, with at least 90 days between each visit

Denominator Criteria (Eligible Cases):
Patients aged ≥ 13 years of age on date of encounter
AND
Diagnosis for HIV/AIDS (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 042, V08
Diagnosis for HIV/AIDS (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B20, Z21
AND
Patient encounters during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Patients with chlamydia, gonorrhea, and syphilis screenings performed at least once since the diagnosis of HIV infection

NUMERATOR NOTE: Report G9228 when results are documented for all of the 3 screenings

Numerator Options:
Chlamydia, gonorrhea and syphilis screening results documented (report when results are present for all of the 3 screenings) (G9228)

OR

Chlamydia, gonorrhea, and syphilis screening results not documented (Patient refusal is the only allowed exclusion) (G9229)

OR

Chlamydia, gonorrhea, and syphilis screening results not documented as performed, reason not otherwise specified (G9230)

RATIONALE:
Sexually transmitted diseases that cause mucosal inflammation (such as gonorrhea and chlamydia) increase the risk for HIV-infection (as these diseases and other sexually transmitted diseases can increase the infectiousness of and a person's susceptibility to HIV) (Galvin, 2004).

CLINICAL RECOMMENDATION STATEMENTS:
All patients should be screened with laboratory tests for STDs at the initial encounter (A-II for syphilis, for trichomoniasis in women, and for chlamydial infection in women aged less than 25 years; B-II for gonorrhea and chlamydial infection in all men and women), and thereafter, depending on reported high-risk behavior, the presence of other STDs, and the prevalence of STDs in the community (B-III). (Aberg, 2004)

Consideration should be given to screening all HIV-infected men and women for gonorrhea and chlamydial infections. However, because of the cost of screening and the variability of prevalence of these infections, decisions about routine screening for these infections should be based on epidemiologic factors (including prevalence of infection in the community or the population being served), availability of tests, and cost. (Some HIV specialists also recommend type-specific serologic testing for herpes simplex virus type 2 for both men and women.) (B-II, for identifying STDs) (CDC, HRSA, NIH, HIVMA of IDSA, 2003)

☾ Measure #217 (NQF 0422): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Knee Impairments

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the knee in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the knee. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional knee deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional knee deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a knee deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the knee and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a knee impairment, who has had an interruption of a Treatment Episode for the same functional knee deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same knee deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the knee

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting knee

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting knee

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Knee at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:
Risk-Adjusted Functional Status Change Residual Score for the knee successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8647)
OR
Risk-Adjusted Functional Status Change Residual Score for the knee successfully calculated and the score was less than zero (< 0) (G8648)

OR

Risk-Adjusted Functional Status Change Residual Scores for the knee not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8649)

OR

Risk-Adjusted Functional Status Change Residual Scores for the knee not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8650)

RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1873)

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾ Measure #218 (NQF 0423): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Hip Impairments

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the hip in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the hip. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional hip deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional hip deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a hip deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the hip and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a hip impairment, who has had an interruption of a Treatment Episode for the same functional hip deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same hip deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the hip

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting the hip

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting the hip

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Hip at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate

- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:
Risk-Adjusted Functional Status Change Residual Score for the hip successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8651)
OR
Risk-Adjusted Functional Status Change Residual Score for the hip successfully calculated and the score was less than zero (< 0) (G8652)
OR
Risk-Adjusted Functional Status Change Residual Scores for the hip not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8653)
OR
Risk-Adjusted Functional Status Change Residual Scores for the hip not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8654)

RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1872)

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾ Measure #219 (NQF 0424): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lower Leg, Foot or Ankle Impairments

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lower leg, foot or ankle in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the lower leg, foot or ankle. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional lower leg, foot or ankle deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional lower leg, foot or ankle deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a lower leg, foot or ankle deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the lower leg, foot or ankle and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a lower leg, foot or ankle impairment, who has had an interruption of a Treatment Episode for the same functional lower leg, foot or ankle deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same lower leg, foot or ankle deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the lower leg, foot or ankle

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting the lower leg, foot or ankle

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting the lower leg, foot or ankle

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Lower Leg, Foot or Ankle at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities, and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient, and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment

variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot or ankle successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8655)

OR

Risk-Adjusted Functional Status Change Residual Score for the lower leg, foot or ankle successfully calculated and the score was less than zero (< 0) (G8656)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lower leg, foot or ankle not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8657)

OR

Risk-Adjusted Functional Status Change Residual Scores for the lower leg, foot or ankle not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8658)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1874)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾ Measure #220 (NQF 0425): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Lumbar Spine Impairments

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the lumbar spine in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the lumbar spine. This is an outcomes measure, and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter, and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional lumbar spine deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional lumbar spine deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a lumbar spine deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the lumbar spine and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a lumbar spine impairment, who has had an interruption of a Treatment Episode for the same functional lumbar spine deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same lumbar spine deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the lumbar spine

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting the lumbar spine

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting the lumbar spine

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Lumbar Spine at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:
Risk-Adjusted Functional Status Change Residual Score for the lumbar spine successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8659)
OR
Risk-Adjusted Functional Status Change Residual Score for the lumbar spine successfully calculated and the score was less than zero (< 0) (G8660)
OR
Risk-Adjusted Functional Status Change Residual Scores for the lumbar spine not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8661)
OR
Risk-Adjusted Functional Status Change Residual Scores for the lumbar spine not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8662)

RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-2632)

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾ Measure #221 (NQF 0426): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Shoulder Impairments

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the shoulder in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the shoulder. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional shoulder deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional shoulder deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a shoulder deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the shoulder and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a shoulder impairment, who has had an interruption of a Treatment Episode for the same functional shoulder deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same shoulder deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the shoulder

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting the shoulder

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting the shoulder

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Shoulder at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.
Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:
Risk-Adjusted Functional Status Change Residual Score for the shoulder successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8663)
OR
Risk-Adjusted Functional Status Change Residual Score for the shoulder successfully calculated and the score was less than zero (< 0) (G8664)
OR
Risk-Adjusted Functional Status Change Residual Scores for the shoulder not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8665)
OR
Risk-Adjusted Functional Status Change Residual Scores for the shoulder not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8666)

RATIONALE:
Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-2633)

CLINICAL RECOMMENDATION STATEMENTS:
The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾ Measure #222 (NQF 0427): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the elbow, wrist or hand in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the elbow, wrist or hand. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional elbow, wrist or hand deficits will report this measure.

Definitions:
Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional elbow, wrist or hand deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for an elbow, wrist or hand deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.
Admission – An Admission is the first encounter for a functional deficit involving the elbow, wrist or hand and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with an elbow, wrist or hand impairment, who has had an interruption of a Treatment Episode for the same functional elbow, wrist or hand deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.
Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same elbow, wrist or hand deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.
Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.
Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the elbow, wrist or hand

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting elbow, wrist or hand

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting elbow, wrist or hand

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Elbow, Wrist or Hand at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment

variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist or hand successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8667)

OR

Risk-Adjusted Functional Status Change Residual Score for the elbow, wrist or hand successfully calculated and the score was less than zero (< 0) (G8668)

OR

Risk-Adjusted Functional Status Change Residual Scores for the elbow, wrist or hand not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8669)

OR

Risk-Adjusted Functional Status Change Residual Scores for the elbow, wrist or hand not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8670)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-1874)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

☾ Measure #223 (NQF 0428): Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 or older that receive treatment for a functional deficit secondary to a diagnosis that affects the neck, cranium, mandible, thoracic spine, ribs, or other general orthopedic impairment in which the change in their Risk-Adjusted Functional Status is measured

INSTRUCTIONS:
This outcomes measure is to be reported once per treatment episode for all patients with a functional deficit related to the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment. This is an outcomes measure and its calculation requires reporting of the patient's functional status score, as a minimum, at admission to and again at discharge from an episode of rehabilitation. The admission score, estimated using patient self-report surveys, is recorded during the first rehabilitation treatment encounter and the discharge score is recorded at or near the conclusion of the final rehabilitation treatment encounter. It is anticipated that physical and occupational therapists providing treatment for functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficits will report this measure.

Definitions:

Treatment Episode – A Treatment Episode is defined as beginning with an Admission for a functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit, progressing to development of a plan of care, including treatment, without interruption of care (for example, a hospitalization or surgical intervention), and ending with Discharge from clinical care by the Eligible Professional. A patient currently under clinical care for a neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit remains in a single episode of care until the Discharge is conducted and documented by the Eligible Professional.

Admission – An Admission is the first encounter for a functional deficit involving the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment and includes an evaluation (CPT 97001 or 97003) and development of a plan of care by the Eligible Professional. A patient presenting with a neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment, who has had an interruption of a Treatment Episode for the same functional neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit secondary to an appropriate reason like hospitalization or surgical intervention, is a new Admission.

Discharge – Discharge is accompanied by a re-evaluation (CPT 97002 or 97004) identifying the close of a Treatment Episode for the same neck, cranium, mandible, thoracic spine, ribs or other general orthopedic deficit identified at admission and documented by a discharge report by the Eligible Professional. An interruption in clinical care for an appropriate reason like hospitalization or surgical intervention requires a discharge from the current Treatment Episode.

Encounter – A face to face visit between the patient and the provider for the purpose of assessing and/or improving a functional deficit.

Patient Reported – The patient directly, or through a proxy, provides answers to functional status survey items using standardized, reliable and valid, computerized adaptive testing or paper and pencil survey methods.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who receive a treatment episode for a functional deficit related to the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

Option 1 – Physical Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97001
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97002
AND
Functional deficit affecting neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

OR

Option 2 – Occupational Therapy Denominator Criteria (Eligible Cases):
All patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period identifying evaluation (CPT): 97003
AND
Patient encounter during the reporting period identifying re-evaluation (CPT): 97004
AND
Functional deficit affecting neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment

NUMERATOR:
Patients presented FOTO's Functional Intake Survey for the Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairment at admission and FOTO's Functional Status Survey at discharge for the purpose of calculating the patient's Risk-adjusted Functional Status Change Residual Score

Definitions:
Patient's Functional Status Score – A functional status score is produced when the patient completes the FOTO functional status survey (either by paper and pencil or computerized adaptive testing administration). The functional status score is continuous and linear. Scores range from 0 (low function) to 100 (high function). The survey is standardized, and the scores are validated for the measurement of function for this population.
Patient's Functional Status Change Score – A functional status change score is calculated by subtracting the Patient's Functional Status Score at Admission from the Patient's Functional Status Score at Discharge.
Predicted Functional Status Change Score – Functional Status Change Scores for patients are risk adjusted using multiple linear regression methods that include the following independent variables: Patient's Functional Status Score at Admission, patient age, symptom acuity, surgical history, gender, number of co-morbidities, and level of fear-avoidance. The Patient's Functional Status Change Score is the dependent variable. The statistical regression produces a Risk-Adjusted Predicted Functional Status Change Score.
Risk-Adjusted Functional Status Change Residual Score – The difference between the raw non-risk-adjusted Patient's Functional Status Change Score and the Risk-Adjusted Predicted Functional Status Change Score (raw minus predicted) is the Risk-Adjusted Functional Status Change Residual Score, which is in the same units as the Patient's Functional Status Scores, and should be interpreted as the unit of

functional status change different than predicted given the risk-adjustment variables of the patient being treated. As such, the Risk-Adjusted Residual Change Score represents Risk-Adjusted Change corrected for the level of severity of the patient. Risk-Adjusted Residual Change Scores of zero (0) or greater (> 0) should be interpreted as functional status change scores that were predicted or better than predicted given the risk-adjustment variables of the patient, and risk-adjusted residual change scores less than zero (< 0) should be interpreted as functional status change scores that were less than predicted given the risk-adjustment variables of the patient. Aggregated Risk-Adjusted Residual Scores allow meaningful comparisons amongst clinicians or clinics.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refused to participate
- Patient unable to complete the questionnaire due to blindness, illiteracy, severe mental incapacity or language incompatibility and an adequate proxy is not available
- Prior to conclusion of Plan of Care, intervention was interrupted or discontinued for any reason including by the referring physician, the provider, the payer or the patient, and attempts by the provider to complete a follow-up functional status survey near Discharge were unsuccessful.

Numerator Options:

Risk-Adjusted Functional Status Change Residual Score for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment successfully calculated and the score was equal to zero (0) or greater than zero (> 0) (G8671)

OR

Risk-Adjusted Functional Status Change Residual Score for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment successfully calculated and the score was less than zero (< 0) (G8672)

OR

Risk-Adjusted Functional Status Change Residual Scores for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, patient Not Eligible/Not Appropriate (G8673)

OR

Risk-Adjusted Functional Status Change Residual Scores for the neck, cranium, mandible, thoracic spine, ribs or other general orthopedic impairment not measured because the patient did not complete FOTO's Functional Intake on admission and/or follow up Status Survey near discharge, reason not given (G8674)

RATIONALE:

Functional deficits are common in the general population and are costly to the individual, their family and society. Improved functional status has been associated with greater quality of life, self-efficacy, improved financial well-being and lower future medical costs. Improving functional status in people seeking rehabilitation has become a goal of the American Physical Therapy Association. Therefore, measuring change in functional status is important for providers treating patients in rehabilitation and can be used to assess the success of treatment and direct modification of treatment.

Change in functional status represents the activity domain of the International Classification of Function. If treatment is designed to improve the functional deficit, it is logical to assess functional status at discharge using a standardized score to determine if treatment improved the functional status of the patient over the treatment episode.

The National Quality Measures Clearinghouse has approved the measurement of change in functional status, using this survey. (NQMC-0022)

CLINICAL RECOMMENDATION STATEMENTS:

The American Physical Therapy Association (APTA), in their *Guide to Physical Therapy Practice*, described five recommended elements of patient management: examination, evaluation, diagnosis, prognosis and intervention. The elements were intended to direct therapists in their approach to patient treatment for the purpose of optimizing patient outcomes. The APTA clearly identifies functional status data as one of the major forms of data to be collected for patients receiving rehabilitation. The functional status measures should be used to assist in the planning, implementation and modification of treatment interventions and should be used as measures of outcomes. The current functional status scores can be used by therapists to fulfill the recommended methods of the APTA in the management of patients in rehabilitation.

*Measure #224 (NQF 0562): Melanoma: Overutilization of Imaging Studies in Melanoma

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients with a current diagnosis of melanoma or a history of melanoma who are seen for an office visit during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with melanoma who have an office visit during the reporting period.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

There are two reporting criteria for this measure:
(1) Patients with a diagnosis of stage 0 through IIC melanoma without signs or symptoms

OR

(2) Patients with a history of any stage melanoma without signs or symptoms

REPORTING CRITERIA 1: Patients with a current diagnosis of stage 0 through IIC melanoma without signs or symptoms
DENOMINATOR (REPORTING CRITERIA 1):
All patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma without signs or symptoms suggesting systematic spread, seen for an office visit during the one-year measurement period

Definitions:
Signs - For the purposes of this measure, signs include tenderness, jaundice, localized neurologic signs such as weakness, or any other sign.
Symptoms - For the purposes of this measure, symptoms include cough, dyspnea, pain, paresthesia, or any other symptom suggesting the possibility of systemic spread.

Denominator Criteria (Eligible Cases) 1:
Diagnosis for melanoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
Diagnosis for melanoma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22,

D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
AJCC Melanoma Cancer Stage 0 through IIC Melanoma: G8944
AND
Absence of signs of melanoma (cough, dyspnea, tenderness, localized neurologic signs such as weakness, jaundice, or any other sign suggesting systemic spread) or absence of symptoms of melanoma (pain, paresthesia, or any other symptom suggesting the possibility of systemic spread of melanoma): G8749

NUMERATOR (REPORTING CRITERIA 1):
Patients for whom no diagnostic imaging studies were ordered

Numerator Instructions: A higher score indicates appropriate treatment of patients with melanoma without additional signs or symptoms.

Definition:
Diagnostic Imaging Studies – CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans. Ordering any of these imaging studies during the one year measurement period is considered a failure of the measure, unless a justified reason is documented through use of a medical or system reason for exception.

Numerator Options:
None of the following diagnostic imaging studies ordered: CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans (3320F)
OR
Documentation of medical reason(s) for ordering diagnostic imaging studies (eg, patient has co-morbid condition that warrants imaging, other medical reasons) (3319F *with* 1P)
OR
Documentation of system reason(s) for ordering diagnostic imaging studies (eg, requirement for clinical trial enrollment, ordered by another provider, other system reasons) (3319F *with* 3P)
OR
One of the following diagnostic imaging studies ordered; chest x-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans (3319F)

OR

REPORTING CRITERIA 2: Patients with a history of any stage melanoma without signs or symptoms
DENOMINATOR (REPORTING CRITERIA 2):
All patients, regardless of age, with a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period

Definitions:
Signs - For the purposes of this measure, signs include tenderness, jaundice, localized neurologic signs such as weakness, or any other sign.
Symptoms - For the purposes of this measure, symptoms include cough, dyspnea, pain, paresthesia, or any other symptom suggesting the possibility of systemic spread.

Denominator Criteria (Eligible Cases) 2:

Diagnosis for history of melanoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V10.82
Diagnosis for history of melanoma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z85.820
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
Absence of signs of melanoma (cough, dyspnea, tenderness, localized neurologic signs such as weakness, jaundice or any other sign suggesting systemic spread) or absence of symptoms of melanoma (pain, paresthesia, or any other symptom suggesting the possibility of systemic spread of melanoma): G8749

NUMERATOR (REPORTING CRITERIA 2):
Patients for whom no diagnostic imaging studies were ordered

Numerator Instructions: A higher score indicates appropriate treatment of patients with melanoma without additional signs or symptoms.

Definition:
Diagnostic Imaging Studies – CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans. Ordering any of these imaging studies during the one year measurement period is considered a failure of the measure, unless a justified reason is documented through use of a medical or system reason for exception.

Numerator Options:
None of the following diagnostic imaging studies ordered: CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans (3320F)

OR

Documentation of medical reason(s) for ordering diagnostic imaging studies (eg, patient has co-morbid condition that warrants imaging, other medical reasons) (3319F *with* 1P)
OR
Documentation of system reason(s) for ordering diagnostic imaging studies (eg, requirement for clinical trial enrollment, ordered by another provider, other system reasons) (3319F *with* 3P)

OR

One of the following diagnostic imaging studies ordered; chest x-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans (3319F)

RATIONALE:
There is no valid indication for expensive imaging studies in early stage melanoma in the absence of signs or symptoms. There is a perception that radiologic studies are being administered for melanoma that are clinically unnecessary and create economic burden to the patient and payer. This measure is addressing the over-utilization of diagnostic imaging studies in patients with melanoma.

CLINICAL RECOMMENDATION STATEMENTS:
In asymptomatic patients with localized cutaneous melanoma of any thickness, baseline blood tests and imaging studies are generally not recommended and should only be performed as clinically indicated for suspicious signs and symptoms. (AAD, 2011)

Routine cross-sectional imaging (CT, PET, MRI) is not recommended for patient with localized melanoma. For patients with stage IA melanoma, this is consistent with the National Institutes of Health guideline. For patients with stage IB to IIC, this recommendation is based on the very low yield of detection of subclinical disease. In patients with stage IIB-IIC, chest x-ray is optional. In any patient with localized melanoma, cross-sectional imaging should only be used to investigate specific signs or symptoms. (NCCN, 2011)

❑ Measure #225 (NQF 0509): Radiology: Reminder System for Mammograms

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram

INSTRUCTIONS:
This measure is to be reported each time a screening mammogram is performed during the reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for reminding patients when follow-up mammograms are due.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 40 years and older undergoing a screening mammogram

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 40 years on date of encounter
> AND
> Diagnosis for mammogram screening (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V76.11, V76.12
> Diagnosis for mammogram screening (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z12.31
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 77057, G0202

NUMERATOR:
Patients whose information is entered into a reminder system with a target due date for the next mammogram

> Numerator Instructions: The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient identifier,

patient contact information, dates(s) of prior screening mammogram(s) (if known), and the target due date for the next mammogram.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Information Entered into a Reminder System with Target Due Date for the Next Mammogram
CPT II 7025F: Patient information entered into a reminder system with a target due date for the next mammogram

OR

Patient Information not Entered into a Reminder System, Reason Not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 7025F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
7025F *with* 8P: Patient Information not entered into a reminder system, reason not otherwise specified

RATIONALE:
Although screening mammograms can reduce breast cancer mortality by 20-35% in women aged 40 years and older, recent evidence has suggested a decreasing trend in screening rates and a need for intervention. (MMWR, 2007) Moreover, many American women do not receive mammograms at recommended intervals, as illustrated by a multiyear study of mammography utilization in a large screening center at Massachusetts General Hospital. The study found that more than half of women who received a mammogram in 1992 had fewer than five mammograms during the subsequent 10 years (the expected number if following a 2-year screening interval), and that only 6 percent received annual mammograms during the entire 10 years. (Blanchard, K., Colbart JA, Puri D, et al., 2004)

The use of patient reminders is associated with an increase in screening mammography and is currently recommended based on the results of a systematic review of studies conducted by the Task Force on Community Preventive Services. (Nass S, Ball J, eds., 2005) Encouraging the implementation of a reminder system could therefore help to reverse the trend and lead to an increase in mammography.

CLINICAL RECOMMENDATION STATEMENTS:
The Task Force [on Community Preventive Services] recommends client reminders to increase breast cancer screening on the basis of strong evidence of effectiveness. (TFCPS, 2005)

▲ Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting via Claims:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.
The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:
Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

> Definitions:
> Tobacco Use – Includes use of any type of tobacco.
> Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.
>
> *NUMERATOR NOTE*: *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Screened for Tobacco Use
CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user
OR
Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco
CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator
4004F *with* 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)

OR

Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason Not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4004F *with* 8P: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified

RATIONALE:
This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of

effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)

♠ Measure #228: Heart Failure (HF): Left Ventricular Function (LVF) Testing

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients 18 years and older with Left Ventricular Function (LVF) testing documented as being performed within the previous 12 months or LVF testing performed prior to discharge for patients who are hospitalized with a principal diagnosis of Heart Failure (HF) during the reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients hospitalized with a principal diagnosis of HF during the reporting period. This measure is intended to reflect the quality of services provided for patients hospitalized with a principal diagnosis of HF during hospitalization or within the previous 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 Registry:
ICD-9-CM/ ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older and hospitalized with a principal discharge diagnosis of HF during the reporting period

DENOMINATOR NOTE: Please note that patients may have a diagnosis of heart failure with reduced or preserved systolic function (ejection fraction).

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Principal diagnosis for HF (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
Principal diagnosis for HF (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9
AND
Patient encounter during reporting period (CPT): 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99291

NUMERATOR:
Patients with LVF testing documented as being performed either prior to discharge or in the previous 12 months

Definitions:
Left ventricular function (LVF) testing - Assessment of hearts function by Left Ventricular (LVF) Testing includes but is not limited to Echocardiography, Transoesophageal Echocardiography, Doppler

Echocardiography, Stress Echocardiography, Cardiac Magnetic Resonance Tomography, Single-Photon Emission Computed Tomography (SPECT), Radionuclide Ventriculography (Gated SPECT), Positron Emission Tomography Imaging (PET), Computed Tomography (CT), and/or Coronary Angiography with Ventriculogram.

PLEASE NOTE: Echocardiography is the recommended test of choice for evaluation of LV function.

Not Eligible - A patient is not eligible if one or more of the following reasons are documented:

- Patient refuses LVF testing
- Other reason documented by the eligible professional the patient is not eligible for LVF testing
- Patients who had a left ventricular assistive device (LVAD) or heart transplant procedure during hospital stay
- Patients who have a length of stay greater than 120 days
- Patients enrolled in clinical trials
- Patients who left against medical advice
- Patients who expired
- Patients discharged to home for palliative care
- Patients discharged to a health care facility for palliative care

Numerator Options:

LVF testing documented as being performed prior to discharge or in the previous 12 months (G8682)

OR

LVF testing not performed prior to discharge or in the previous 12 months for a documented medical or patient reason (G8683)

OR

LVF testing not documented as being performed prior to discharge or in the previous 12 months, reason not given (G8685)

RATIONALE:

Evaluation of LVF in HF patients provides important clinical information required to diagnose, monitor and direct appropriate treatment. (Bonow et al., 2012; McKelvie et al., 2013; McMurray et al., 2012) National guidelines advocate the evaluation of left ventricular systolic function as the single most important diagnostic test in the management of all patients with HF. (McMurray et al., 2012; McKelvie et al., 2013).

Heart failure (HF) is associated with impaired ventricular function, either reduced or preserved systolic function (ejection fraction). Treatment to reduce morbidity and mortality requires evaluation to determine the extent of impairment, through ventricular function testing (Bonow et al., 2012; McKelvie et al., 2013; McMurray et al.,2012).

Echocardiography has been recognized as the gold standard for LVF evaluation, (McMurray et al., 2012; Ananthasubramaniam, 2011; Penicka, 2010).

The pathophysiology of HF is diverse and many patients remain asymptomatic despite significant dysfunction. Impaired ventricular function, however, is a definitive characteristic of heart failure and the cornerstone of evaluation when HF is suspected (McKelvie et al.,2013; McMurray et al.,2012).

CLINICAL RECOMMENDATION STATEMENTS:

Echocardiography is the recommended left ventricular function evaluation test of choice due to reasons of accuracy, availability, safety and cost (McKelvie et al., 2013; McMurray et al, 2012). Two-dimensional echocardiography with Doppler should be performed during initial evaluation of patients presenting with HF to assess LVF, left ventricular size, wall thickness, and valve function. Radionuclide ventriculography can be performed to assess LVF and volumes. (McKelvie et al., 2013; McMurray et al., 2012; Jessup et al., 2009; Lindenfeld et al., 2010).

Repeat measurement of EF and the severity of structural remodeling can be useful to provide information in patients with HF who have had a change in clinical status or who have experienced or recovered from a clinical event or received treatment that might have had a significant effect on cardiac function (McKelvie et. al., 2013; Jessup et al., 2009; Lindenfeld et al., 2010).

An echocardiogram to confirm the diagnosis of heart failure and/or cardiac dysfunction is mandatory and should be performed shortly following suspicion of the diagnosis of HF (McKelvie et al., 2013; McMurray et al., 2012).

❑ Measure #231: Asthma: Tobacco Use: Screening - Ambulatory Care Setting

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 5 through 64 years with a diagnosis of asthma (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke within their home environment at least once during the one-year measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with asthma seen during the measurement period. This measure is intended to reflect the quality of services provided for the primary management of patients with asthma. For the purpose of this measure, the primary caregiver can respond on behalf of the patient if the patient is unable to provide a response (eg, pediatric patient).

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measures.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 5 through 64 years with a diagnosis of asthma during the one-year measurement period

> Denominator Criteria (Eligible Cases):
> Patients aged 5 through 64 years of age on date of encounter
> AND
> Diagnosis for asthma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
> Diagnosis for asthma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke within their home environment at least once

Numerator Instructions: Information regarding tobacco exposure for patients under 18 obtained from a parent or guardian is valid for reporting the numerator. In order to meet the measure, there must be a note in the medical record documenting that the patient was queried about both smoking status AND exposure to environmental smoke in the home environment.

NUMERATOR NOTE: For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including smokeless tobacco users eg, chew, snuff).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Tobacco Use Assessed, Including Exposure to Second hand Smoke
CPT II 1031F: Smoking status and exposure to second hand smoke in the home assessed

OR

Tobacco Use, Including Exposure to Second hand Smoke not Assessed, Reason Not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1031F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1031F *with* 8P: Smoking status and exposure to second hand smoke in the home not assessed, reason not otherwise specified

RATIONALE:
Patients with asthma who smoke or are exposed to second hand smoke are at greater risk for experiencing increased frequency in asthma symptoms, a decrease in lung function, and an increased use of health services. (Sippel JM, 1999; Eisner MD, 2007) By identifying patients who are tobacco users or who are exposed to second hand smoke, intervention can be offered, resulting in the possibility of decreasing the adverse effects.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that clinicians advise persons who have asthma not to smoke or be exposed to environmental tobacco smoke (ETS). (Evidence C) (NHLBI, 2007)

Query patients about their smoking status and specifically consider referring to smoking cessation programs adults who smoke and have young children who have asthma in the household. (Evidence B) (NHLBI, 2007)

All patients should be asked if they use tobacco and should have their tobacco-use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (Fiore, Jaen et al., 2008)

❑ Measure #232: Asthma: Tobacco Use: Intervention - Ambulatory Care Setting

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 5 through 64 years with a diagnosis of asthma who were identified as tobacco users (or their primary caregiver) who received tobacco cessation intervention at least once during the one-year measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with asthma seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with asthma. For the purpose of this measure, the primary caregiver can respond on behalf of the patient if the patient is unable to provide a response (eg, pediatric patient).

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II and/or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code OR 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 claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 5 through 64 years with a diagnosis of asthma identified as tobacco users during the measurement period

> Definition:
> Tobacco users – Include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.
>
> Denominator Criteria (Eligible Cases):
> Patients aged 5 through 64 years on date of encounter
> AND
> Diagnosis for asthma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92
> Diagnosis for asthma (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J45.20, J45.21, J45.22, J45.30, J45.31, J45.32, J45.40, J45.41, J45.42, J45.50, J45.51, J45.52, J45.901, J45.902, J45.909, J45.990, J45.991, J45.998

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients (or their primary caregiver) who received tobacco use cessation intervention

Numerator Instructions: Practitioners providing tobacco cessation interventions to a pediatric patient's primary caregiver are still numerator compliant even if the primary caregiver is not the source of second hand smoke in the home.

Definitions:

Tobacco Users – Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.

Tobacco Use Cessation Intervention – May include brief counseling (3 minutes or less) and/or pharmacotherapy.

NUMERATOR NOTE: For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including smokeless tobacco users (eg, chew, snuff).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patients (or their Primary Caregiver) who Received Tobacco Use Cessation Intervention

*(Two CPT II codes [*400xF & 1032F*] are required on the claim form to submit this numerator option)*

CPT II 4000F: Tobacco use cessation intervention, counseling

OR

CPT II 4001F: Tobacco use cessation intervention, pharmacologic therapy

AND

Current Tobacco Smoker OR Current Exposure to Second Hand Smoke

CPT II 1032F: Current tobacco smoker OR currently exposed to second hand smoke

OR

If patient is not eligible for this measure because patient (or primary caregiver) is a non-tobacco user AND has no exposure to second hand smoke, report:

*(One CPT II code [*1033F*] is required on the claim form to submit this numerator option)*

CPT II 1033F: Current tobacco non-smoker AND not currently exposed to second hand smoke

OR

Tobacco Use, not Assessed, Reason Not Given

*(One quality-data code [*G8751*] is required on the claim form to submit this numerator option)*

G8751: Smoking status and exposure to second hand smoke in the home not assessed, reason not given

OR

Tobacco Use Cessation Intervention not Performed, Reason Not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 4000F OR 4001F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

*(Two CPT II codes [*400xF-8P & 1032F*] are required on the claim form to submit this numerator option)*

4000F *with* 8P: Tobacco use cessation intervention, counseling, not performed, reason not otherwise specified

OR

4001F *with* 8P: Tobacco use cessation intervention, pharmacologic therapy, not performed, reason not otherwise specified

AND
Current Tobacco Smoker OR Currently Exposed to Second Hand Smoke
CPT II 1032F: Current tobacco smoker OR currently exposed to second hand smoke

RATIONALE:
There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in both the primary care setting and hospital settings are successful in helping tobacco users quit. (Fiore MC, 2008) Patients who are able to stop smoking or their exposure to second hand smoke may experience an increase in quality of life, a decrease in asthma symptoms, and may not use health resources as often. (NHLBI, 2007)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The Expert Panel recommends that clinicians advise persons who have asthma not to smoke or be exposed to environmental tobacco smoke (ETS). (Evidence C) (NHLBI, 2007)

Query patients about their smoking status and specifically consider referring to smoking cessation programs adults who smoke and have young children who have asthma in the household. (Evidence B) (NHLBI, 2007)

All *physicians* should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (Fiore, Jaen et al., 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (Fiore MC, 2008)

The interventions found to be effective in this Guideline have been shown to be effective in a variety of populations. In addition, many of the studies supporting these interventions comprised diverse samples of tobacco users. Therefore, interventions identified as effective in this Guideline are recommended for all individuals who use tobacco, except when the medication use is contraindicated or with specific populations in which medication has not been shown to be effective (pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = B) (Fiore MC, 2008)

Ω Measure #233 (NQF 0457): Thoracic Surgery: Recording of Performance Status Prior to Lung or Esophageal Cancer Resection

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing resection for lung or esophageal cancer for whom performance status was documented and reviewed within 2 weeks prior to surgery

INSTRUCTIONS:
This measure is to be reported each time a major cancer resection of the lung or esophagus is performed. This measure is intended to reflect the quality of services provided for patients undergoing resection for lung or esophageal cancer. The performance status of lung and esophageal cancer patients guides the decision-making process when choosing optimal treatment modality which may or may not include surgery. It is anticipated that clinicians who perform the listed surgical procedures with a diagnosis of lung or esophageal cancer will submit this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older undergoing resection for lung or esophageal cancer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for lung or esophageal cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 150.3, 150.4, 150.5, 150.8, 151.0, 162.2, 162.3, 162.4, 162.5, 162.9
Diagnosis for lung or esophageal cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C15.3, C15.4, C15.5, C15.8, C16.0, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92
AND
Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505, 32506, 32507, 32663, 32666, 32667, 32668, 32669, 32670, 32671, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124

NUMERATOR:
Patients undergoing resection for lung and esophageal cancer for whom performance status was documented and reviewed within 2 weeks prior to surgery

Numerator Options:
Performance status documented and reviewed within 2 weeks prior to surgery (3328F)

OR

Performance status not documented and reviewed within 2 weeks prior to surgery, reason not otherwise specified (3328F *with* 8P)

RATIONALE:
There is wide consensus, supported by the source documentation, that preoperative assessment (within two weeks of surgery) of performance status in lung and esophageal cancer resection is a necessary step in evaluating and appropriately selecting patients for surgical therapy. For lung and esophageal cancer, the patient's functional status or performance status (PS) is a key determinant of not only the patient's ability to undergo therapy, but also the patient's prognosis. PS is a general measure of a patient's physiologic status, taking into account the cancer and its associated effects along with other concurrent medical problems, such as cardiac or pulmonary disease. Preoperative assessment of PS provides a standardized measure to compare patient and treatment outcomes in order to provide continuing quality improvement.

Review of the current STS General Thoracic Database identified a 10% gap in recording for PS in patients undergoing major pulmonary resection for cancer. Remediation of this gap should decrease the morbidity and mortality rates for these procedures by reducing the number of high-risk patients inappropriately selected to undergo surgery.

CLINICAL RECOMMENDATION STATEMENTS:
STS identified 3 preoperative factors that were associated with an increased risk of pulmonary complications: age, spirometric values, and PS. Others have demonstrated that advanced age and preoperative respiratory dysfunction are associated with postoperative pulmonary complications. It may be intuitively apparent that the factors identified are predictive of the relative risk of development of pulmonary complications. The benefit of this analysis does not lie in the uniqueness of our observations. Instead, it directs the clinician to focus on a few specific factors and provides the ability to quantitate the relative effect of these factors before making treatment recommendations. (Annals of Thoracic Surgery, 2000) & (Journal Thoracic Cardiovascular Surgery, 2002)

Ω Measure #234 (NQF 0458): Thoracic Surgery: Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of thoracic surgical patients aged 18 years and older undergoing at least one pulmonary function test within 12 months prior to a major lung resection (pneumonectomy, lobectomy, or formal segmentectomy)

INSTRUCTIONS:
This measure is to be reported each time a major resection of the lung is performed. This measure is intended to reflect the quality of services provided for patients undergoing lung resection. There is wide consensus that preoperative pulmonary function testing is a necessary step in evaluating and appropriately selecting patients with lung cancer for major anatomic resection. Preoperative pulmonary function testing also provides a standardized measure to compare patient and treatment outcomes in order to provide continuing quality improvement.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients undergoing major anatomic lung resection

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32663, 32669, 32670, 32671
AND
Operation status is elective

NUMERATOR:
Patients who had a pulmonary function test performed within 12 months prior to a major anatomic lung resection

Numerator Options:
Pulmonary function test performed within 12 months prior to surgery (3038F)

OR

Documentation of medical reason(s) for pulmonary function test not being performed within 12 months prior to surgery. Acceptable medical reasons include: Patients who are unable to perform pulmonary function testing (tracheostomy, patient inability to cooperate with pulmonary function test) or those with urgent/emergent need of lung resection (lung abscess, massive hemoptysis, bronchopleural fistula, etc.) (3038F *with* 1P)

OR

Pulmonary function test not performed within 12 months prior to surgery, reason not otherwise specified (3038F *with* 8P)

RATIONALE:
Evaluation of lung function for patients having thoracic surgery, for patients having thoracotomies, for patients having surgery in which the chest is opened and in patients with respiratory disease, eg esophagectomy, lung excision or resection is vital to determine what treatment is needed, safe and effective. Evaluation of lung function for patients being considered for lung cancer resection is critical to assessing suitability for resection and prediction of post-operative lung function.

Review of the 6,723 eligible patients in the STS General Thoracic Database identified a significant gap with respect to preoperative pulmonary function testing.

PFT testing was done in 89% of eligible patients, and hospital-specific estimates ranged from 28.2% to 99.0%. Remediation of this process gap should improve quality by reducing inappropriate selection of high-risk patients for surgery.

CLINICAL RECOMMENDATION STATEMENTS:
"Lung function tests were considered to be appropriate for patients undergoing spinal surgery, for ASA grade 3 patients having thoracic surgery, for patients having thoracotomies and for surgery in which the chest is opened in patients with respiratory disease, e.g. esophagectomy, lung excision or resection. (Chest, 2003)
ASA grade 3 - A patient with severe systemic disease
ASA grade 4 - A patient with severe systemic disease that is a constant threat to life
Preoperative tests: The use of routine preoperative tests for elective surgery

In patients being considered for lung cancer resection, spirometry should be performed. If the forced expiratory volume in 1 second (FEV1) is > 80% predicted normal or > 2 L, the patient is suitable for resection including pneumonectomy without further evaluation. If the FEV1 is > 1.5 L, the patient is suitable for a lobectomy without further evaluation. Level of evidence, fair; benefit, substantial; grade of recommendation, B. (National Institute for Clinical Excellence, 2003)

In patients being considered for lung cancer resection, if either the FEV1 or DLCO are < 80% predicted, postoperative lung function should be predicted through additional testing. Level of evidence, fair; benefit, substantial; grade of recommendation, B. (National Institute for Clinical Excellence, 2003)

♦ Measure #236 (NQF 0018): Controlling High Blood Pressure

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with hypertension seen during the reporting period. The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Do not include blood pressure readings that meet the following criteria:

- Blood pressure readings from the patient's home (including readings directly from monitoring devices).
- Taken during an outpatient visit which was for the sole purpose of having a diagnostictest or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed "not controlled."

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS code and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ ICD-10-CM diagnosis codes, CPT or HCPCS codes and the appropriate quality-data code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.
The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

Denominator Criteria (Eligible Cases):
Patients 18 through 85 years of age on date of encounter
AND

Diagnosis for hypertension (ICD-9-CM) [for use 01/01/2014-09/30/2014]: 401.0, 401.1, 401.9
Diagnosis for hypertension (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I10
AND
Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402, G0438, G0439

NUMERATOR:
Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

Numerator Instructions: To describe both systolic and diastolic blood pressure values, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Most Recent Blood Pressure Measurement Performed
Systolic pressure (Select one (1) code from this section):
G8752: Most recent systolic blood pressure < 140 mmHg
OR
G8753: Most recent systolic blood pressure ≥ 140 mmHg
AND
Diastolic pressure (Select one (1) code from this section):
G8754: Most recent diastolic blood pressure < 90 mmHg
OR
G8755: Most recent diastolic blood pressure ≥ 90 mmHg

OR

Patient not Eligible for Recommended Blood Pressure Parameters for Documented Reasons
G9231: Documentation of end stage renal disease (ESRD), dialysis, renal transplant or pregnancy.

OR

Blood Pressure Measurement not Documented, Reason not Given
G8756: No documentation of blood pressure measurement, reason not given

RATIONALE:
Hypertension is a very significant health issue in the United States. Fifty million or more Americans have high blood pressure that warrants treatment, according to the National Health and Nutrition Examination Survey (NHANES) survey (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003). The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adults aged 18 and older for high blood pressure (United States Preventive Services Task Force 2007).

The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. The increased risks of hypertension are present in individuals ranging from 40 to 89 years of age. For every 20 mmHg systolic or 10 mmHg diastolic increase in blood pressure, there is a doubling of mortality from both ischemic heart disease and stroke (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

Better control of blood pressure has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. The relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40 percent), myocardial infarction incidence (20-25 percent) and heart failure incidence (>50 percent) (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

CLINICAL RECOMMENDATION STATEMENTS:

The United States Preventive Services Task Force (2007) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003): Treating systolic blood pressure and diastolic blood pressure to targets that are < 140/90 mmHg is associated with a decrease in cardiovascular disease complications.

♦ Measure #241 (NQF 0075): Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control (< 100 mg/dL)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had each of the following during the measurement period: a complete lipid profile and LDL-C was adequately controlled (< 100 mg/dL)

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with IVD seen during the reporting period. *The performance period for this measure is 12 months from the date of service.* This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate quality-data code(s). There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions however these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 years of age and older with the diagnosis of ischemic vascular disease (IVD) during the measurement period, OR who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for ischemic vascular disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22,

440.23, 440.24, 440.29, 440.4, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

Diagnosis for ischemic vascular disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.11, I21.19, I21.21, I21.29, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.89, I25.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I70.1, I70.201, I70.202, I70.203, I70.208, I70.209, I70.211, I70.212, I70.213, I70.218, I70.219, I70.221, I70.222, I70.223, I70.228, I70.229, I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.261, I70.262, I70.263, I70.268, I70.269, I70.291, I70.292, I70.293, I70.298, I70.299, I70.92, I74.01, I74.09, I74.10, I74.11, I74.19, I74.2, I74.3, I74.4, I74.5, I74.8, I74.9, I75.011, I75.012, I75.013, I75.019, I75.021, I75.022, I75.023, I75.029, I75.81, I75.89

OR

Diagnosis for acute myocardial infarction (ICD-9-CM) [for use 01/1/2014-09/30/2014]: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

Diagnosis for acute myocardial infarction (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4

AND

Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

OR

Patient encounter during the reporting period (CPT) - Procedure: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92920, 92924, 92928, 92933, 92937, 92941, 92943

NUMERATOR:

Patients who received at least one lipid profile (or ALL component tests) with most recent LDL-C < 100 mg/dL

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Lipid Profile Performed and Most Recent LDL-C < 100 mg/dL

*(Two quality-data codes [*G8593 & G8595*] are required on the claim form to submit this numerator option)*

G8593: Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)

Note: If LDL-C could not be calculated due to high triglycerides, count as complete lipid profile.

AND

G8595: Most recent LDL-C < 100 mg/dL

OR

Lipid Profile not Performed, Reason not Given

*(One quality-data code [*G8594*] is required on the claim form to submit this numerator option)*

G8594: Lipid profile not performed, reason not given

OR

Most Recent LDL-C **≥ 100 mg/dL**
*(Two quality-data codes [*G8593 & G8597*] are required on the claim form to submit this numerator option)*
G8593: Lipid panel results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)
AND
G8597: Most recent LDL-C ≥ 100 mg/dL

RATIONALE:
A 10 percent decrease in total cholesterol levels (population wide) may result in an estimated 30 percent reduction in the incidence of coronary heart disease (CHD) (Centers for Disease Control and Prevention 2000). Based on data from the Third Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults:

- Less than half of persons who qualify for any kind of lipid-modifying treatment for CHD risk reduction are receiving it
- Less than half of even the highest-risk persons, those who have symptomatic CHD, are receiving lipid-lowering treatment
- Only about a third of treated patients are achieving their LDL goal; less than 20 percent of CHD patients are at their LDL goal (National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Pressure 2002).

According to data from the Behavioral Risk Factor Surveillance System (BRFSS) from 1991–2003, the prevalence of cholesterol screening during the preceding 5 years increased from 67.3 percent in 1991 to 73.1 percent in 2003 (Centers for Disease Control and Prevention 2005).

Between 1988–94 and 1999–2002, the age-adjusted mean total serum cholesterol level of adults 20 years of age and older decreased from 206 mg/dL to 203 mg/dL, and LDL cholesterol levels decreased from 129 mg/dL to 123 mg/dL. The mean level of LDL cholesterol for American adults age 20 and older is 123 mg/dL (Carroll et al. 2005). However, even given this decrease, there is still a significant amount of room for improvement.

CLINICAL RECOMMENDATION STATEMENTS:
Third report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III). (2001) AND Implications of recent clinical trials for the National Cholesterol Education Program Adult Treatment Panel III guidelines (2004)
In high-risk persons, the recommended LDL-C goal is < 100 mg/dL.

- An LDL-C goal of < 70 mg/dL is a therapeutic option on the basis of available clinical trial evidence, especially for patients at very high risk.
- If LDL-C is > 100 mg/dL, an LDL-lowering drug is indicated simultaneously with lifestyle changes.
- If baseline LDL-C is < 100 mg/dL, institution of an LDL-lowering drug to achieve an LDL-C level < 70 mg/dL is a therapeutic option on the basis of available clinical trial evidence.
- If a high-risk person has high triglycerides or low HDL-C, consideration can be given to combining a fibrate or nicotinic acid with an LDL-lowering drug. When triglycerides are > 200 mg/dL, non-HDL-C is a secondary target of therapy, with a goal 30 mg/dL higher than the identified LDL-C goal.

The U.S. Preventive Services Task Force (USPSTF) strongly recommends screening men aged 35 and older for lipid disorders and recommends screening men aged 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease. The USPSTF also strongly recommends screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease and recommends screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.

Measure #242: Coronary Artery Disease (CAD): Symptom Management

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period with results of an evaluation of level of activity and an assessment of whether anginal symptoms are present or absent with appropriate management of anginal symptoms within a 12 month period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of coronary artery disease seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with CAD based on the services provided and the measure-specific denominator coding. Only patients who had at least two denominator eligible visits during the reporting period will be counted into the denominator of this measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period with results of an evaluation of level of activity and an assessment of whether anginal symptoms are present or absent

Denominator Instructions:
Evaluation of level of activity and evaluation of presence or absence of angina symptoms should include:

- Documentation of Canadian Cardiovascular Society (CCS) Angina Class OR
- Completion of a disease-specific questionnaire (eg, Seattle Angina Questionnaire or other validated questionnaire) to quantify angina and level of activity

Definition:
Canadian Cardiovascular Society (CCS) Angina Classification:

Class 0: Asymptomatic
Class 1: Angina with strenuous exercise
Class 2: Angina with moderate exertion
Class 3: Angina with mild exertion
1. Walking 1-2 level blocks at normal pace
2. Climbing 1 flight of stairs at normal pace

Class 4: Angina at any level of physical exertion

Denominator Criteria (Eligible Cases):
Patient aged ≥ 18 years on date of encounter
AND
Diagnosis for coronary artery disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50,

410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82

Diagnosis for coronary artery disease (ICD-10-CM) [[for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

AND

Two Denominator Eligible Visits

AND

Severity of angina assessed by level of activity: 1010F

NUMERATOR:

Patients with appropriate management of anginal symptoms within a 12 month period

Definition:

Appropriate Management of Anginal Symptoms Includes the Following:

1. Absence of anginal symptoms as determined by evaluation of level of activity and symptoms

OR

2. Presence of anginal symptoms as determined by evaluation of level of activity and symptoms and a plan of care is documented to achieve control of anginal symptoms

Documented plan of care may include:

- 2 or more anti-anginal medications prescribed**, OR
- Referral for consideration for coronary revascularization, OR
- Referral for additional evaluation or treatment of anginal symptoms

** Prescribed may include prescription given to the patient for anti-anginal medication at one or more visits in the measurement period OR patient already taking 2 or more anti-anginal medications as documented in current medication list.

Numerator Options:

Angina present (1011F)

AND

Plan of care to manage anginal symptoms documented (0557F)

OR

Angina absent (1012F)

OR

Angina present (1011F)

AND

Documentation of medical reason(s) for not providing any specified element of plan of care to achieve control of anginal symptoms (eg, allergy, intolerance, other medical reasons) (0557F *with* 1P)

OR

Documentation of patient reason(s) for not providing any specified element of plan of care to achieve control of anginal symptoms (eg, patient declined, other patient reasons) (0557F *with* 2P)

OR

Documentation of system reason(s) for not providing any specified element of plan of care to achieve control of anginal symptoms (eg, financial reasons, other reasons attributable to the health care system) (0557F *with* 3P)

OR

Angina present (1011F)
AND
Plan of care to achieve control of angina symptoms was not performed, reason not otherwise specified (0557F *with* 8P)

RATIONALE:
In order to effectively manage the symptoms of a patient with chronic stable coronary artery disease, an assessment of those symptoms needs to be performed. This assessment is the basis of any treatment modification that needs to be made. Effective management of the symptoms associated with chronic stable coronary artery disease (eg, chest pain, shortness of breath) through medication management or referral for consideration of revascularization or other additional treatment. This may lead to improved patient quality of life, an important patient-centered outcome.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

The treatment of chronic stable angina has two complementary objectives: to reduce the risk of mortality and morbid events and to reduce symptoms. From the patient's perspective, it is often the latter that is of greater concern. The cardinal symptom of [coronary artery disease (CAD)] is anginal chest pain or equivalent symptoms, such as exertional dyspnea. Often the patient suffers not only from discomfort of the symptom itself but also from accompanying limitations on activities and the associated anxiety that the symptoms may produce. (ACC/AHA, 2002)

Beta-blockers as initial therapy in the absence of contraindications in patients with prior MI or without prior MI. (Class I Recommendation; Level of Evidence A [with prior MI]) (Class I Recommendation; Level of Evidence B [without prior MI]) (ACC/AHA, 2002)

Sublingual nitroglycerin or nitroglycerin spray for the immediate relief of angina. (Class I Recommendation; Level of Evidence B) (ACC/AHA, 2002)

Calcium antagonists* or long-acting nitrates as initial therapy for reduction of symptoms when beta-blockers are contraindicated. (Class I Recommendation; Level of Evidence B) (ACC/AHA, 2002)

Calcium antagonists* or long-acting nitrates in combination with beta-blockers when initial treatment with beta-blockers is not successful. (Class I Recommendation; Level of Evidence B) (ACC/AHA, 2002)

Calcium antagonists* and long-acting nitrates as a substitute for beta-blockers if initial treatment with beta-blockers leads to unacceptable side effects. (Class I Recommendation; Level of Evidence C) (ACC/AHA, 2002)
*Short-acting, dihydropyridine calcium antagonists should be avoided.

Measure #243 (NQF 0643): Cardiac Rehabilitation Patient Referral from an Outpatient Setting

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program

Definition:
Referral - A referral is defined as an official communication between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an outpatient CR program. This also includes a written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office note may potentially be formatted to include the necessary patient information to communicate to the CR program (the patient's cardiovascular history, testing, and treatments, for instance). According to standards of practice for cardiac rehabilitation programs, care coordination communications are sent to the referring provider, including any issues regarding treatment changes, adverse treatment responses, or new non-emergency condition (new symptoms, patient care questions, etc.) that need attention by the referring provider. These communications also include a progress report once the patient has completed the program. All communications must maintain an appropriate level of confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA).

Note: A patient with a qualifying diagnosis should have a referral to CR within the subsequent 12 months. In the event that the patient has a second (recurrent) qualifying event before the original 12 month "referral" period has ended, a new 12 month "referral" period for CR referral starts at the time of the second qualifying event, since the patient again becomes eligible for CR at that time.

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period who had a qualifying diagnosis within the previous 12 months and who have not already participated in an outpatient CR program. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients age ≥ 18 years evaluated in the outpatient setting during the reporting period who have a qualifying event/diagnosis [chronic stable angina (CSA), or who within the previous 12 months have had an acute myocardial

infarction (AMI) or have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation] who do not meet any of the exclusion criteria (patient factors, medical factors, health care system factors) and who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program

Denominator Instructions:
Coronary Artery Bypass Graft, Percutaneous Coronary Intervention, Cardiac Valve surgery, Cardiac Transplant or Acute Myocardial Infarction, in order to meet the criteria for inclusion of the measure, must have occurred or been performed within 12 months of date of encounter.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0438, G0439
AND

Diagnosis of Chronic Stable Angina (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 413.0, 413.1, 413.9
Diagnosis for Chronic Stable Angina (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.1, I20.8, I20.9
OR
Diagnosis of Acute Myocardial Infarction (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412
Diagnosis of Acute Myocardial Infarction (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I25.2
OR
Coronary Artery Bypass Graft Surgery (CPT): 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33572, 33999, 35500, 35600
OR
Percutaneous Coronary Intervention (CPT): 92920, 92924, 92928, 92933, 92937, 92941, 92943
OR
Cardiac Valve Surgery (CPT): 33361, 33362, 33363, 33364, 33365, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33412, 33413, 33414, 33415, 33416, 33417, 33420, 33422, 33425, 33426, 33427, 33430, 33463, 33464, 33465, 33468, 33470, 33471, 33472, 33474, 33475, 33476, 33478, 33496, 33600, 33602
OR
Cardiac Transplantation (CPT): 33935, 33945

AND
Qualifying cardiac event/diagnosis in previous 12 months: 1460F

NUMERATOR:
Patients who have had a qualifying event/diagnosis within the previous 12 months, who have been referred to an outpatient cardiac rehabilitation/secondary prevention (CR) program

Numerator Instructions:
CR programs may include a traditional CR program based on face-to-face interactions and training sessions or other options that include home-based approaches. If alternative CR approaches are used, they should be designed to meet appropriate safety standards.

Numerator Options:
Referral to an outpatient cardiac rehabilitation/secondary prevention program
Referred to an outpatient cardiac rehabilitation program (4500F)

OR

Documentation of medical reason(s) for not referring to an outpatient CR program (4500F *with* 1P)
OR
Documentation of patient reason(s) for not referring to an outpatient CR program (4500F *with* 2P)
OR
Documentation of system reason(s) for not referring to an outpatient CR program (4500F *with* 3P)
OR
Previous cardiac rehabilitation for qualifying cardiac event completed (4510F)

OR

Patient not referred to outpatient CR/secondary prevention program, reason not otherwise specified (4500F *with* 8P)

RATIONALE:
Cardiac rehabilitation services have been shown to help reduce morbidity and mortality in persons who have experienced a recent coronary artery disease event, but these services are used in less than 30% of eligible patients(1). A key component to CR utilization is the appropriate and timely referral of patients to an outpatient CR program. While referral takes place generally while the patient is hospitalized for a qualifying event (MI, CSA, CABG, PCI, cardiac valve surgery, or heart transplantation), there are many instances in which a patient can and should be referred from an outpatient clinical practice setting (e.g., when a patient does not receive such a referral while in the hospital, or when the patient fails to follow through with the referral for whatever reason).

This performance measure has been developed to help health care systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.

This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve disease states or other conditions for which CR services have been found to be appropriate and beneficial (e.g., following MI, CABG surgery)(2, 3). This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.

Referral of appropriate outpatients to a CR program is the responsibility of the health care provider within a health care system that is providing the primary cardiovascular care to the patient in the outpatient setting.

CLINICAL RECOMMENDATION STATEMENTS:
2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery(4)
Class I
Cardiac rehabilitation is recommended for all eligible patients after CABG. (Level of Evidence: A)

ACC/AHA 2007 Update of the Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction(5)
Class I
Advising medically supervised programs (cardiac rehabilitation) for high-risk patients (e.g., recent acute coronary syndrome or revascularization, heart failure) is recommended. (Level of Evidence: B)

ACC/AHA 2007 Guidelines for the Management of Patients with Unstable Angina and Non–ST-Segment Elevation Myocardial Infarction(6)
Class I
Cardiac rehabilitation/secondary prevention programs are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and/or those moderate- to high-risk patients in whom supervised exercise training is particularly warranted. (Level of Evidence: B)

Cardiac rehabilitation/secondary prevention programs, when available, are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and those moderate- to high-risk patients in whom supervised or monitored exercise training is warranted. (Level of Evidence: B)

ACC/AHA 2007 Chronic Angina Focused Update of the Guidelines for the Management of Patients With Chronic Stable Angina (7)
Class I
Medically supervised programs (cardiac rehabilitation) are recommended for at-risk patients (e.g., recent acute coronary syndrome or revascularization, heart failure). (Level of Evidence: B)

2009 Focused update incorporated into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults (8)
Class I
Exercise training is beneficial as an adjunctive approach to improve clinical status in ambulatory patients with current or prior symptoms of HF and reduced LVEF. (Level of Evidence: B)

Effectiveness-based Guidelines for the Prevention of Cardiovascular Disease in Women--2011 update: A Guideline from the American Heart Association(9)*Class I*
A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (Class I; Level of Evidence A) or current/prior symptoms of heart failure and an LVEF ≤35%. (Class I; Level of Evidence B)

ACC/AHA/SCAI 2007 Focused Update of the Guidelines for Percutaneous Coronary Intervention(10)
Class I
Medically supervised exercise programs (cardiac rehabilitation) should be recommended to patients after PCI, particularly for patients at moderate to high risk, for whom supervised exercise training is warranted. (Class I; Level of Evidence A)

⌘Measure #245: Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without the use of a wound surface culture technique

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of a chronic skin ulcer seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 on date of encounter
AND
Diagnosis for chronic skin ulcer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 454.0, 454.2, 459.11, 459.13, 459.31, 459.33, 707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09, 707.10, 707.11, 707.12, 707.13, 707.14, 707.15, 707.19, 707.8, 707.9
Diagnosis for chronic skin ulcer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.531, I70.532, I70.533, I70.534, I70.535, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.548, I70.549, I70.55, I70.631, I70.632, I70.633, I70.634, I70.635, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.648, I70.649, I70.65, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744,

I70.745, I70.748, I70.749, I70.75, I83.001, I83.002, I83.003, I83.004, I83.005, I83.008, I83.009, I83.011, I83.012, I83.013, I83.014, I83.015, I83.018, I83.019, I83.021, I83.022, I83.023, I83.024, I83.025, I83.028, I83.029, I83.201, I83.202, I83.203, I83.204, I83.205, I83.208, I83.209, I83.211, I83.212, I83.213, I83.214, I83.215, I83.218, I83.219, I83.221, I83.222, I83.223, I83.224, I83.225, I83.228, I83.229, I87.011, I87.012, I87.013, I87.019, I87.031, I87.032, I87.033, I87.039, I87.311, I87.312, I87.313, I87.319, I87.331, I87.332, I87.333, I87.339, L89.000, L89.001, L89.002, L89.003, L89.004, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.139, L89.140 , L89.141, L89.142, L89.143, L89.144, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.500, L89.501, L89.502, L89.503, L89.504, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L97.101, L97.102, L97.103, L97.104, L97.109, L97.111, L97.112, L97.113, L97.114, L97.119, L97.121, L97.122, L97.123, L97.124, L97.129, L97.201, L97.202, L97.203, L97.204, L97.209, L97.211, L97.212, L97.213, L97.214, L97.219, L97.221, L97.222, L97.223, L97.224, L97.229, L97.301, L97.302, L97.303, L97.304, L97.309, L97.311, L97.312, L97.313, L97.314, L97.319, L97.321, L97.322, L97.323, L97.324, L97.329, L97.401, L97.402, L97.403, L97.404, L97.409, L97.411, L97.412, L97.413, L97.414, L97.419, L97.421, L97.422, L97.423, L97.424, L97.429, L97.501, L97.502, L97.503, L97.504, L97.509, L97.511, L97.512, L97.513, L97.514, L97.519, L97.521, L97.522, L97.523, L97.524, L97.529, L97.801, L97.802, L97.803, L97.804, L97.809, L97.811, L97.812, L97.813, L97.814, L97.819, L97.821, L97.822, L97.823, L97.824, L97.829, L97.901, L97.902, L97.903, L97.904, L97.909, L97.911, L97.912, L97.913, L97.914, L97.919, L97.921, L97.922, L97.923, L97.924, L97.929, L98.411, L98.412, L98.413, L98.414, L98.419, L98.421, L98.422, L98.423, L98.424, L98.429, L98.491, L98.492, L98.493, L98.494, L98.499

AND

Patient encounter during the reporting period (CPT): 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patient visits without the use of a wound surface culture technique

Numerator Instructions: A higher score indicates appropriate treatment of patients with chronic skin ulcer.

NUMERATOR NOTE: *The numerator will also be met if there is documentation that a technique other than surface culture of the wound exudate has been used to acquire the wound culture (eg, Levine/deep swab technique, semiquantitative or quantitative swab technique).*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Wound Surface Culture Technique Not Used

CPT II 4261F: Technique other than surface culture of the wound exudate used (eg, Levine/deep swab technique, semiquantitative or quantitative swab technique) OR wound surface culture technique not used

OR

Wound Surface Culture Technique Used for Medical Reasons

Append a modifier (1P) to Category II code 4260F to report documented circumstances that appropriately exclude patients from the denominator.
4260F *with* 1P: Documentation of medical reason(s) for using a wound surface culture technique (eg, surface culture for methicillin-resistant staphylococcus aureus [MRSA] screening)

OR

Wound Surface Culture Technique Used
CPT II 4260F: Wound surface culture technique used

RATIONALE:
Infections are a potential complication in any patient with a chronic wound. Accurately determining the pathogenic cause of these clinically diagnosed infections has important implications in determining appropriate treatment regimens and minimizing patient complications. Surface swab cultures are inaccurate and unreliable for obtaining specimens for culture. A surface swab of an unprepared wound bed will not necessarily reveal the organism that resides within the tissue but rather only the surface contaminants. A basic tenet of infection within a chronic wound is that the organism must reside in living tissue. Swab culture of the surface may not reveal this in the presence of significant necrotic tissue or exudate. A recent survey of wound care practitioners in the US found that 54% of respondents routinely collect a swab culture while another 42% routinely collect both swab and biopsy specimens depending on the nature of the wound. More importantly, the study demonstrated considerable variability in the type of swab culture commonly obtained - including surface, deep swab and quantitative techniques. Despite their limited utility and the proven efficacy of quantitative swab and other techniques, surface cultures remain a common method for identifying chronic wound infection. The principle here is to avoid swabbing the unprepared wound exudate. Preparation of the wound with physiologic solution and removal of loose tissue matter prior to obtaining the wound culture will not impede the diagnosis of an offending organism, rather it will lessen the probability of identifying and treating a surface contaminant that will not impact progression to healing. In other words, no information is lost by wound bed preparation prior to swab or tissue biopsy technique culture. The goal is to obtain tissue microorganisms from the viable deeper tissue plane.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Avoid swabbing undebrided ulcers or wound drainage. If swabbing the debrided wound base is the only available culture option, use a swab designed for culturing aerobic and anaerobic organisms and rapidly transport it to the laboratory (B-I). (Lipsky et al., IDSA, 2004)

…determine the type and level of infection in the debrided ulcer by tissue biopsy or by a validated quantitative swab technique. (Level II) (WHS, 2006)

[Q]uantitative culture has been shown to have high predictive value, sensitivity, and specificity. Most authors recommend the following technique for acquiring high quality wound cultures: After skin disinfection, a strip of necrotic wound tissue weighing 0.1 to 0.5 gram is excised for quantitative culture. This specimen is placed in an aerobic/anaerobic culture medium. Simultaneously, routine cotton swab is taken from the site of excision-debridement, taking care to avoid the ulcer's surface. It may occasionally be necessary to biopsy the ulcer in order to rule out [the] uncommon causes of lower extremity ulcers. (ASPS, 2007)
...swab specimens collected from wounds using Levine's technique performed better than swab specimens collected using either the wound exudate or Z-technique. Equally important, the findings suggest that swab specimens obtained using Levine's technique and processed using quantitative laboratory procedures are acceptably accurate when compared with the quantitative cultures of wound tissue. …swab specimens obtained with Levine's technique will enable a wider variety of wounds to be monitored for wound bioburden than tissue cultures. In addition, Levine's technique will be much more practical for repeating cultures in suspicious wounds that produce negative findings initially than tissue cultures. (Gardner et al., 2006)

⌘Measure #246: Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without a prescription or recommendation to use wet to dry dressings

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of a chronic skin ulcer seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 on date of encounter
AND
Diagnosis for chronic skin ulcer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 454.0, 454.2, 459.11, 459.13, 459.31, 459.33, 707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09, 707.10, 707.11, 707.12, 707.13, 707.14, 707.15, 707.19, 707.8, 707.9
Diagnosis for chronic skin ulcer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.531, I70.532, I70.533, I70.534, I70.535, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.548, I70.549, I70.55, I70.631, I70.632, I70.633, I70.634, I70.635, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.648, I70.649, I70.65, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744,

I70.745, I70.748, I70.749, I70.75, I83.001, I83.002, I83.003, I83.004, I83.005, I83.008, I83.009, I83.011, I83.012, I83.013, I83.014, I83.015, I83.018, I83.019, I83.021, I83.022, I83.023, I83.024, I83.025, I83.028, I83.029, I83.201, I83.202, I83.203, I83.204, I83.205, I83.208, I83.209, I83.211, I83.212, I83.213, I83.214, I83.215, I83.218, I83.219, I83.221, I83.222, I83.223, I83.224, I83.225, I83.228, I83.229, I87.011, I87.012, I87.013, I87.019, I87.031, I87.032, I87.033, I87.039, I87.311, I87.312, I87.313, I87.319, I87.331, I87.332, I87.333, I87.339, L89.000, L89.001, L89.002, L89.003, L89.004, L89.009, L89.010, L89.011, L89.012, L89.013, L89.014, L89.019, L89.020, L89.021, L89.022, L89.023, L89.024, L89.029, L89.100, L89.101, L89.102, L89.103, L89.104, L89.109, L89.110, L89.111, L89.112, L89.113, L89.114, L89.119, L89.120, L89.121, L89.122, L89.123, L89.124, L89.129, L89.130, L89.131, L89.132, L89.133, L89.134, L89.139, L89.140 , L89.141, L89.142, L89.143, L89.144, L89.149, L89.150, L89.151, L89.152, L89.153, L89.154, L89.159, L89.200, L89.201, L89.202, L89.203, L89.204, L89.209, L89.210, L89.211, L89.212, L89.213, L89.214, L89.219, L89.220, L89.221, L89.222, L89.223, L89.224, L89.229, L89.300, L89.301, L89.302, L89.303, L89.304, L89.309, L89.310, L89.311, L89.312, L89.313, L89.314, L89.319, L89.320, L89.321, L89.322, L89.323, L89.324, L89.329, L89.40, L89.41, L89.42, L89.43, L89.44, L89.45, L89.500, L89.501, L89.502, L89.503, L89.504, L89.509, L89.510, L89.511, L89.512, L89.513, L89.514, L89.519, L89.520, L89.521, L89.522, L89.523, L89.524, L89.529, L89.600, L89.601, L89.602, L89.603, L89.604, L89.609, L89.610, L89.611, L89.612, L89.613, L89.614, L89.619, L89.620, L89.621, L89.622, L89.623, L89.624, L89.629, L89.810, L89.811, L89.812, L89.813, L89.814, L89.819, L89.890, L89.891, L89.892, L89.893, L89.894, L89.899, L89.90, L89.91, L89.92, L89.93, L89.94, L89.95, L97.101, L97.102, L97.103, L97.104, L97.109, L97.111, L97.112, L97.113, L97.114, L97.119, L97.121, L97.122, L97.123, L97.124, L97.129, L97.201, L97.202, L97.203, L97.204, L97.209, L97.211, L97.212, L97.213, L97.214, L97.219, L97.221, L97.222, L97.223, L97.224, L97.229, L97.301, L97.302, L97.303, L97.304, L97.309, L97.311, L97.312, L97.313, L97.314, L97.319, L97.321, L97.322, L97.323, L97.324, L97.329, L97.401, L97.402, L97.403, L97.404, L97.409, L97.411, L97.412, L97.413, L97.414, L97.419, L97.421, L97.422, L97.423, L97.424, L97.429, L97.501, L97.502, L97.503, L97.504, L97.509, L97.511, L97.512, L97.513, L97.514, L97.519, L97.521, L97.522, L97.523, L97.524, L97.529, L97.801, L97.802, L97.803, L97.804, L97.809, L97.811, L97.812, L97.813, L97.814, L97.819, L97.821, L97.822, L97.823, L97.824, L97.829, L97.901, L97.902, L97.903, L97.904, L97.909, L97.911, L97.912, L97.913, L97.914, L97.919, L97.921, L97.922, L97.923, L97.924, L97.929, L98.411, L98.412, L98.413, L98.414, L98.419, L98.421, L98.422, L98.423, L98.424, L98.429, L98.491, L98.492, L98.493, L98.494, L98.499

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patient visits without a prescription or recommendation to use wet to dry dressings

Numerator Instructions: A higher score indicates appropriate treatment of patients with chronic skin ulcer.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

No Prescription or Recommendation for Use of Wet to Dry Dressings

CPT II 4266F: Use of wet to dry dressings neither prescribed nor recommended

OR

Use of Wet to Dry Dressings Prescribed or Recommended for Medical Reasons

Append a modifier (1P) to Category II code 4265F to report documented circumstances that appropriately exclude patients from the denominator.

4265F *with* 1P: Documentation of medical reason(s) for prescribing/recommending wet to dry dressings (eg, presence of necrotic tissue requiring debridement, highly exudative wound that is unlikely to dry out between dressing changes)

OR

Use of Wet to Dry Dressings Prescribed or Recommended
CPT II 4265F: Use of wet to dry dressings prescribed or recommended

RATIONALE:
A moist wound environment is essential to accelerate wound healing. Nevertheless, "wet to dry and gauze dressings are the most widely used primary dressing material in the United States" and evidence suggests that they are used inappropriately. In a recent study examining wound care practices, the use of dressings to maintain moist wound conditions ranged from 41.7% to 58.5% for diabetic and venous ulcers, respectively. Wet-to-dry dressings should not be utilized in the care of patients with chronic wounds as they may actually impede healing and are associated with an increased risk of infection, prolonged inflammation, and increased patient discomfort.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Use clinical judgment to select a wound dressing that facilitates continued moisture. (Level I) Wet-to-dry dressings are not considered continuously moist. Continuously moist saline gauze dressings are as effective as other types of moist wound healing in terms of healing rate, although they may have other drawbacks such as maceration of the peri-ulcer skin, practicality of use, and cost effectiveness. It can also be very difficult, practically, to keep gauze dressings continuously moist. (WHS, 2006)

Maintain moist environment
- Remove soluble factors detrimental to wound healing
- Use appropriate dressings (available evidence shows no superiority in dressing materials)
- Consider classic dressings (gauze, foam, hydrocolloid, hydrogels)

Consider bioactive dressings (Grade B) (ASPS, 2007)

⌘Measure #247: Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of alcohol dependence seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of current alcohol dependence

> Denominator Criteria (Eligible Cases):
> Patient aged ≥ 18 years on date of encounter
> AND
> Diagnosis for alcohol dependence (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 303.90, 303.91, 303.92
> Diagnosis for alcohol dependence (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29
> AND
> Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Patient Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence
CPT II 4320F: Patient counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence

OR

Patient not Counseled Regarding Psychosocial AND Pharmacologic Treatment Options for Alcohol Dependence, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4320F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4320F *with* 8P: Patient was not counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence, reason not otherwise specified

RATIONALE:
Research has shown that among patients diagnosed with alcohol dependence, only 4.64% were referred for psychosocial treatment in the form of substance abuse counseling, inpatient rehabilitation programs, outpatient rehabilitation programs, or mutual help groups. While pharmacologic therapy has established efficacy, often in combination with psychosocial therapy, in promoting abstinence and preventing relapse in alcohol-dependent patients, physician rates of prescribing pharmacologic therapy for alcohol dependence are also considerably low. A recent study found that these low rates prevail even among addiction medicine physicians who prescribed naltrexone to only 13% of their alcohol-dependent patients. Pharmacotherapy and psychosocial treatment should be routinely considered for all patients with alcohol dependence, and patients should be informed of this option.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Psychosocial treatments found effective for some patients with an alcohol use disorder include motivational enhancement therapy (MET) (Category I), cognitive-behavioral therapy (CBT) (Category I), behavioral therapies (Category I), 12-step facilitation (TSF) (Category I), marital and family therapies (Category I), group therapies (Category II), and psychodynamic therapy/interpersonal therapy (IPT) (Category III). (APA, 2006)
Specific pharmacotherapies for alcohol-dependent patients have well-established efficacy and moderate effectiveness:

- Naltrexone may attenuate some of the reinforcing effects of alcohol, although data on its long-term efficacy are limited. The use of long-acting, injectable naltrexone may promote adherence, but published research is limited and FDA approval is pending. *[Note: Extended-release naltrexone for injection has since received FDA approval]* (Category I)
- Acamprosate, a γ-aminobutyric acid (GABA) analog that may decrease alcohol craving in abstinent individuals, may also be an effective adjunctive medication in motivated patients who are concomitantly receiving psychosocial treatment. (Category I)
- Disulfiram is an effective adjunct to a comprehensive treatment program for reliable, motivated patients whose drinking may be triggered by events that suddenly increase alcohol craving. (Category II) (APA, 2006)

Empirically validated psychosocial treatment interventions should be initiated for all patients with substance use illnesses. Pharmacotherapy should be offered and available to all adult patients diagnosed with alcohol dependence and without medical contraindications. Pharmacotherapy, if prescribed, should be provided in addition to and directly linked with psychosocial treatment/support. (NQF, 2007)

⌘Measure #248: Substance Use Disorders: Screening for Depression Among Patients with Substance Abuse or Dependence

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of current substance abuse or dependence seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilizes claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of current substance abuse or dependence

Denominator Criteria (Eligible Cases):
Patient aged ≥ 18 years on date of encounter
AND
Diagnosis for substance abuse or dependence (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 303.90, 303.91, 303.92, 304.00, 304.01, 304.02, 304.10, 304.11, 304.12, 304.20, 304.21, 304.22, 304.30, 304.31, 304.32, 304.40, 304.41, 304.42, 304.50, 304.51, 304.52, 304.60, 304.61, 304.62, 304.70, 304.71, 304.72, 304.80, 304.81, 304.82, 304.90, 304.91, 304.92, 305.00, 305.01, 305.02, 305.20, 305.21, 305.22, 305.30, 305.31, 305.32, 305.40, 305.41, 305.42, 305.50, 305.51, 305.52, 305.60, 305.61, 305.62, 305.70, 305.71, 305.72, 305.80, 305.81, 305.82, 305.90, 305.91, 305.92
Diagnosis for substance abuse or dependence (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F10.10, F10.120, F10.121, F10.129, F10.14, F10.150, F10.151, F10.159, F10.180, F10.181, F10.182, F10.188, F10.19, F10.20, F10.220, F10.221, F10.229, F10.230, F10.231, F10.232, F10.239, F10.24, F10.250, F10.251, F10.259, F10.26, F10.27, F10.280, F10.281, F10.282, F10.288, F10.29, F11.10, F11.120, F11.121, F11.122, F11.129, F11.14, F11.150, F11.151, F11.159, F11.181, F11.182, F11.188, F11.19,

F11.20, F11.220, F11.221, F11.222, F11.229, F11.23, F11.24, F11.250, F11.251, F11.259, F11.281, F11.282, F11.288, F11.29, F12.10, F12.120, F12.121, F12.122, F12.129, F12.150, F12.151, F12.159, F12.180, F12.188, F12.19, F12.20, F12.220, F12.221, F12.222, F12.229, F12.250, F12.251, F12.259, F12.280, F12.288, F12.29, F13.10, F13.120, F13.121, F13.129, F13.14, F13.150, F13.151, F13.159, F13.180, F13.181, F13.182, F13.188, F13.19, F13.20, F13.220, F13.221, F13.229, F13.230, F13.231, F13.232, F13.239, F13.24, F13.250, F13.251, F13.259, F13.26, F13.27, F13.280, F13.281, F13.282, F13.288, F13.29, F14.10, F14.120, F14.121, F14.122, F14.129, F14.14, F14.150, F14.151, F14.159, F14.180, F14.181, F14.182, F14.188, F14.19, F14.20, F14.220, F14.221, F14.222, F14.229, F14.23, F14.24, F14.250, F14.251, F14.259, F14.280, F14.281, F14.282, F14.288, F14.29, F15.10, F15.120, F15.121, F15.122, F15.129, F15.14, F15.150, F15.151, F15.159, F15.180, F15.181, F15.182, F15.188, F15.19, F15.20, F15.220, F15.221, F15.222, F15.229, F15.23, F15.24, F15.250, F15.251, F15.259, F15.280, F15.281, F15.282, F15.288, F15.29, F16.10, F16.120, F16.121, F16.122, F16.129, F16.14, F16.150, F16.151, F16.159, F16.180, F16.183, F16.188, F16.19, F16.20, F16.220, F16.221, F16.229, F16.24, F16.250, F16.251, F16.259, F16.280, F16.283, F16.288, F16.29, F18.10, F18.120, F18.121, F18.129, F18.14, F18.150, F18.151, F18.159, F18.17, F18.180, F18.188, F18.19, F18.20, F18.220, F18.221, F18.229, F18.24, F18.250, F18.251, F18.259, F18.27, F18.280, F18.288, F18.29, F19.10, F19.120, F19.121, F19.122, F19.129, F19.14, F19.150, F19.151, F19.159, F19.16, F19.17, F19.180, F19.181, F19.182, F19.188, F19.19, F19.20, F19.220, F19.221, F19.222, F19.229, F19.230, F19.231, F19.232, F19.239, F19.24, F19.250, F19.251, F19.259, F19.26, F19.27, F19.280, F19.281, F19.282, F19.288, F19.29

AND

Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were screened for depression within the 12-month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Depression

CPT II 1220F: Patient screened for depression

OR

Patient not Screened for Depression for Medical Reasons

Append a modifier (1P) to CPT Category II code 1220F to report documented circumstances that appropriately exclude patients from the denominator.

1220F *with* 1P: Documentation of medical reason(s) for not screening for depression

OR

Patient not Screened for Depression, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 1220F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1220F *with* 8P: Patient was not screened for depression, reason not otherwise specified

RATIONALE:

Depression is one of the most common co-occurring psychiatric conditions in patients with substance use disorders and a condition for which a variety of screening methods have proven effective. Identifying depression and other co-occurring psychiatric disorders in patients with substance use disorders is essential for proper management and key to developing an integrated treatment approach, which is associated with better outcomes. Despite its importance, research has shown that more than 30% of patients with risk factors for depression, including alcohol or other drug abuse, were not asked about the presence or absence of depression or depressive symptoms.

CLINICAL RECOMMENDATION STATEMENTS:

The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

All patients with a substance use disorder should be carefully assessed for the presence of co-occurring psychiatric disorders, including additional substance use disorders. (APA, 2006)

All positive screening tests should trigger full diagnostic interviews that use standard diagnostic criteria (ie, those from the fourth edition of Diagnostic and Statistical Manual of Mental Disorders [DSM-IV]) to determine the presence or absence of specific depressive disorders, such as major depression and/or dysthymia. The severity of depression and co-morbid psychological problems (eg, anxiety, panic attacks, or substance abuse) should be addressed. (USPSTF, 2002)

In general, treatment of depressive symptoms of moderate to severe intensity should begin concurrently or soon after initiating treatment of the co-occurring substance use disorder, particularly if there is evidence of prior mood episodes. In individuals without prior episodes of depression or a family history of mood disorders, it may be appropriate to delay the treatment of mild to moderate depressive symptoms for the purpose of diagnostic clarification. Clinicians are advised to monitor symptoms, assess and reassess for suicidal ideation, provide education, encourage abstinence from substances, and observe changes in mental status during the substance-free period while actively considering whether antidepressant intervention is indicated. (APA, 2006)

Measure #249: Barrett's Esophagus

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of esophageal biopsy reports that document the presence of Barrett's mucosa that also include a statement about dysplasia

INSTRUCTIONS:
This measure is to be reported each time a patient's surgical pathology report demonstrates Barrett's Esophagus; however, only one QDC per date of service for a patient is required. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR quality-data code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All surgical pathology biopsy reports for Barrett's Esophagus

> Denominator Criteria (Eligible Cases):
> Diagnosis for Barrett's esophagus (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 530.85
> Diagnosis for Barrett's esophagus (ICD-10-CM) [for use 10/01/2014-12/31/2014]: K22.70, K22.710, K22.711, K22.719
> AND
> Patient encounter during the reporting period (CPT): 88305

NUMERATOR:
Esophageal biopsy report documents the presence of Barrett's mucosa and includes a statement about dysplasia

> *NUMERATOR NOTE: Report quality data codes once per patient for each date-of-service*.
>
> Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that Contains a Statement about Dysplasia (present, absent, or indefinite)
CPT II 3125F: Esophageal biopsy reports with the histological finding of Barrett's mucosa that contains a statement about dysplasia (present, absent, or indefinite)

OR

Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that Contains a Statement about Dysplasia (present, absent, or indefinite) not Performed for Medical Reasons
Append a modifier (1P) to Category II code 3125F to report documented circumstances that appropriately exclude patients from the denominator
3125F *with* 1P: Documentation of medical reason(s) for not reporting the histological finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia)

OR

If patient is not eligible for this measure because the specimen is not of esophageal origin report:
G8797: Specimen site other than anatomic location of esophagus

OR

Esophageal Biopsy Reports with the Histological Finding of Barrett's Mucosa that does not Contain a Statement about Dysplasia (present, absent, or indefinite), Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3125F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3125F *with* 8P: Pathology report with the histological finding of Barrett's mucosa that does not contain a statement about dysplasia (present, absent, or indefinite), reason not otherwise specified

RATIONALE:
Endoscopy is the technique of choice used to identify suspected Barrett's esophagus and to diagnose complications of GERD. Biopsy must be added to confirm the presence of Barrett's epithelium and to evaluate for dysplasia (ACG, 2005).

There is a rapidly rising incidence of adenocarcinoma of the esophagus in the United States. A diagnosis of Barrett's esophagus increases a patient's risk for esophageal adenocarcinoma by 30 to 125 times that of people without Barrett's esophagus (although this risk is still small 0.4% to 0.5% per year). Esophageal adenocarcinoma is often not curable, partly because the disease is frequently discovered at a late stage and because treatments are not effective. A diagnosis of Barrett's esophagus could allow for appropriate screening of at risk patients as recommended by the American College of Gastroenterology.

Standard endoscopy with biopsy currently is the most reliable means of establishing a diagnosis of Barrett's esophagus. The definitive diagnosis of Barrett's esophagus requires a pathologist's review of an esophageal biopsy. Dysplasia is the first step in the neoplastic process, and information about dysplasia is crucial for clinical decision-making directing therapy. The presence and grade of dysplasia cannot be determined by routine endoscopy, and pathologist's review of a biopsy is essential for recognition of dysplasia. Endoscopic surveillance detects curable neoplasia in patients with Barrett's esophagus.

CLINICAL RECOMMENDATION STATEMENTS:
The diagnosis of Barrett's esophagus requires systematic biopsy of the abnormal-appearing esophageal mucosa to document intestinal metaplasia and to detect dysplasia.

Measure #250: Radical Prostatectomy Pathology Reporting

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status

INSTRUCTIONS:
This measure is to be reported each time a radical prostatectomy surgical pathology examination is performed during the reporting period for prostate patients. Each unique CPT Category I code or quality-data code submitted on the claim will be counted for denominator inclusion. It is anticipated that clinicians who examine prostate tissue specimens following resection in a laboratory or institution will submit this measure. Independent Laboratories (ILs) and Independent Diagnostic Testing Facilities (IDTFs), using indicator Place of Service 81, are not included in PQRS. If the specimen is not primary prostate tissue (e.g., breast, lung), report only G8798.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM /ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR quality-data codes OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.
The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All radical prostatectomy surgical pathology examinations performed during the measurement period for prostate cancer patients

Denominator Criteria (Eligible Cases):
Diagnosis for malignant neoplasm of prostate (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 185
Diagnosis for malignant neoplasm of prostate (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C61
AND
Patient encounter during the reporting period (CPT): 88309

NUMERATOR:
Radical Prostatectomy reports that include the pT category, the pN category, Gleason score and a statement about margin status

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Radical Prostatectomy Report includes pT category, pN category, Gleason Score and Statement about Margin Status
CPT II 3267F: Pathology report includes pT category, pN category, Gleason score and statement about margin status
OR
pT category, pN category, Gleason Score and Statement about Margin Status not Documented for Medical Reasons
Append a modifier (1P) to Category II code 3267F to report documented circumstances that appropriately exclude patients from the denominator.
3267F *with* 1P: Documentation of medical reason(s) for not including pT category, pN category, Gleason score and statement about margin status in the pathology report (eg, specimen originated from other malignant neoplasms, transurethral resections of the prostate (TURP), or secondary site prostatic carcinomas)

OR

If patient is not eligible for this measure because the specimen is not primary prostate tissue from a radical resection report:
G8798: Specimen site other than anatomic location of prostate

OR

pT category, pN category, Gleason Score and Statement about Margin Status not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3267F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3267F *with* 8P: pT category, pN category, Gleason score and statement about margin status were not documented in pathology report, reason not otherwise specified

RATIONALE:
Therapeutic decisions for prostate cancer management are stage driven and cannot be made without a complete set of pathology descriptors. Incomplete pathology reports for prostate cancer may result in misclassification of patients, rework and delays, and suboptimal management. The College of American Pathologists Cancer Committee has produced an evidence-based protocol/checklist of essential pathologic parameters that are recommended to be included in prostate cancer resection pathology reports. Conformance of pathology reports with the CAP checklist is a requirement for Cancer Center certification by the ACS.

The protocol recommends the use of the TNM Staging System for carcinoma of the prostate of the American Joint Committee on Cancer (AJCC) and the International Union Against Cancer (UICC). The radical prostatectomy checklist also includes extraprostatic extension.

In a study of cancer recurrence following radical prostatectomy, it was noted that "The relatively high proportion of patients who have biopsy-proven local recurrence who have organ-confined disease is probably inaccurate and, in large part, reflects under sampling and under recognition of extraprostatic extension."

The CAP Q probes data (2006) indicates that 11.6% of prostate pathology reports had missing elements. Extent of invasion (pTNM) was most frequently missing (52.1% of the reports missing elements), and extraprostatic extension was the second most frequently missing (41.7% of the reports missing elements). Margin status was missing in 8.3% of reports.

A sampling from prostate cancer cases in 2000 through 2001 from the College of Surgeons National Cancer Data Base found only 48.2% of surgical pathology reports for prostate cancer documented pathologic stage similar to the more recent data from the CAP Q probes study. The NCDB data showed the Gleason score was present 86.3% of

the time, slightly less than the 100% compliance found in the CAP Q probes study and that margin status was present in 84.9% of reports.

CLINICAL RECOMMENDATION STATEMENTS:

Patient management and treatment guidelines promote an organized approach to providing quality care. The (American College of Surgeons Committee on Cancer) CoC requires that 90% of pathology reports that include a cancer diagnosis contain the scientifically validated data elements outlined in the surgical case summary checklist of the College of American Pathologists (CAP) publication *Reporting on Cancer Specimens*. The College regards the reporting elements in the "Surgical Pathology Cancer Case Summary (Checklist)" portion of the protocols as essential elements of the pathology report. However, the manner in which these elements are reported is at the discretion of each specific pathologist, taking into account clinician preferences, institutional policies, and individual practice.

Pathologic staging is usually performed after surgical resection of the primary tumor. Pathologic staging depends on pathologic documentation of the anatomic extent of disease, whether or not the primary tumor has been completely removed.

Measure #251: Immunohistochemical (IHC) Evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) for Breast Cancer Patients

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
This is a measure based on whether quantitative evaluation of Human Epidermal Growth Factor Receptor 2 Testing (HER2) by immunohistochemistry (IHC) uses the system recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer

INSTRUCTIONS:
This measure should be reported each time a quantitative HER2 IHC pathology examination is performed during the reporting period for patients with breast cancer; however, only one QDC per date of service for a patient is required. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All breast cancer patients with quantitative breast tumor evaluation by HER2 IHC

> Denominator Criteria (Eligible Cases):
> Diagnosis for breast cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
> Diagnosis for breast cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
> AND
> Patient encounter during the reporting period (CPT): 88360, 88361

NUMERATOR:

Breast cancer patients receiving quantitative breast tumor HER2 IHC evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in the ASCO/CAP guideline

NUMERATOR NOTE: Report CPT II quality data codes once per patient for each date-of-service.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Quantitative Evaluation of HER2 by IHC Performed
CPT II 3394F: Quantitative HER2 by IHC evaluation consistent with scoring system defined in the ASCO/CAP guidelines

OR

If patient is not eligible for this measure because quantitative non-HER2 IHC evaluation was performed (eg, testing for estrogen or progesterone, receptors, [ER/PR]) report:
CPT II 3395F: Quantitative non-HER2 IHC evaluation (eg, testing for estrogen or progesterone receptors, [ER/PR]) performed

OR

Quantitative Evaluation of HER2 by IHC Performed but did not use the System Recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3394F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3394F *with* 8P: Quantitative evaluation of HER2 did not use the system recommended in the ASCO/CAP Guidelines for Human Epidermal Growth Factor Receptor 2 Testing in breast cancer, reason not otherwise specified

RATIONALE:
Through a cooperative effort with the American Society of Clinical Oncologists (ASCO) and the CAP, new guidelines for Human Epidermal Growth Factor 2 testing in breast cancer were published in January 2007.

The ASCO/CAP Guideline recommendations for quantitative HER2 IHC evaluation were designed to enhance concordance with FISH assays for HER2 Amplified and Non-amplified tumor status. The recommendations are different from those provided by HER2 antibody manufacturers and compliance is likely to be considerably less than 100%. Implementation of Guideline scoring would promote uniformity and quality among interpreting pathologists.

CLINICAL RECOMMENDATION STATEMENTS:
"Positive HER2 test – Based on a literature review of clinical trials, international studies and protocols, expert consensus, and US Food and Drug Administration Panel findings, a positive HER2 test is defined as either … uniform intense membrane staining of > 30% of invasive tumor cells… or FISH result of amplified *HER2* gene copy number (average of > six gene copies/nucleus for test systems without internal control probe) or *HER2*/CEP 17 ratio of more than 2.2, where CEP 17 is a centromeric probe for chromosome 17 on which the *HER2* gene resides. The 30% [criterion] for a positive IHC is further discussed in Appendix G."

"For IHC assays of HER2 protein expression, the original US Food and Drug Administration-approved interpretation guidelines provide insufficient specificity. Several experts, including those serving as central reviewers on clinical trials, have specified that a threshold of more than 30% of tumor (rather than the originally specified 10%) should show strong circumferential membrane staining for a positive result. This means that according to this guideline, strong circumferential staining of 30% or less of cells would be considered equivocal and be subjected to confirmatory FISH testing.

Measure #254 (NQF 0651): Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of pregnant female patients aged 14 to 50 who present to the emergency department (ED) with a chief complaint of abdominal pain or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound to determine pregnancy location

INSTRUCTIONS:
This measure is to be reported each time a patient who presents in the emergency department with a chief complaint of abdominal pain and/or vaginal bleeding who receive a trans-abdominal or trans-vaginal ultrasound during the reporting period. It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All pregnant female patients aged 14 to 50 who present to the ED with a chief complaint of abdominal pain or vaginal bleeding

Denominator Criteria (Eligible Cases):
Pregnant females aged 14 to 50
AND
Diagnosis of Other Current Condition in the Mother Classifiable Elsewhere but Complicating Pregnancy, Childbirth, or the Puerperium (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 648.90, 648.93
Diagnosis of Other Current Condition in the Mother Classifiable Elsewhere but Complicating Pregnancy, Childbirth, or the Puerperium (ICD-10-CM) [for use 10/01/2014-12/31/2014]: O26.899, O26.90, O26.91
AND
Diagnosis for Abdominal Pain (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 789.00, 789.03, 789.04, 789.05, 789.06, 789.07, 789.09, 789.60, 789.63, 789.64, 789.65, 789.66, 789.67, 789.69

Diagnosis for Abdominal Pain (ICD-10-CM) [for use 10/01/2014-12/31/2014]: R10.0, R10.10, R10.13, R10.2, R10.30, R10.31, R10.32, R10.33, R10.813, R10.814, R10.815, R10.816, R10.817, R10.819, R10.823, R10.824, R10.825, R10.826, R10.827, R10.829, R10.84, R10.9

OR

Diagnosis for Vaginal Bleeding (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 640.00, 640.03, 640.80, 640.83, 640.90, 640.93, 641.10, 641.13, 641.20, 641.23, 641.30, 641.33, 641.80, 641.83, 641.90, 641.93
Diagnosis for Vaginal Bleeding (ICD-10-CM) [for use 10/01/2014-12/31/2014]: O20.0, O20.8, O20.9, O44.10, O44.11, O45.001, O45.009, O45.011, O45.019, O45.021, O45.029, O45.091, O45.099, O45.8X1, O45.8X9, O45.90, O45.91, O46.001, O46.009, O46.011, O46.019, O46.021, O46.029, O46.8X1, O46.8X9, O46.90, O46.91, O46.091, O46.099
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:
Patients who receive a trans-abdominal or trans-vaginal ultrasound with documentation of pregnancy location in medical record

Numerator Instructions: This measure is to be reported each time a patient meets the requirements as indicated in the denominator. If the clinician documents that the clinical event surrounding the patient, with or without performance of trans-abdominal or trans-vaginal ultrasound, does not meet the intent of the measure report quality-data code G8807.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Trans-Abdominal or Trans-Vaginal Ultrasound Performed and Pregnancy Location Documented During ED Visit
G8806: Performance of trans-abdominal or trans-vaginal ultrasound
OR
Trans-Abdominal or Trans-Vaginal Ultrasound not Performed for Documented Reasons
G8807: Trans-abdominal or trans-vaginal ultrasound not performed for reasons documented by clinician (e.g., patient has visited the ED multiple times within 72 hours, patient has a documented Intrauterine Pregnancy [IUP])

OR

Trans-Abdominal or Trans-Vaginal Ultrasound not Performed, Reason not Given
G8808: Performance of trans-abdominal or trans-vaginal ultrasound not ordered, reason not given (e.g., patient has visited the ED multiple times with no documentation of a trans-abdominal or trans-vaginal ultrasound within ED or from referring eligible professional)

RATIONALE:
Ectopic Pregnancy is a relatively common condition which can result in morbidity or mortality if misdiagnosed resulting in a delay to appropriate treatment. Abdominal pain is a frequent presenting complaint of women with ruptured ectopic pregnancy. Pelvic ultrasound can establish a pregnancy as intrauterine and identify high risk features for ectopic pregnancy (pelvic free fluid, complex adnexal mass). Early ultrasound can shorten the time to diagnosis of ectopic pregnancy and can help risk stratify pregnant patients with the complaint of abdominal pain or vaginal bleeding for discharge with routine follow-up, discharge with early follow-up or admission.

CLINICAL RECOMMENDATION STATEMENTS:

Use of emergency ultrasound in pelvic disorders centers on the detection of intrauterine pregnancy (IUP), detection of ectopic pregnancy, detection of fetal heart rate in all stages of pregnancy, dating of the pregnancy, and detection of significant free fluid. Bedside pelvic ultrasound during the first trimester of pregnancy can be used to exclude ectopic pregnancy by demonstrating an intrauterine pregnancy. Studies of EP-performed ultrasound in this setting have demonstrated sensitivity of 76-90% and specificity of 88- 92% for the detection of ectopic pregnancy. In one study, EPs were able to detect an intrauterine pregnancy in 70% of patients with suspected ectopic pregnancy (first trimester pregnancy with abdominal pain or vaginal bleeding). When intrauterine fetal anatomy was visualized at the bedside, ectopic pregnancy was ruled out with a negative predictive value of essentially 100%. When bedside ultrasound evaluation was incorporated into a clinical algorithm for the evaluation of patients with suspected ectopic pregnancy, the incidence of discharged patients returning with ruptured ectopic pregnancy was significantly reduced.

Measure #255 (NQF 0652): Rh Immunoglobulin (Rhogam) for Rh-Negative Pregnant Women at Risk of Fetal Blood Exposure

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of Rh-negative pregnant women aged 14-50 years at risk of fetal blood exposure who receive Rh-Immunoglobulin (Rhogam) in the emergency department (ED)

INSTRUCTIONS:
This measure is to be reported each time a pregnant patient presents to the emergency department with complaints including blunt abdominal trauma, vaginal bleeding, ectopic pregnancy, and threatened or spontaneous abortion. Claims data will be analyzed to determine the emergency department discharge. Patients who present to the emergency department with these complaints should have documentation in the medical record of receiving an order for Rh-Immunoglobulin (Rhogam). It is anticipated that clinicians who provide care in the emergency department will submit this measure. The Part B claim form place of service field must indicate that the encounter has taken place in the emergency department.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, Place of Service Indicator, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All pregnant female patients aged 14 to 50 years who are Rh-negative and at significant risk of fetal blood exposure

Denominator Criteria (Eligible Cases):
Female patients aged 14 to 50 years on date of encounter
AND
Diagnosis for Rh-Negative (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 656.10, 656.13
Diagnosis for Rh-Negative (ICD-10-CM) [for use 10/01/2014-12/31/2014]: O36.0110, O36.0111, O36.0190, O36.0191, O36.0910, O36.0911, O36.0990, O36.0991
AND
Diagnosis of High Risk Pregnancy Complications (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 632, 633.80, 633.81, 633.90, 633.91, 634.10, 634.11, 634.12, 636.10, 636.11, 636.12, 637.10, 637.11, 637.12, 638.1, 639.1, 640.00, 640.03, 640.80, 640.83, 640.90, 640.93, 641.10, 641.13, 641.20, 641.23, 641.30, 641.33, 641.80, 641.83, 641.90, 641.93, 656.00, 656.03

Diagnosis of High Risk Pregnancy Complications (ICD-10-CM) [for use 10/01/2014-12/31/2014]:
O00.8, O00.9, O02.1, O03.1, O03.6, O04.6, O07.1, O08.1, O20.0, O20.8, O20.9, O43.011, O43.019, O44.10, O44.11, O45.001, O45.009, O45.011, O45.019, O45.021, O45.029, O45.091, O45.099, O45.8X1, O45.8X9, O45.90, O45.91, O46.001, O46.011, O46.021, O46.8X1, O46.8X9, O46.90, O46.91
AND
Patient encounter during the reporting period (CPT): 99281, 99282, 99283, 99284, 99285, 99291
AND
Place of Service Indicator: 23
(The Part B claim form Place of Service field must indicate emergency department)

NUMERATOR:
Patients who receive an order for Rh-Immunoglobulin (Rhogam) in the ED

Numerator Instructions: This measure is to be reported each time a patient meets the requirements as indicated in the denominator. In the clinical event a patient has documented receipt of Rhogam report quality-data code G8810.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Documentation in Medical Record that Rh-immunoglobulin (Rhogam) Ordered
G8809: Rh-immunoglobulin (Rhogam) ordered
OR
Rh-immunoglobulin (Rhogam) not Ordered for Documented Reasons
G8810: Rh-immunoglobulin (Rhogam) not ordered for reasons documented by clinician (e.g., patient had prior documented receipt of Rhogam within 12 weeks, patient refusal)
OR
Rh-immunoglobulin (Rhogam) not Ordered, Reason not Given
G8811: Documentation Rh-immunoglobulin (Rhogam) was not ordered, reason not given

RATIONALE:
The potential for maternal exposure to fetal blood is a concern among pregnant patients presenting to the emergency department with a number of common complaints or diagnoses including abdominal pain, blunt abdominal trauma, vaginal bleeding, ectopic pregnancy, threatened or spontaneous abortion, or pelvic instrumentation. This concern increases after the first trimester as fetal RBC mass increases.

CLINICAL RECOMMENDATION STATEMENTS:
Exposure to less than 0.1 ml of fetal blood of a different rhesus (Rh) antigenicity among Rh negative has been shown to increase the risk of maternal alloimmunization. Alloimmunization can result in hemolytic disease of the fetus or newborn including spontaneous abortion, fetal hemolytic anemia, hydrops fetalis and severe neonatal jaundice in subsequent pregnancies.

Anti-D-immunoglobulin reduces the likelihood of alloimmunization. Routine administration of antenatal anti-D-immunoglobulin has been demonstrated as an effective prophylaxis and is recommended by the American College of Obstetricians and Gynecologists (ACOG). Guidelines (UK) recommend administration of anti-D-immunogloblin after the first trimester for a number of sensitizing episodes including but not limited to uterine bleeding and for recurrent, painful or heavy uterine bleeding in the first trimester.

Routine use of anti-D prophylaxis is somewhat controversial as this is done to prevent so-called silent sensitization occurring in the absence of a clear hemorrhage, but this is generally performed in the UK and the US. As anti-D-immunoglobulin does cross the placenta, there are some concerns that this could cause fetal anemia, however, this was felt to be a minor concern relative to the benefits of administration.

✦Measure #257: Statin Therapy at Discharge after Lower Extremity Bypass (LEB)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older undergoing infra-inguinal lower extremity bypass who are prescribed a statin medication at discharge

INSTRUCTIONS:
This measure is to be reported each time an infra-inguinal lower extremity is performed during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

ANY registry that includes anatomic details or CPT procedure codes and captures prescription of statin at hospital discharge as well as documented reasons for not prescribing statin medication is required to identify patients for numerator inclusion or denominator exclusion. The Society for Vascular Surgery Vascular Quality Initiative (SVS VQI) and the Vascular Study Group of New England (VSGNE) are examples of registries that capture detailed anatomic information, but the measure is not limited to these registries.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients who received an infra-inguinal lower extremity bypass

> Denominator Criteria (Eligible Cases):
> All patients aged 18 years and older
> AND
> Patient encounter during the reporting period (CPT): 35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671

NUMERATOR:
Patients prescribed a statin medication at discharge

> Numerator Options:
> Statin medication prescribed at discharge (G8816)
> OR
> Statin therapy not prescribed for documented reasons (e.g., medical intolerance to statin, death of patient prior to discharge, transfer of care to another acute care or federal hospital, hospice admission, left against medical advice) (G8815)

OR

> Statin therapy not prescribed at discharge, reason not given (G8817)

RATIONALE:

Patients who require lower extremity revascularization procedures are at high risk of subsequent cardiovascular morbidity and mortality because of their widespread atherosclerotic disease. Statin therapy in this patient population has been associated with a significant decrease in cardiovascular events. Hospitalization for lower extremity revascularization provides an opportunity for initiating statin therapy on patients without contraindications who are not already on statin therapy.

CLINICAL RECOMMENDATION STATEMENTS:

Patients who present with lower extremity ischemia bear a large systemic burden of atherosclerotic disease, and therefore face not only the immediate risk of limb loss (Dormandy/Rutherford, TASC, 2000) but also an increased risk for cardiovascular events. (Criqui, et al., N Engl J Med, 1992; McKenna/Wolfson/Kuller, Atherosclerosis, 1991; Howell, et al., J Vasc Surg, 1989) The benefits of statin therapy for cardiovascular risk reduction in the PAD population have been demonstrated in several studies, most notably the Heart Protection Study.

(MRC/BHF, Lancet, 2002) The Heart Protection Study (HPS) is the largest trial to assess the effects of statins on major morbidity and mortality. The investigators enrolled over 20,000 patients deemed to be at high risk for cardiovascular events and randomized them to receive either 40mg of simvastatin or placebo. On survival analysis, they demonstrated that treatment with a statin was significantly associated with a decrease in all-cause mortality (12.9% vs. 14.7%, p=.0003) and that this effect was primarily driven by the reduction in death from vascular causes (7.6% vs. 9.1%, $p < .0001$). A recently published subgroup analysis (Randomized trial, J Vasc Surg, 2007) focusing specifically on patients with documented PAD (n=6748) did not include mortality data. However, the authors demonstrated a significant reduction in the rate of first major vascular event in the simvastatin treatment arm (relative reduction of 22%; $p < .0001$), when compared to placebo.

The PREVENT III trial was a prospective, randomized, double-blinded, multicenter trial designed to examine the efficacy of a novel pharmacologic agent (edifoligide) in preventing autogenous vein graft failure in 1404 patients who underwent infra-inguinal vein bypass at 83 hospitals exclusively for the treatment of critical limb ischemia. (Conte, et al., J Vasc Surg, 2006) This LEB trial, with its high-risk critical limb ischemia (CLI) population, provides another relevant database for examination of the role of statins. The salient finding from this study is that the use of statin drugs was associated with a significant one-year survival benefit in patients undergoing surgical bypass for CLI.(Schanzer, et al., J Vasc Surg, 2008) The Kaplan-Meier analysis also suggested that the benefit continues to increase with time, and might be even greater with longer term follow-up. In these 1404 patients, those not receiving statins experienced a 40% increase in the risk of death at one year. This effect was demonstrated both in the propensity score weighted analysis (HR 1.40, CI 1.02-1.92), and in the Cox proportional hazards model (HR 1.47, CI 1.11-1.96). These findings are consistent with prior observational studies that have examined the effects of statins, albeit, in heterogeneous PAD populations. (Feringa HH, et al., J Vasc Surg, 2007; Ward RP, et al., Int J Cardiol, 2005; Kertai MD, et al., Am J Med, 2004) The largest of these observational studies, conducted by Feringa and colleagues, enrolled 1374 patients with PAD and followed them for a mean duration of 6.4 years. The authors demonstrated a strong independent association between statin use and all-cause mortality (HR 1.41 for non-users, $p < 0.0001$). (Feringa HH, et al., J Vasc Surg, 2007)

The DECREASE study randomized 497 patients who had not previously been treated with a statin to receive either 80 mg of extended-release fluvastatin or placebo once daily before undergoing major non-cardiac vascular surgery. (Schouten O, et al., N Engl J Med, 2009) On evaluation of the primary endpoint, statin therapy conferred a 45% decreased hazard ratio (10.8% versus 19%, p=0.01) for peri-operative myocardial infarction. Furthermore, death from cardiovascular causes or myocardial infarction occurred in 4.8% of patients in the fluvastatin group and 10.1% of patients in the placebo group (hazard ratio, 0.47; 95% CI, 0.24 to 0.94; p= 0.03). Fluvastatin therapy was not associated with a significant increase in the rate of adverse events. Several additional studies in patients undergoing LEB have shown similar reductions in peri-operative morbidity and mortality associated with statin use. (Ward RP, et al., Int J Cardiol, 2005; Poldermans O, et al., Circulation, 2003; O'Neil-Callahan K, et al., J Am Coll Cardiol, 2005)

Recent studies have also demonstrated a specific benefit in graft patency after LEB in patients on statin therapy. (Christenson J, Cardiovasc Surg, 2001; Abbruzzese TA, et al., J Vasc Surg, 2004; Henke PK, et al., J Vasc Surg, 2004) Abbruzzese et al. observed that statin use was associated with improved secondary patency (3-fold increased risk compared to non-users) among 197 patients who had undergone lower extremity bypass using saphenous vein, in a single-center retrospective analysis. (Abbruzzese TA, et al., J Vasc Surg, 2004)

✦ Measure #258: Rate of Open Repair of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post-Operative Day #7)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of patients undergoing open repair of small or moderate sized non-ruptured abdominal aortic aneurysms who do not experience a major complication (discharge to home no later than post-operative day #7)

INSTRUCTIONS:
This measure is to be reported each time an open repair AAA is performed during the reporting period. It is anticipated that clinicians who provide services of AAA repair, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All open repairs of non-ruptured, infrarenal abdominal aortic aneurysms

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 35081, 35102
AND NOT
For women:
Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9003F
OR
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F
OR
For men:
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F

NUMERATOR:
Patients discharged to home no later than post-operative day #7

Definition:

Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission prior to procedure of AAA. For example, if the patient comes from a skilled facility and returns to the skilled facility post AAA repair, this would meet criteria for discharged to home.

Numerator Options:
Patient discharge to home no later than post-operative day #7 (G8818)

OR

Patient not discharged to home by post-operative day #7 (G8825)

RATIONALE:
Elective repair of a small or moderate sized AAA is a prophylactic procedure and the mortality/morbidity of the procedure must be contrasted with the risk of rupture over time. Surgeons should select patients for intervention who have a reasonable life expectancy and who do not have a high surgical risk. Discharge to home within one week of open AAA repair is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
The Care of Patients with an Abdominal Aortic Aneurysm: The Society for Vascular Surgery Practice Guidelines. (Chaikof et al, J Vasc Surg, 50:4, supplement, 2009)

Elective repair is recommended for patients that present with a fusiform AAA ≥ 5.5 cm in maximum diameter, in the absence of significant co-morbidities.
Level of recommendation: Strong
Quality of evidence: High

Surveillance is recommended for most patients with a fusiform AAA in the range of 4.0 cm to 5.4 cm in maximum diameter.
Level of recommendation: Strong
Quality of evidence: Moderate

Measure #259: Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) without Major Complications (Discharged to Home by Post Operative Day #2)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of patients undergoing endovascular repair of small or moderate non-ruptured abdominal aortic aneurysms (AAA) that do not experience a major complication (discharged to home no later than post-operative day #2)

INSTRUCTIONS:
This measure is to be reported each time an open repair AAA is performed during the reporting period. It is anticipated that clinicians who provide services of AAA repair, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All endovascular repairs of non-ruptured, infrarenal abdominal aortic aneurysms

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 34800, 34802, 34803, 34804, 34805
AND NOT

For women:
Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9003F
OR
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F
OR
For men:
Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F

NUMERATOR:
Patients discharged to home no later than post-operative day #2 following EVAR of AAA

Definition:

Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission prior to procedure of AAA. For example, if the patient comes from a skilled facility and returns to the skilled facility post AAA repair, this would meet criteria for discharged to home.

Numerator Options:
Patient discharged to home no later than post-operative day #2 following EVAR (G8826)

OR

Patient not discharged to home by post-operative day #2 following EVAR (G8833)

RATIONALE:
Elective repair of a small or moderate sized AAA is a prophylactic procedure and the mortality/morbidity of the procedure must be contrasted with the risk of rupture over time. Surgeons should select patients for intervention who have a reasonable life expectancy and who do not have a high surgical risk. Discharge to home within two days of endovascular AAA repair is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
The Care of Patients with an Abdominal Aortic Aneurysm: The Society for Vascular Surgery practice Guidelines. (Chaikof et al, J Vasc Surg, 50:4, supplement, 2009)

Elective repair is recommended for patients that present with a fusiform AAA ≥ 5.5 cm in maximum diameter, in the absence of significant comorbidities.
Level of recommendation: Strong
Quality of evidence: High

Surveillance is recommended for most patients with a fusiform AAA in the range of 4.0 cm to 5.4 cm in maximum diameter.
Level of recommendation: Strong
Quality of evidence: Moderate

✦ Measure #260: Rate of Carotid Endarterectomy (CEA) for Asymptomatic Patients, without Major Complications (Discharged to Home by Post-Operative Day #2)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CEA who are discharged to home no later than post-operative day #2

INSTRUCTIONS:
This measure is to be reported each time a CEA is performed during the reporting period. It is anticipated that clinicians who provide services of CEA, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All carotid endarterectomy procedures

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 35301
AND NOT
Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure: 9006F
OR
Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke: 9007F

NUMERATOR:
Patients that are asymptomatic neurologically who were discharged alive, to home no later than post-operative day #2 following CEA

Definition:
Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission for procedure of CEA. For example, if the patient comes from a skilled facility and returns to the skilled facility post CEA, this would meet criteria for discharged to home.

Numerator Options:
Patient discharged to home no later than post-operative day #2 following CEA (G8834)

OR

Patient not discharged to home by post-operative day #2 following CEA (G8838)

RATIONALE:
Surgeons performing CEA on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. Discharge to home within two days of the procedure is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication (e.g., disabling stroke, myocardial infarction). The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
Updated Society for Vascular Surgery guidelines for management of extracranial carotid disease. (Ricotta et al, J Vasc Surg, 54:3, 2011)

Neurologically asymptomatic patients with ≥ 60% diameter stenosis should be considered for CEA for reduction of long-term risk of stroke, provided the patient has a 3- to 5-year life expectancy and perioperative stroke/death rates can be ≤ 3% (GRADE 1, Level of Evidence A).

Measure #261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged birth and older referred to a physician (preferably a physician specially trained in disorders of the ear) for an otologic evaluation subsequent to an audiologic evaluation after presenting with acute or chronic dizziness

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period who present with acute or chronic dizziness. This measure is intended to ensure that patients with acute or chronic dizziness receive a referral in order to receive appropriate care. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged birth and older presenting with acute or chronic dizziness

> Denominator Criteria (Eligible Cases):
> Patients aged birth and older
> AND
> Diagnosis for Dizziness (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 386.11, 780.4
> Diagnosis for Dizziness (ICD-10-CM) [for use 10/01/2014-12/31/2014]: H81.10, H81.11, H81.12, H81.13, R42
> AND
> Patient encounter during the reporting period (CPT): 92540, 92541, 92542, 92543, 92544, 92545, 92546, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92575

NUMERATOR:
Patients referred to a physician for an otologic evaluation subsequent to an audiologic evaluation who present with acute or chronic dizziness

NUMERATOR NOTE: The physician receiving the referral, or providing care currently, should preferably be specially trained in disorders of the ear.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Referral for Otologic Evaluation
G8856: Referral to a physician for an otologic evaluation performed

OR

Referral for Otologic Evaluation not Performed for Documented Reasons
G8857: Patient is not eligible for the referral for otologic evaluation measure (e.g., patients who are already under the care of a physician for acute or chronic dizziness)

OR

Referral for Otologic Evaluation not Performed, Reason not Given
G8858: Referral to a physician for an otologic evaluation not performed, reason not given

RATIONALE:
Studies demonstrate that patients who present with acute or chronic dizziness may suffer from underlying problems, so therefore referral is necessary. Without referral, patients may suffer consequences of the underlying problems.

CLINICAL RECOMMENDATION STATEMENTS:
The American Academy of Otolaryngology-Head and Neck Surgery policy statement (approved 9/12/2002):
Hearing loss and balance disorders are medical conditions. Only licensed physicians with medical training may diagnose and direct the management of disease and medical disorders. A full history and physical examination by a physician (preferably a physician specially trained in disorders of the ear) to determine the accurate medical diagnosis and appropriate medical/surgical treatment for hearing loss and balance disorders are indicated for patients with the following "red flags":

1. Hearing loss with a positive history of familial hearing loss, TB, syphilis, HIV, Meniere's disease, autoimmune disorder, otosclerosis, von Recklinghausen's neurofibromatosis, Paget's disease of bone, head trauma related to onset.
2. History of pain, active drainage, or bleeding from an ear.
3. Sudden onset or rapidly progressive hearing loss.
4. Acute, chronic, or recurrent episodes of dizziness.
5. Evidence of congenital or traumatic deformity of the ear.
6. Visualization of blood, pus, cerumen plug, or foreign body in the ear canal.
7. Conductive hearing loss or abnormal tympanogram.
8. Unilateral or asymmetric hearing loss; or bilateral hearing loss > 80 dB.
9. Unilateral or pulsatile tinnitus.
10. Unilateral or asymmetrically poor speech discrimination scores.

The red flags do not include all indications for a medical referral and are not intended to replace clinical judgment in determining the need for consultation with an otolaryngologist.

21 C.F.R. Section 801.420:
A hearing aid dispenser should advise a prospective hearing aid user to consult promptly with a licensed physician (preferably an ear specialist) before dispensing a hearing aid if the hearing aid dispenser determines through inquiry, actual observation, or review of any other available information concerning the prospective user, that the prospective user has any of the following conditions:
(i) Visible congenital or traumatic deformity of the ear.
(ii) History of active drainage from the ear within the previous 90 days.
(iii) History of sudden or rapidly progressive hearing loss within the previous 90 days.
(iv) Acute or chronic dizziness.

(v) Unilateral hearing loss of sudden or recent onset within the previous 90 days.
(vi) Audiometric air-bone gap equal to or greater than 15 decibels at 500 hertz (Hz), 1,000 Hz, and 2,000 Hz.
(vii) Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
(viii) Pain or discomfort in the ear.

✿ Measure #262: Image Confirmation of Successful Excision of Image-Localized Breast Lesion

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Image confirmation of lesion(s) targeted for image guided excisional biopsy or image guided partial mastectomy in patients with nonpalpable, image-detected breast lesion(s). Lesions may include: microcalcifications, mammographic or sonographic mass or architectural distortion, focal suspicious abnormalities on magnetic resonance imaging (MRI) or other breast imaging amenable to localization such as positron emission tomography (PET) mammography, or a biopsy marker demarcating site of confirmed pathology as established by previous core biopsy

INSTRUCTIONS:
This measure is to be reported each time an image guided excisional biopsy or wire localized partial mastectomy is performed in patients with non-palpable, image-detected breast lesions. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Number of patients aged 18 years and older on date of encounter with non-palpable, image-detected (by mammogram, ultrasound, or breast MRI, PET mammography or other imaging modality) breast lesion requiring localization of lesion (benign or malignant) for targeted resection (either excisional biopsy or partial mastectomy)

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date on encounter
> AND
> Diagnosis for Breast Lesion (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 198.81, 217, 239.3, 610.0, 610.1, 610.2, 610.3, 610.4, 610.8, 610.9, 611.0, 611.1, 611.2, 611.3, 611.4, 611.5, 611.6, 611.71, 611.72, 611.79, 611.81, 611.82, 611.83, 611.89, 611.9, 793.80, 793.81, 793.82, 793.89
> Diagnosis for Breast Lesion (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529,

C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81, D24.1, D24.2, D24.9, D49.3, N60.01, N60.02, N60.09, N60.11, N60.12, N60.19, N60.21, N60.22, N60.29, N60.31, N60.32, N60.39, N60.41, N60.42, N60.49, N60.81, N60.82, N60.89, N60.91, N60.92, N60.99, N61, N62, N63, N64.0, N64.1, N64.2, N64.3, N64.4, N64.51, N64.52, N64.53, N64.59, N64.81, N64.82, N64.89, N64.9, R92.0, R92.1, R92.2, R92.8, T85.44XA, T85.44XD, T85.44XS

AND

Patient encounter during the reporting period (CPT): 19125, 19301, 19302

NUMERATOR:

Patients undergoing excisional biopsy or partial mastectomy of a non-palpable lesion whose excised breast tissue was evaluated by imaging (x-ray, ultrasound, MRI, PET mammography or other imaging modality) intraoperatively to confirm successful inclusion of targeted lesion

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Image Confirmation of Lesion(s) Targeted for Image Guided Excisional Biopsy or Image Guided Partial Mastectomy in Patients with Non-palpable, Image-detected Breast Lesion(s)

G8872: Excised tissue evaluated by imaging intraoperatively to confirm successful inclusion of targeted lesion

OR

Imaging Abnormality was Visible Only on an MRI of the Breast or Other Imaging Modality that does not Permit Direct Imaging of Excised Tissue (e.g., PET mammography), Patient not Eligible

G8873: Patients with needle localization specimens which are not amenable to intraoperative imaging such as MRI needle wire localization, or targets which are tentatively identified on mammogram or ultrasound which do not contain a biopsy marker but which can be verified on intraoperative inspection or pathology (e.g., needle biopsy site where the biopsy marker is remote from the actual biopsy site)

OR

Image Confirmation of Lesion(s) Targeted for Image Guided Excisional Biopsy or Image Guided Partial Mastectomy in Patients with Non-palpable, Image-detected Breast Lesion(s) not Performed, Reason not Given

G8874: Excised tissue not evaluated by imaging intraoperatively to confirm successful inclusion of targeted lesion, reason not given

RATIONALE:

Many benign breast lesions and breast cancers are image-detected and will involve some form of image localization. Specimen radiography or specimen ultrasonography should routinely be performed for all excisions of image-detected abnormalities to document success of the procedure in excising the target.

CLINICAL RECOMMENDATION STATEMENTS:

Specimen radiography or specimen ultrasonography should be routinely performed for all excisions of image-detected abnormalities to help document the success of the procedure in finding the target. Specimen radiography should use two 90-degree orthogonal views. (The American Society of Breast Surgeons, 2001)

✿ Measure #263: Preoperative Diagnosis of Breast Cancer

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
The percent of patients undergoing breast cancer operations who obtained the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method

INSTRUCTIONS:
This measure is to be reported each time a patient aged 18 and older undergoes a breast cancer operation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
The number of patients aged 18 years and older on date of encounter undergoing breast cancer operations

> Denominator Criteria (Eligible Cases):
> Patients aged 18 and older on date of encounter
> AND
> Diagnosis for Female/Male Breast Cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 198.81
> Diagnosis for Female/Male Breast Cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C79.81
> AND
> Patient encounter during the reporting period (CPT): 19301, 19302, 19303, 19307

NUMERATOR:
The number of patients aged 18 and older undergoing breast cancer operations who had breast cancer diagnosed preoperatively by a minimally invasive biopsy

Definition:
Minimally invasive biopsy methods: Includes fine needle aspiration, percutaneous core needle biopsy, percutaneous automated vacuum assisted rotating biopsy device, skin biopsy, skin shave or punch biopsy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Breast Cancer Preoperatively Diagnosed by a Minimally Invasive Biopsy Method
G8875: Clinician diagnosed breast cancer preoperatively by a minimally invasive biopsy method

OR

Clinician Determination that a Minimally Invasive Biopsy Method was not Indicated in this Instance, Patient not Eligible
G8876: Documentation of reason(s) for not performing minimally invasive biopsy to diagnose breast cancer preoperatively (e.g., Clinical and imaging findings consistent with a benign lesion, lesion too close to skin, implant, chest wall, etc., lesion could not be adequately visualized for needle biopsy, patient condition prevents needle biopsy [weight, breast thickness, etc.], duct excision without imaging abnormality, prophylactic mastectomy, reduction mammoplasty, excisional biopsy performed by another physician)
OR
Minimally Invasive Biopsy Method was attempted but was not diagnostic of Breast Cancer
G8946: Minimally Invasive Biopsy Method attempted but not diagnostic of Breast Cancer (e.g., High Risk Lesion of Breast such as atypical ductal hyperplasia, lobular neoplasia, atypical lobular hyperplasia, lobular carcinoma in situ, atypical columnar hyperplasia, flat epithelial atypia, radial scar, complex sclerosing lesion, papillary lesion, or any lesion with spindle cells)

OR

Breast Cancer not Preoperatively Diagnosed by a Minimally Invasive Biopsy Method, Reason not Given
G8877: Clinician did not attempt to achieve the diagnosis of breast cancer preoperatively by a minimally invasive biopsy method, reason not given

RATIONALE:
The preoperative diagnosis of breast cancer by minimally invasive methods is recommended by the American Society of Breast Surgeons, the National Comprehensive Cancer Network, the European Society of Breast Cancer Specialists, the American College of Radiology, a recent consensus conference on image detected breast cancer, and a panel of experts who conducted a comparative effectiveness study of needle biopsy compared to open biopsy that was funded by Agency for Healthcare Research and Quality (AHRQ).

The policy of attempting to diagnose breast cancer by needle techniques has also been incorporated into quality measurement programs developed by the American Society of Breast Surgeons and the National Consortium of Breast Centers. (The American Society of Breast Surgeons, 2006)

The advantages of preoperative cancer diagnosis by minimally invasive method include the patient centered measures of a smaller scar, good cosmesis, timeliness, and good pain control. Other advantages include a greater likelihood of achieving negative lumpectomy surgical margins and allowing concurrent scheduling of axillary lymph node surgery, reducing the number of operations required to treat breast cancer.

CLINICAL RECOMMENDATION STATEMENTS:
A major goal of modern breast medicine is to minimize the number of patients with benign lesions who undergo open surgical breast biopsies for diagnosis. Image guided percutaneous needle biopsy is the diagnostic procedure of choice for image-detected breast abnormalities. Patients with a clearly palpable breast mass should also have a minimally invasive percutaneous biopsy with or without image guidance depending on the size of the mass. (The American Society of Breast Surgeons, 2006) It is not possible to achieve a 100% success rate for the diagnosis of breast cancer by a minimally invasive technique due to some technical issues described above or sampling issues with high risk lesions of the breast.

✿ Measure #264: Sentinel Lymph Node Biopsy for Invasive Breast Cancer

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The percentage of clinically node negative (clinical stage T1N0M0 or T2N0M0) breast cancer patients who undergo a sentinel lymph node (SLN) procedure

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for patients age 18 years and older who are operated upon for invasive breast cancer that are clinically node negative (clinical stage T1N0M0 or T2N0M0). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients aged 18 and older with primary invasive breast cancer

Denominator Criteria (Eligible Cases):
Patients aged 18 and older at date of encounter
AND
Diagnosis for Female/Male Breast Cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9
Diagnosis for Female/Male Breast Cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929
AND
Patient encounter during the reporting period (CPT): 19301, 19302, 19307, 38500, 38510, 38520, 38525, 38530, 38542, 38740, 38745, 38900
AND
Clinically Node Negative (T1N0M0 or T2N0M0) Invasive Breast Cancer: G8879

NUMERATOR:
Patients who undergo a SLN procedure

Numerator Options:
Sentinel lymph node biopsy procedure performed (G8878)
OR

Documentation of reason(s) sentinel lymph node biopsy not performed (e.g., reasons could include but not limited to; non-invasive cancer, incidental discovery of breast cancer on prophylactic mastectomy, incidental discovery of breast cancer on reduction mammoplasty, pre-operative biopsy proven lymph node (LN) metastases, inflammatory carcinoma, stage 3 locally advanced cancer, recurrent invasive breast cancer, patient refusal after informed consent) (G8880)

OR

Sentinel lymph node biopsy procedure not performed, reason not given (G8882)

RATIONALE:

A sentinel lymph node (SLN) procedure is defined as a method of axillary or other regional lymph node assessment that requires either a radioisotope and/or blue dye injection in the breast with subsequent identification of radioactive or blue stained node(s) in the axilla or other lymph node basin. There is level one evidence that breast cancer SLN biopsy is as accurate as axillary dissection for breast cancer staging and is associated with less morbidity than routine axillary dissection.

CLINICAL RECOMMENDATION STATEMENTS:

The current body of reported surgical experience shows that SLN biopsy is suitable for virtually all clinically node-negative T1-2 invasive breast cancers. (The American Society of Breast Surgeons, 2010)

★Measure #265 (NQF 0645): Biopsy Follow-Up

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients who are seen for an office visit and have a biopsy performed during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Note: While this measure is only required to be reported once per eligible patient per reporting period, it is recommended that the eligible professional performing the biopsy communicates the results to the primary care/referring physician and patient each time a biopsy is done.

Measure Reporting via Registry:
CPT codes and demographics codes are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. The listed denominator options are the codes used in practice for various biopsies.

DENOMINATOR:
All patients undergoing a biopsy

Denominator Criteria (Eligible Cases):
All patients regardless of age on date of encounter
AND
Patient procedure during the reporting period (CPT): 11100, 11755, 19081, 19083, 19085, 19100, 19101, 19125, 20200, 20205, 20206, 20220, 20225, 20240, 20245, 20250, 20251, 21550, 21920, 21925, 23065, 23066, 23100, 23101, 24065, 24066, 24100, 24101, 25065, 25066, 25100, 25101, 26100, 26105, 26110, 27040, 27041, 27050, 27052, 27323, 27324, 27330, 27331, 27613, 27614, 27620, 28050, 28052, 28054, 29800, 29805, 29830, 29840, 29860, 29870, 29900, 30100, 31050, 31051, 31237, 31510, 31576, 31625, 31628, 31629, 31632, 31633, 31717, 32096, 32097, 32098, 32400, 32405, 32604, 32606, 32607, 32608, 32609, 37200, 37609, 38221, 38500, 38505, 38510, 38520, 38525, 38530, 38570, 38572, 39400, 40490, 40808, 41100, 41105, 41108, 42100, 42400, 42405, 42800, 42804, 42806, 43193, 43197, 43198, 43202, 43239, 43261, 43605, 44010, 44020, 44025, 44100, 44322, 44361, 44377, 44382, 44386, 44389, 45100, 45305, 45331, 45380, 45392, 46606, 47000, 47001, 47100, 47553, 47561, 48100, 48102, 49000, 49010, 49180, 49321, 50200, 50205, 50555, 50557, 50574, 50576, 50955, 50957, 50974, 50976, 52007, 52204, 52224, 52250, 52354, 53200, 54100, 54105, 54500, 54505, 54800, 54865, 55700, 55705, 55706, 55812, 55842, 55862, 56605, 56821, 57100, 57105, 57421, 57454, 57455, 57460, 57500, 57520, 58100, 58558, 58900, 59015, 60100, 60540, 60545, 60650, 61140, 61575, 61576, 61750, 61751, 62269, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63615, 64795, 65410, 67346, 67400, 67450, 67810, 68100, 68510, 68525, 69100, 69105, 75970, 89290, 89291, 93505
AND
Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205

NUMERATOR:
Patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and the patient by the physician performing the biopsy. The physician performing the biopsy must also acknowledge and/or document the communication in a biopsy tracking log and document in the patient's medical record.

Numerator Instructions: To satisfy this measure, the biopsying physician must:

- Review the biopsy results with the patient
- Communicate those results to the primary care/referring physician
- Track communication in a log
- Document tracking process in the patient's medical record

Definition:
The components of a tracking log incorporate the following:

- Initials of physician performing the biopsy
- Patient name
- Date of biopsy
- Type of biopsy
- Biopsy result
- Date of biopsy result

Numerator Options:
Biopsy Results Reviewed and Communicated to the Patient and the Patient's Primary Care/Referring Physician, Communication Tracked in a Log, and Tracking Process Documented in the Patient's Medical Record.
Biopsy results reviewed, communicated, tracked, and documented (G8883)

OR

Documentation of Patient OR System Reason(s) for not Performing up to Three of the Four Components of the Numerator Instructions: Reviewing, Communicating, Tracking, and/or Documenting Biopsy Results, Patient not Eligible
Clinician documented reason that patient's biopsy results were not reviewed, [e.g., patient asks that biopsy results not be communicated to the primary care/referring physician, patient does not have a primary care/referring physician or is a self-referred patient] (G8884)

OR

Biopsy Results not Reviewed, not Communicated to the Patient and the Patient's Primary Care/Referring Physician, Communication not Tracked in a Log, and/or Tracking Process not Documented in the Patient's Medical Record.
Biopsy results not reviewed, communicated, tracked, or documented (G8885)

RATIONALE:
The purpose of this measure is to ensure that biopsy results with potentially serious consequences for patient care are not lost or ignored. Large health plan/delivery systems have identified a prominent quality of care issue as involving missing or overlooked biopsy pathology reports. All biopsy results should be accounted for and the results communicated to the patient or patient's guardian/caregiver and to the patient's primary care physician and/or other physician/professional responsible for follow-up care. Failure of the medical team to take appropriate action based on the result of a biopsy may lead to significant delays in obtaining appropriate treatment with subsequent poor outcomes, complications and even death. This measure will facilitate physician quality assurance that all biopsies are read, recorded and the results communicated.

CLINICAL RECOMMENDATION STATEMENTS:

The measure does not directly address that follow-up care has been concluded, but rather addresses the critical **first** step in the treatment chain. Appropriate follow-up care must be specifically tailored to each clinical diagnosis. Biopsy results are not only essential to making a final diagnosis, but they are also essential to disease staging and treatment planning. The patient needs to be informed of the biopsy results so they can not only be completely aware of their condition, but also so they can make informed decisions about their care and treatment.

♮ Measure #266: Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure frequency(ies) for each seizure type documented in the medical record

INSTRUCTIONS:
This measure is to be reported at all visits for patients with a diagnosis of epilepsy during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients with a diagnosis of epilepsy

> Denominator Criteria (Eligible Cases):
> Diagnosis for Epilepsy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91
> Diagnosis for Epilepsy (ICD-10-CM) [for use 10/01/2014-12/31/2014]: G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.901, G40.909, G40.911, G40.919
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309

NUMERATOR:
Patient visits with seizure type(s) specified and current seizure frequency(ies) for each seizure type documented in the medical record

> Numerator Quality-Data Coding Options for Reporting Satisfactorily:
> Seizure type(s) and Current Seizure Frequency(ies) Documented

CPT II 1200F: Seizure type(s) and current seizure frequency(ies) documented

OR

Seizure type(s) and Current Seizure Frequency(ies) not Documented for Medical or Patient Reasons
Append a modifier (1P or 2P) to Category II code 1200F to report documented circumstances that appropriately exclude patients from the denominator.
1200F *with* 1P: Documentation of medical reason(s) for not documenting seizure type(s) and current seizure frequency(ies) (eg, patient is unable to communicate and no informant is available)
1200F *with* 2P: Documentation of patient reason(s) for not documenting seizure type(s) and current seizure frequency(ies) (eg, patient and/or informant refuses to answer or comply) for not documenting seizure type(s) and current seizure frequency for each seizure type

OR

Seizure type(s) and Current Seizure Frequency not Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1200F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1200F *with* 8P: Seizure type(s) and current seizure frequency was not documented, reason not otherwise specified

RATIONALE:
Seizures are divided into generalized and partial (or focal) types based on whether they begin throughout the brain simultaneously or in one focal region (Dreifuss et al 1981). The main objective in treating epilepsy is to reduce the frequency of seizures and eventually achieve seizure freedom without medication side effects. In order to know that a treatment is effective, the patient's seizure frequency must be known before an intervention is begun so it can be compared to the seizure frequency determined during follow-up visits after an intervention is instituted. Antiepileptic drugs reduce the frequency of seizures in controlled clinical trials. Seizure freedom is associated with improvement in health-related quality of life, for example after epilepsy surgery. Therefore, accurate assessment of seizure frequency is necessary to provide most forms of care for epilepsy.

CLINICAL RECOMMENDATION STATEMENTS:
Detailed history of the attack should be obtained from the person who had the attack symptoms and from eyewitness(es) to the attack. (Level B) NICE (Oct. 2004)

The seizure type(s) and epilepsy syndrome should be identified. (Level C) SIGN (April 2003)

When a patient with epilepsy receives follow-up care, then an estimate of the number of seizures since the last visit and assessment of drug side-effects should be documented. (Level D 1+/ Primary) (Pugh, 2007)
IF a patient is thought to have a diagnosis of epilepsy THEN the diagnosis should include a best estimation of seizure types. (Level C 2+/Secondary) (Pugh, 2007)

♮ Measure #267: Epilepsy: Documentation of Etiology of Epilepsy or Epilepsy Syndrome

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
All visits for patients with a diagnosis of epilepsy who had their etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic

INSTRUCTIONS:
This measure is to be reported at **all visits** for patients with a diagnosis of epilepsy during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All visits for patients with a diagnosis of epilepsy

> Denominator Criteria (Eligible Cases):
> Diagnosis for Epilepsy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91
> Diagnosis for Epilepsy (ICD-10-CM) [for use 10/01/2014-12/31/2014]: G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.901, G40.909, G40.911, G40.919
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309

NUMERATOR:
Patient visits with documentation of etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic

> *NUMERATOR NOTE: Report **1205F** if documentation of etiology is known, unknown or cryptogenic.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Etiology of Epilepsy or Epilepsy Syndrome(s) Reviewed and Documented
CPT II 1205F: Etiology of epilepsy or epilepsy syndrome(s) reviewed and documented
OR
Etiology of Epilepsy or Epilepsy Syndrome(s) not Reviewed and Documented, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 1205F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
1205F *with* 8P: Etiology of epilepsy or epilepsy syndrome(s) not reviewed and documented, reason not otherwise specified

RATIONALE:
The natural history, selection of treatment, expected response to treatment, and content of counseling are determined by the etiology of epilepsy or epilepsy syndrome (Commission on Classification 1989). Therefore, the etiology of epilepsy or epilepsy syndrome should be determined at the initial visit. Epilepsy is a chronic condition in which treatments must be instituted over long durations, such as achieving maximum tolerated doses of antiepileptic drugs. Since it is often a relatively long interval between starting an intervention and determining if it is effective, the etiology of epilepsy or syndrome should be reviewed at each visit to determine if an alternative therapy is warranted.

CLINICAL RECOMMENDATION STATEMENTS:
The seizure type(s) and epilepsy syndrome should be identified. (Level C) SIGN (April 2003)

Determine: seizure type(s), epilepsy syndrome, etiology and co-morbidity. (Level C) NICE (Oct. 2004)
If a patient is thought to have a diagnosis of epilepsy then the diagnosis should include a best estimation of seizure types. (Level C 2+/Secondary) (Pugh, 2007)

♮ Measure #268: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
All female patients of childbearing potential (12 - 44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year

INSTRUCTIONS:
This measure is to be reported at all visits for patients with a diagnosis of epilepsy during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All females of childbearing potential (12-44 years old) with a diagnosis of epilepsy

> Denominator Criteria (Eligible Cases):
> All females age 12-44 years old
> AND
> Diagnosis for Epilepsy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91
> Diagnosis for Epilepsy (ICD-10-CM) [for use 10/01/2014-12/31/2014]: G40.001, G40.009, G40.011, G40.019, G40.101, G40.109, G40.111, G40.119, G40.201, G40.209, G40.211, G40.219, G40.309, G40.311, G40.319, G40.401, G40.409, G40.411, G40.419, G40.901, G40.909, G40.911, G40.919
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309

NUMERATOR:
Female patients counseled about epilepsy and how its treatment may affect contraception and pregnancy and documented in the medical record at least once a year

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Counseling for Women of Childbearing Potential with Epilepsy
CPT II 4340F: Counseling for women of childbearing potential with epilepsy

OR

Counseling for Women of Childbearing Potential with Epilepsy not Performed for Medical Reasons
Append a modifier (1P) to Category II code 4340F to report documented circumstances that appropriately exclude patients from the denominator.
4340F *with* 1P: Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy

OR

Counseling for Women of Childbearing Potential with Epilepsy not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4340F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4340F *with* 8P: Counseling about epilepsy specific safety issues provided to patient or caregiver was not performed, reason not otherwise specified

RATIONALE:
Epilepsy is associated with sexual dysfunction, reduced fertility, increased pregnancy risks, and risks for malformations in the infant. Seizures can transiently disrupt pituitary hormone secretion. Treatment of seizures with antiepileptic drugs may alter hormone levels, render oral contraceptives less effective and may interfere with embryonic and fetal development. Certain antiepileptic mediations may have specific malformation risks. Since unplanned pregnancy is common, patients need to be informed about the risks of epilepsy and antiepileptic drug therapy prior to pregnancy. Folic acid supplementation, monotherapy for epilepsy, using lower doses of medication when possible and proper obstetrical, prenatal and pre-pregnancy care should all be discussed with the patient so they understand the risks involved and how to mitigate these risks.

CLINICAL RECOMMENDATION STATEMENTS:
Women (and, if appropriate, their family and/or caregivers or others closely involved) should be given information about contraception, conception, pregnancy and breastfeeding. Information should be given in advance of sexual activity or pregnancy. (Level C) NICE 2004

IF a woman with epilepsy is of childbearing potential and receives oral contraceptives in conjunction with an enzyme inducing AED, THEN decreased effectiveness of oral contraception should be addressed. (higher doses of the oral contraceptive, alternative birth control methods, or change AED). (Level A 2++/Primary) (Pugh, 2007)

If AEDs are to be used in pregnancy the relative risks of seizures and fetal malformation should be discussed with the woman. (Level C) SIGN(April 2003)
Whenever possible, a woman should conceive on the lowest effective dose of one AED appropriate for her epilepsy syndrome. If she has good seizure control and presents already pregnant, there is probably little to be gained by altering her AEDs. (Level C) SIGN(April 2003)

Patients with epilepsy should receive an annual review of information including topics such as:

- Chronic effects of epilepsy and its treatment including drug side-effects, drug-drug interactions, effect on bone health
- Contraception, family planning, and how pregnancy and menopause may affect seizures (EVIDENCE GRADE C)
- Screening for mood disorders
- Triggers and lifestyle issues that may affect seizures
- Impact of epilepsy on other chronic and acute diseases
- Driving and safety issues (Level D/Secondary) (Pugh, 2007)

✤Measure #303: Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older in sample who had cataract surgery and had improvement in visual function achieved within 90 days following the cataract surgery, based on completing a pre-operative and post-operative visual function survey

INSTRUCTIONS:
This measure is to be calculated when a procedure for cataracts is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

Note: This is an outcome measure and will be calculated solely using registry data.

- *For patients who receive the cataract surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient had improvement in visual function achieved within 90 days following the cataract surgery.*
- *Include only procedures performed through **September 30** of the reporting period. This will allow the post-operative period to occur before registries must submit data to CMS.*
- *It is the responsibility of a third party, which may be the registry or another third party designated by the eligible professional to administer, receive results, and review the surveys. Each registry must work directly with eligible professionals who wish to report these measures to determine who (a registry or another third party) will be administering, receiving and reviewing the surveys.*

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery

Denominator Instructions: Clinicians who indicate modifier 56 (pre-operative management) or modifier 55 (post-operative management) only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged > 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984

NUMERATOR:
Patients 18 years and older who had improvement in visual function achieved within 90 days following cataract surgery, based on completing a pre-operative and post-operative visual function survey

Numerator Options:
Improvement in visual function achieved within 90 days following cataract surgery (G0913)

OR

Patient care survey was not completed by patient (G0914)

OR

Improvement in visual function not achieved within 90 days following cataract surgery (G0915)

RATIONALE:

1. Scientific Basis for Measuring Visual Function Outcomes after Cataract Surgery.

Visual function has been described as having multiple components, including central near, intermediate, and distance visual acuity; peripheral vision; visual search; binocular vision; depth perception; contrast sensitivity; perception of color; adaptation; and visual processing speed. Visual function also can be measured in terms of functional disability caused by visual impairment. Many activities are affected by more than one of these visual components.

Health services researchers have increasingly emphasized function and quality of life as the outcomes of treatment that are most critical and applicable to the patient. As previously stated, the primary purpose in managing a patient with cataract is to improve functional vision and the quality of life. In well-designed observational studies, cataract surgery consistently has been shown to have a significant impact on vision-dependent function. The Cataract Patient Outcomes Research Team (PORT) reported that 90% of patients under-going first-eye cataract surgery noted improvement in functional status and satisfaction with vision.

The Activities of Daily Vision Study of elderly patients with a high prevalence of coexisting ocular and medical diseases reported improved visual function in 80% of patients at 12 months after surgery. A National Cataract Study conducted in England of 1,139 patients who had cataract surgery found that preoperative functional impairment varied in relation to gender, age, and visual acuity. Men were more likely to have trouble with driving, glare, and employment, and women were more likely to have difficulties with activities of daily living and recreational activities. Studies have found that regardless of the preoperative visual acuity in the better eye, most patients reported improvement in their ability to perform visually dependent tasks after undergoing cataract surgery.

Several studies have reported an association between improved visual function after cataract surgery and improved health-related quality of life. Visual function plays an important role in physical function, particularly in terms of mobility. The loss of visual function in the elderly is associated with a decline in physical and mental functioning as well as in independence in activities of daily living, including night-time driving, daytime driving, community activities, and home activities. Elderly patients with visual impairment only (and no other physical or mental impairments) were 2.5 times as likely to experience functional decline than elderly patients without visual impairment.

Improved visual function following cataract surgery can ameliorate the progressive deterioration of quality of life seen in elderly patients. In a cohort of 464 patients 65 years old and older, cataract extraction improved visual function and health-related quality of life. Patients with an improvement in their Activities of Daily Vision Scale (ADVS), a brief measure of vision-specific functional status, had from 10% to 59% less decline in nearly all Short Form (SF)-36 dimensions. The SF-36 is a generic global measure of multidimensional health-related quality of life. A nationally representative population of 7,114 persons who were 70 years old and older showed that limitations in vision correlated with decreased functional status. The unadjusted functional score of a person with reported poor vision was four times worse than the score for a person with excellent vision. This difference was comparable with the differences found in other chronic conditions such as arthritis. This relationship with vision persisted, even after adjustment for health, demographics, and economic status. Individuals who rated their vision as other than excellent reported worse functional status, even when controlled for the presence of other medical conditions, education, income, general health status, and other symptoms. By improving visual function, cataract surgery may play an important role in preserving overall functional status, reducing associated injuries and accidents, and preventing disability in at-risk elderly patients.

An analysis of the Medical Outcomes Study found that having blurred vision more than once or twice a month has a significant impact on functional status and well-being, particularly on problems with work or other daily activities as a result of physical health. This impact was found to be greater than the impact of several other chronic conditions,

such as hypertension, history of myocardial infarction, type 2 diabetes mellitus, indigestion, trouble urinating, and headache. In one study, patients planning to undergo cataract surgery assigned a mean preoperative preference value of 0.68 on a scale ranging from 0 to 1 (where 0 is death and 1 is excellent health), indicating that the visual impairment from cataracts had a substantial impact on their quality of life. Visual impairment is an important risk factor for falls and for hip fracture. Specifically, the Study for Osteoporotic Fractures Research Group found that poor depth perception and decreased contrast sensitivity independently increased the risk of hip fracture.

Visual impairment, in particular a decrease of visual acuity and contrast sensitivity, has been shown to be associated with difficulties in driving. In one study, older drivers with visually significant cataract were twice as likely as older drivers without cataract to report reduction in days driven and four times as likely to report difficulties in challenging driving situations. Drivers with visually significant cataract were 2.5 times more likely to have had an at-fault involvement in a motor vehicle crash in the past 5 years compared with drivers without cataract. This association was significant, even after accounting for other factors such as impaired general health, age, mental status deficit or depression. In this study, visually significant cataract was determined by reviewing the participant's medical record and most recent eye examination by an eye care specialist. The study required that cataract in both eyes was the cause of the visual impairment, based on the medical record; an additional inclusion criterion was best-corrected visual acuity in one eye of 20/40 or worse. A further study in the same group demonstrated that drivers with a history of crash involvement were eight times more likely to have a serious contrast sensitivity deficit (defined as a Pelli-Robson score of 1.25 or less) in the worse eye than those who had no history of crash involvement. A severe contrast sensitivity deficit in only one eye was still significantly associated with crash involvement.

Binocular vision is better than the vision of a single eye. The simultaneous use of the two eyes is complex and requires the integration of disparate images from each eye. A study demonstrated that binocular vision resulted in better perception of form, color, and the relationship of the body to the environment, which facilitated manipulation, reaching, and balance, particularly under dim illumination. However, if the vision of one eye is reduced due to cataract, visual performance can fall below the level of monocular vision by a mechanism known as binocular inhibition, which reduces patients' visual acuity and contrast sensitivity. A study of the Framingham Study Cohort found that poor vision in one or both eyes was associated with an increased risk of hip fracture. It also found that patients with good vision in one eye and moderately impaired vision in the other eye had a higher risk of fracture than those with similar visual impairment in both eyes. A study of 150 patients before and after cataract surgery found that poor binocular visual acuity was related to more problems in activities of daily living. Another study, based on patients who reported no beneficial outcomes after first-eye cataract surgery in the National Swedish Cataract Outcome register, found that anisometropia was the reason for the poor outcome in one-third of cases. These studies have shown that second-eye surgery is important to visual and physical function.

In summary, these studies demonstrate that physical function, emotional well-being, and overall quality of life can be enhanced when visual function is restored by cataract extraction.

Improved visual function as a result of cataract surgery includes the following:

- Better optically corrected vision.
- Better uncorrected vision with reduced spectacle dependence.
- Increased ability to read or do near work.
- Reduced glare.
- Improved ability to function in dim levels of light.
- Improved depth perception and binocular vision.
- Improved color vision.

Improved physical function as a critical outcome of cataract surgery includes the following:

- Increased ability to perform activities of daily living.
- Increased opportunity to continue or resume an occupation.
- Increased mobility (walking, driving).

Improved mental health and emotional well-being as a second critical outcome of cataract surgery includes the following benefits:

- Improved self-esteem and independence.
- Increased ability to avoid injury.
- Increased social contact and ability to participate in social activities.
- Relief from fear of blindness.

Most patients achieve improved visual function after cataract surgery. This outcome is achieved consistently through careful attention through the patient selection process, accurate measurement of axial length and corneal power, appropriate selection of an IOL power calculation formula, etc. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery would reflect patterns of patient selection or treatment that should be assessed for opportunities for improvement.

Sometimes cataract surgery is performed for other medical reasons other than to improve impaired visual function caused by cataract. These circumstances include the following: clinically significant anisometropia in the presence of a cataract; when the lens opacity interferes with optimal diagnosis or management of posterior segment conditions, when the lens causes inflammation (phacolysis, phacoanaphylaxis) and when the lens induces angle closure (phacomorphic or phacotopic). In these situations, improved visual function as a result of the removal of the cataract is not expected, because of the pre-existing comorbid conditions.

2. Evidence of a Gap in Care

This is an outcome of surgery indicator of direct relevance and import to patients, their families and referring providers. The available evidence suggests that cataract surgery achieves this in about 90% of patients. While the potential for improvement is seemingly small, the volume of cataract surgery in the U.S. of over 2.8 million surgeries means that the impact could affect more than 100,000 patients per year. Ideally, performance on this indicator would be as high as possible, with lower rates suggestive of opportunities for improvement.

3. Sampling Strategy

The survey methodology is described as follows. The survey could be administered by a third party or a registry for reporting of PQRS measures to prevent or minimize bias which might be introduced if it is an in-office paper survey with questions asked by the office staff. Options would be provided to the patient, either online survey, mail survey or phone survey (third party or registry only), depending on their preferences and abilities.

The survey would be of a sample of those individuals with cataract surgery. The sample size would be postulated at 20, because this is a well-accepted statistical sample and used by the CMS for reporting on measure groups in PQRS. Because visual function is reported at 90 days after surgery, this would allow physicians to identify 20 cases from January – September for reporting purposes.

4. Improvement in Visual Function

The strategy to identify improvement in visual function is as follows. The instrument proposed for visual function evaluation is the Rasch-scaled Short Version of the Visual Function-14, VF-8R. Reliability and validity testing have been performed on the VF-14 as well as the VF-8R. This instrument is scored on a scale of 0-100, with 0 indicating the lack of ability to perform functional activities and 100 indicating complete ability to perform functional activities. The difference between the pre-operative and post-operative scores on the VF-8R indicates a change in functional activities. Improvement in visual function would be defined as an increase in the visual function score between pre-operative and post-operative assessment on the VF-8R in the range of 5 points or greater.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no recommendation statements in the guideline specific to this measurement topic.

✤Measure #304: Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older in sample who had cataract surgery and were satisfied with their care within 90 days following the cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey

INSTRUCTIONS:
This measure is to be calculated when a procedure for cataracts is performed in the sample during the reporting period. This measure is intended to reflect the quality of services provided for the patient receiving cataract surgery.

Note: This is an outcome measure and will be calculated solely using registry data.

- *For patients who receive the cataract surgical procedures specified in the denominator coding in the sample, it should be reported whether or not the patient was satisfied with their care within 90 days following the cataract surgery.*
- *Include only procedures performed through **September 30** of the reporting period. This will allow the post-operative period to occur before registries must submit data to CMS.*
- *It is the responsibility of a third party, which may be the registry or another third party designated by the eligible professional to administer, receive results, and review the surveys. Each registry must work directly with eligible professionals who wish to report these measures to determine who (a registry or another third party) will be administering, receiving and reviewing the surveys.*

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older in the sample who had cataract surgery

Denominator Instructions: Clinicians who indicate modifier 56 (pre-operative management) or modifier 55 (post-operative management) only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged > 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984

NUMERATOR:
Patients 18 years and older in the sample who were satisfied with their care within 90 days following cataract surgery, based on completion of the Consumer Assessment of Healthcare Providers and Systems Surgical Care Survey

Numerator Options:
Satisfaction with care achieved within 90 days following cataract surgery (G0916)

OR
Patient care survey was not completed by patient (G0917)
OR
Satisfaction with care not achieved within 90 days following cataract surgery (G0918)

RATIONALE:

1. Scientific Basis for Measuring Patient Satisfaction after Cataract Surgery

Patient satisfaction is a valuable performance indicator for measuring the quality of care delivered by ophthalmologists providing cataract surgery. In the broadest sense, patient satisfaction is an assessment of the patient's experience with the care process delivered by health plans, clinicians, health systems, hospitals, etc. This experience can cover domains as diverse as information/education, interpersonal manner, emotional support, accessibility, convenience, outcomes or results, environment, personalization, involvement in care, finances, etc.

In 1996, The American Academy of Ophthalmology launched the National Eyecare Outcomes Network (NEON) database. From January 1, 1996 through March 30, 2001, 249 ophthalmologists at 114 different practice sites submitted data to the NEON cataract surgery database. Post-operative patient satisfaction responses were collected for 6,154 patients, or about 34.5% of all patients who had pre-operative forms submitted. This assessment was performed at a median of 4.1 weeks postoperatively for all patients enrolled in the database. A 12-item questionnaire was used to assess patient satisfaction. Patient satisfaction was associated with younger age and absence of ocular comorbidity.

Other studies of patient satisfaction after cataract surgery were conducted in Austria and in Spain. The Austrian study found that patients with pre-existing eye disease, including those patients with improved visual acuity after surgery, were the least satisfied with the results of surgery. In these cases, improved patient education prior to surgery could be helpful in improving patient satisfaction. The Spanish study found that patient satisfaction was associated with expectations prior to surgery.

Most patients are satisfied with their care and results after cataract surgery. This outcome is achieved consistently through careful attention through the patient selection process, accurate measurement of axial length and corneal power, appropriate selection of an IOL power calculation formula, etc. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this satisfaction after surgery would reflect patterns of patient selection or treatment that should be assessed for opportunities for improvement.

Use of this indicator in PQRS claims-based reporting method would require some modification to the current reporting of post-operative care for patients undergoing cataract surgery, since this indicator would be operative during the 90 day global period. However, there is a strong and practical precedent for such modifications in that reporting arrangements have previously been made to accommodate co-management of care by different providers during the post-operative period. A similar adjustment to allow for filing of a claim of meeting this goal at one point in the 90 day global period would be sufficient, potentially drawing upon the methods to demarcate the onset of co-management transfer of post-operative care.

Various patient satisfaction instruments exist, but an instrument developed by the program, Consumer Assessment of Healthcare Providers and Systems (CAHPS), Agency for Healthcare Research and Quality develops and supports the use of a comprehensive and evolving family of standardized surveys that ask consumers and patients to report on and evaluate their experiences with health care. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. AHRQ first launched the CAHPS program in October 1995 in response to concerns about the lack of good information about the quality of health plans from the enrollees' perspective. At that time, numerous public and private organizations collected information on enrollee and patient satisfaction, but the surveys varied from sponsor to sponsor and often changed from year to year.

The CAHPS Surgical Care Survey asks adult patients to report on surgical care, surgeons, their staff, and anesthesiologists. It was developed by the American College of Surgeons and the Surgical Quality Alliance to assess patients' experiences before, during, and after surgery. In early 2010, the CAHPS Consortium voted to adopt the Surgical Care Survey as an official CAHPS survey. The Surgical Care Survey expands on the current CAHPS Clinician & Group Survey, which focuses on primary and specialty care, by incorporating domains that are relevant to surgical care, such as informed consent, anesthesia care, and post-operative follow-up. The survey is unique in that it assesses patients' experiences with surgical care in both the inpatient and outpatient settings by asking respondents about their care before, during, and after surgery.

The main purpose of the CAHPS Surgical Care Survey is to address the need to assess and improve the experiences of surgical patients. Like other CAHPS surveys, this questionnaire focuses on aspects of surgical quality that are important to patients and for which patients are the best source of information. The survey results are expected to be useful to everyone with a need for information on the quality of surgeons and surgical care, including patients, practice groups, health plans, insurers, and specialty boards. Patients can use the information to help make better and more informed choices about their surgical care. Practices, health plans, and insurers can use the survey results for quality improvement initiatives and incentives. Specialty boards may use the survey for maintenance of certification.

The composite measures of surgical quality from the S-CAPHS that are most relevant and significant for this physician-level performance measure include:

- How well surgeon communicates with patients before surgery
- How well surgeon communicates with patients after surgery
- Rating of overall care from this surgeon

2. Evidence of a Gap in Care

This is an outcome of surgery indicator of direct relevance and importance to patients, their families and referring providers. The available evidence suggests that cataract surgery achieves this in about 90% of patients. While the potential for improvement appears seemingly small, the volume of cataract surgery in the U.S. of over 2.8 million surgeries means that the impact could affect more than 100,000 patients per year. Ideally performance on this indicator should be as high as possible, with rates lower than 95-100% suggestive of opportunities for improvement.

3. Sampling Strategy

The survey methodology is described as follows. The survey could be administered by a third party or a registry for reporting of PQRS measures to prevent or minimize bias which might be introduced if it is an in office paper survey with questions asked by the office staff. Options would be provided to the patient, either online survey, mail survey or phone survey (third party or registry only), depending on their preferences and abilities.

The survey would be of a sample of those individuals with cataract surgery. The sample size would be postulated at 20, because this is a well-accepted statistical sample and used by the CMS for reporting on measure groups in PQRS. Because patient satisfaction is reported at 90 days after surgery, this would allow physicians to identify 20 cases from January – September for reporting purposes.

4. Definition of Patient Satisfaction

The strategy for defining patient satisfaction is described as follows. CAHPS scores are actually normative scores, that is, they provide relative rankings rather than absolute rankings (where a score is compared with an 'objective criterion'). Patient satisfaction would be defined as a score above the lowest 5% of scores on the CAHPS.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no recommendation statements in the guideline specific to this measurement topic.

♠ Measure #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Eligible professionals who report the measure must perform the blood pressure screening at the time of a qualifying visit and may not obtain measurements from external sources. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow up plan must be related to the current BP reading as indicated, example: "Patient referred to primary care provider for BP management."

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Percentage of patients aged 18 years and older

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on the date of the encounter
> AND
> Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90880, 92002, 92004, 92012, 92014, 96118, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0402, G0438, G0439

NUMERATOR:
Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive

NUMERATOR NOTE: Although the recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, a BP screening must be performed once per measurement period. The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. Normal blood pressure follow-up is not recommended for patients with clinical or symptomatic hypotension.

Definitions:

BP Classification - BP is defined by four BP reading classifications as listed in the "Recommended Blood Pressure Follow-Up" table below including Normal, Pre-Hypertensive, First Hypertensive, and Second Hypertensive Readings.

Recommended BP Follow-Up - The current *Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* (JNC) recommends BP screening intervals, lifestyle modifications and interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow-Up" table below.

Lifestyle Modifications - The current JNC report outlines lifestyle modifications which must include one or more of the following as indicated: Weight Reduction, Dietary Approaches to Stop Hypertension (DASH) Eating Plan, Dietary Sodium Restriction, Increased Physical Activity, or Moderation in Alcohol (ETOH) Consumption.

Second Hypertensive Reading - Requires a BP reading of Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg.

Second Hypertensive Reading Interventions - The current JNC report outlines interventions based on BP Readings shown in the "Recommended Blood Pressure Follow-Up" table and must include one or more of the following as indicated: Anti-Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG).

Recommended Blood Pressure Follow-Up Table

BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up *(must include all indicated actions for each BP Classification)*
Normal BP Reading	< 120	AND < 80	• No Follow-Up required
Pre-Hypertensive BP Reading	≥ 120 AND ≤ 139	OR ≥ 80 AND ≤ 89	• Rescreen BP within a minimum of 1 year *AND* Recommend Lifestyle Modifications OR • Referral to Alternative/Primary Care Provider
First Hypertensive BP Reading	≥ 140	OR ≥ 90	• Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks *AND* Recommend Lifestyle Modifications OR • Referral to Alternative/Primary Care Provider
Second Hypertensive BP Reading	≥ 140	OR ≥ 90	• Recommend Lifestyle Modifications *AND* 1 or more of the Second Hypertensive Reading Interventions (see definitions) OR • Referral to Alternative/Primary Care Provider

Not Eligible – A patient is not eligible if one or more of the following reason(s) are documented:

- Patient has an active diagnosis of hypertension
- Patient refuses to participate (either BP measurement or follow-up)
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Normal Blood Pressure Reading Documented, Follow-Up not Required

G8783: Normal blood pressure reading documented, follow-up not required

OR

Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, AND Indicated Follow-Up Documented

G8950: Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented

OR

Blood Pressure Reading not Documented, Patient not Eligible

G8784: Blood pressure reading not documented, documentation the patient is not eligible

OR

Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up not Documented, Patient not Eligible

G8951: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, documentation the patient is not eligible

OR

Blood Pressure Reading not Documented, Reason not Given

G8785: Blood pressure reading not documented, reason not given

OR

Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up not Documented, Reason not Given

G8952: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given

RATIONALE:

Hypertension is a prevalent condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40% of the adult population has hypertension; the majority of people over age 65 have a hypertension diagnosis. (Appleton SL, et. al., 2012 and Luehr D, et. al., 2012) Winter (2013) noted that 1 in 3 American adults have hypertension and the lifetime risk of developing hypertension is 90% (Winter KH, et. al., 2013). The African American population or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal disease. Non-Hispanic Blacks have the highest prevalence at 38.6%. (Winter KH, et. al., 2013) Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, renal failure, stroke and dementia. (Luehr D, et. al., 2012)

Hypertension is the most common reason for adult office visits other than pregnancy. Garrison (2013) stated that in 2007, 42 million ambulatory visits were attributed to hypertension. (Garrison GM and Oberhelman S, 2013) It also has the highest utilization of prescription drugs. Numerous resources and treatment options are available, yet only about 40-50% of the hypertensive patients have their blood pressure under control (<140/90). (Appleton SL, et. al., 2012, Luehr D, et. al., 2012) In addition to medication non-compliance, poor outcomes are also attributed to poor adherence to lifestyle changes such as a low-sodium diet, weight loss, increased exercise and limiting alcohol intake. Many adults find it difficult to continue medications and lifestyle changes when they are asymptomatic. Symptoms of elevated blood pressure usually do not occur until secondary problems arise such as with vascular diseases (myocardial infarction, stroke, heart failure and renal insufficiency). (Luehr D, et. al., 2012)

Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. The 2010 ACCF/AHA Guideline for the Assessment of Cardiovascular Risk in Asymptomatic Adults continues to support using a global risk score such as the Framingham Risk Score, to assess risk of coronary heart disease (CHD) in all asymptomatic adults. (Greenland P, et. al., 2010) Lifestyle modifications have demonstrated effectiveness in lowering blood pressure. (JNC 7, 2003) The synergistic effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as ALLHAT have repeatedly proven the efficacy of pharmacologic therapy to control blood pressure and reduce the complications of hypertension. Follow-up intervals based on blood pressure control have been established by the JNC 7 and the USPSTF.

CLINICAL RECOMMENDATION STATEMENTS:

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

♣Measure #320 (NQF 0658): Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into the measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 years and older and receiving a screening colonoscopy without biopsy or polypectomy

> Denominator Instructions: Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into this measure.
>
> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 50 on date of encounter
> AND
> Patient undergoing screening for malignant neoplasm of colon (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V76.51

Patient undergoing screening for malignant neoplasm of colon (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z12.11
AND
Patient encounter during the reporting period (CPT or HCPCS): 44388, 45378, G0121
WITHOUT
CPT Category I Modifiers: 52, 53, 73, 74

NUMERATOR:
Patients who had recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
At Least 10 Year Follow-Up Interval for Colonoscopy Recommended
CPT II 0528F: Recommended follow-up interval for repeat colonoscopy of at least 10 years documented in colonoscopy report

OR

At Least 10 Year Follow-Up Interval for Colonoscopy not Recommended for Medical Reasons
Append a modifier (1P) to CPT Category II code 0528F to report documented circumstances that appropriately exclude patients from the denominator.
0528F *with* 1P: Documentation of medical reason(s) for not recommending at least a 10 year follow-up interval (eg, inadequate prep, other medical reasons)

OR

At Least 10 Year Follow-Up Interval for Colonoscopy not Recommended, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 0528F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
0528F *with* 8P: At least 10 year follow-up interval for colonoscopy not recommended, reason not otherwise specified

RATIONALE:
Guideline recommendations support screening colonoscopy at 10 year intervals, for average risk patients. Non-adherence to guideline recommendations increases patients to unnecessary risk via procedural harms and complications. Colonoscopy screening at more frequent intervals also contributes to increased costs to patients and insurers.

CLINICAL RECOMMENDATION STATEMENTS:
At present, CSPY (colonoscopy) every 10 years is an acceptable option for CRC screening in average-risk adults beginning at age 50 years. (ACS/USMSTF/ACR, 2008)
The preferred CRC prevention test is colonoscopy every 10 years, beginning at age 50. (Grade 1B) (Rex, et al, 2009)

Measure #322 (NQF 0670): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Preoperative Evaluation in Low Risk Surgery Patients

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed in low risk surgery patients 18 years or older for preoperative evaluation during the 12-month reporting period

INSTRUCTIONS:
This measure is to be reported once per procedure of cardiac stress imaging (i.e. SPECT, MPI, ECHO, CCTA, CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for cardiac stress will submit this measure.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA, or CMR primarily performed in low risk surgery patients for preoperative evaluation within 30 days preceding low-risk non-cardiac surgery

Definition:
Low-Risk Surgery - cardiac death or MI less than 1% including, but are not limited to, endoscopic procedures, superficial procedures, cataract surgery, and excisional breast surgery.

NUMERATOR NOTES:
- A lower calculated performance rate for this measure indicates better clinical care or control.This measure is assessing overuse of cardiac stress imaging in low-risk surgery patients.
- Patients that did not have a surgery performed or had a surgery other than those defined as low-risk would report G8962.

- Clinical quality outcome is cardiac stress imaging NOT performed on patient who is a low risk surgery patient within 30 days preceding procedure.

Numerator Options:

Cardiac Stress Imaging Test primarily performed on low-risk surgery patient for preoperative evaluation within 30 days preceding this surgery (G8961)

OR

Cardiac Stress Imaging Test performed on patient for any reason including those who did not have low-risk surgery or test that was performed more than 30 days preceding low-risk surgery (G8962)

RATIONALE:

Cardiac imaging is a mainstay in medical decision-making for patients with known or suspected heart disease. However, expenditures related to imaging comprise a significant portion of the health care budget. Much scrutiny has been focused on cardiovascular imaging with regard to the potential for overuse, especially in view of substantial geographic variation in ordering patterns and the limited amount of evidence-based data supporting the use of imaging as it relates to patient outcomes. Given the significant contribution of heart disease to morbidity and mortality and the prevalence of cardiovascular disease, it is important to determine the appropriate use of diagnostic tests such as stress echocardiography, stress SPECT MPI, CCTA, and CMR.

CLINICAL RECOMMENDATION STATEMENTS:

Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA, and CMR is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes.

In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI and CCTA poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

Measure #323 (NQF 0671): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Routine Testing After Percutaneous Coronary Intervention (PCI)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in patients aged 18 years and older routinely after percutaneous coronary intervention (PCI), with reference to timing of test after PCI and symptom status

INSTRUCTIONS:
This measure is to be reported once per procedure of cardiac stress imaging (i.e., SPECT, MPI, CCTA, and CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for cardiac stress will submit this measure.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions. These codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA and CMR performed in asymptomatic patients within 2 years of the most recent PCI

> *NUMERATOR NOTE: A lower calculated performance rate for this measure indicates better clinical care or control. This measure is assessing overuse of cardiac stress imaging in asymptomatic patients that received PCI. Clinical quality outcome is cardiac stress imaging NOT performed on patient who is asymptomatic or low CHD risk.*
>
> Numerator Options:
> Cardiac Stress Imaging performed primarily for monitoring of asymptomatic patient who had PCI within 2 years (G8963)

OR

Cardiac Stress Imaging test performed primarily for any other reason than monitoring of asymptomatic patient who had PCI within 2 years (e.g., symptomatic patient, patient greater than 2 years since PCI, initial evaluation, etc.) (G8964)

RATIONALE:
Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA and CMR, is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes.

In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI and CCTA poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

CLINICAL RECOMMENDATION STATEMENTS:
2005 PCI Guidelines
Text (No recommendations)
Neither exercise testing nor radionuclide imaging is indicated for the routine, periodic monitoring of asymptomatic patients after PCI without specific indications.

2011 ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines and the Society for Cardiovascular Angiography and Interventions (J Am Coll Cardiol, 2011)

AUC Indications
2008 Appropriateness Criteria for Stress Echocardiography Indication 39: Risk Assessment: Post-Revascularization (PCI or CABG): Asymptomatic: Asymptomatic (e.g. silent ischemia) prior to previous revascularization AND less than 2 years after PCI - Inappropriate (3)
Indication 40: Risk Assessment: Post-Revascularization (PCI or CABG): Asymptomatic: Symptomatic prior to previous revascularization AND less than 2 years after PCI - Inappropriate (2)
ACCF/ASE/AHA/ASNC/HFSA/HRS/SCAI/SCCM/SCCT/SCMR 2011 Appropriate Use Criteria for Echocardiography (J Am Coll Cardiol, 2011)

2009 Appropriate Use Criteria for Cardiac Radionuclide Imaging
Indication 59: Risk Assessment: Post Revascularization (PCI or CABG): Asymptomatic: Less than 2 years after PCI – Inappropriate (3)

2006 Appropriateness Criteria for CCT and CMR Indication 27. Detection of CAD: Post-Revascularization (PCI or CABG) (Use of CCTA): Evaluation for in-stent restenosis and coronary anatomy after
PCI - Inappropriate (2)
2010 Appropriate Use Criteria for Cardiac Computed Tomography (J Am Coll Cardiol, 2010)

Measure #324 (NQF 0672): Cardiac Stress Imaging Not Meeting Appropriate Use Criteria: Testing in Asymptomatic, Low-Risk Patients

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of all stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), and cardiovascular magnetic resonance (CMR) performed in asymptomatic, low coronary heart disease (CHD) risk patients 18 years and older for initial detection and risk assessment

INSTRUCTIONS:
This measure is to be reported once per procedure of cardiac stress imaging (i.e, SPECT, MPI, CCTA, and CMR) for patients seen during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for cardiac stress will submit this measure.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All instances of stress single-photon emission computed tomography (SPECT) myocardial perfusion imaging (MPI), stress echocardiogram (ECHO), cardiac computed tomography angiography (CCTA), or cardiac magnetic resonance (CMR) performed on patients aged 18 years and older during the reporting period

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Cardiac Stress Imaging Performed – Procedure Codes (CPT): 75559, 75563, 75571, 75572, 75573, 75574, 78451, 78452, 78453, 78454, 78491, 78492, 78494, 93350, 93351

NUMERATOR:
Number of stress SPECT MPI, stress echo, CCTA, or CMR primarily performed for asymptomatic, low CHD risk patients for initial detection and risk assessment

> Definition:
> Low CHD risk - clinicians should consider the maximum number of available patient factors used to estimate risk based on Framingham (ATP III criteria), typically age, gender, diabetes, smoking status, and use of blood pressure medication, and integrate age appropriate estimates for missing elements, such as LDL or standard blood pressure.
>
> *NUMERATOR NOTE: A lower calculated performance rate for this measure indicates better clinical care or control.This measure is assessing overuse of cardiac stress imaging in low-risk CHD patients.* ***Clinical***

quality outcome is cardiac stress imaging NOT performed on patient who is asymptomatic or low CHD risk.

Numerator Options:
Cardiac Stress Imaging Test primarily performed on low CHD risk patient for initial detection and risk assessment (G8965)

OR

Cardiac Stress Imaging Test performed on symptomatic or higher than low CHD risk patient or for any reason other than initial detection and risk assessment (G8966)

RATIONALE:
Diagnostic testing, such as stress SPECT MPI, stress echocardiography, CCTA, and CMR, is used to detect disease and provide risk assessment used to modify treatment strategies and approaches. Information provided by such testing can initiate, modify and stop further treatments for coronary heart disease (medications and revascularization) which have an impact on patient outcomes. In addition, false positives and false negatives can adversely impact the patient and their treatment outcomes. Lastly, radiation from stress SPECT MPI poses a minimal but still important consideration for patient safety. Ensuring proper patient selection can avoid using resources in patients not expected to benefit from the testings and for which the associated risks would be unnecessary.

CLINICAL RECOMMENDATION STATEMENTS:
2002 Stable Angina Guideline
"Asymptomatic patients with abnormal findings on ambulatory ECG or EBCT who are able to exercise can be evaluated with exercise ECG testing, although the efficacy of exercise ECG testing in asymptomatic patients is not well established. Stress imaging procedures (i.e., either stress myocardial perfusion imaging or stress echocardiography) are generally not indicated in most such patients."

AUC Indications
2008 Appropriateness Criteria for Stress Echocardiography Indication 11: Detection of CAD and Risk Assessment: Asymptomatic (without Chest Pain Syndrome or Anginal Equivalent): Low CHD risk (Framingham risk criteria) - Inappropriate (1)

2009 Appropriate Use Criteria for Cardiac Radionuclide Imaging Indication 12: Detection of CAD/Risk Assessment Without Ischemic Equivalent: Asymptomatic: Low CHD risk (ATP III risk criteria) - Inappropriate (1)

2006 Appropriateness Criteria for CCT and CMR Indication 10 - Detection of CAD: Asymptomatic (Use of CCTA) (Without Chest Pain Syndrome): Asymptomatic: Low CHD risk (Framingham risk criteria) - Inappropriate (1)

2002 Chronic Stable Angina Guideline
Class III
Recommendations for Cardiac Stress Imaging as the Initial Test for Diagnosis in Asymptomatic Patients
1. Exercise or dobutamine echocardiography in asymptomatic patients with left bundle-branch block. (Level of Evidence: C)
2. Exercise myocardial perfusion imaging, exercise echocardiography, adenosine or dipyridamole myocardial perfusion imaging, or dobutamine echocardiography as the initial stress test in an asymptomatic patient with a normal rest ECG who is not taking digoxin. (Level of Evidence: C)
3. Adenosine or dipyridamole myocardial perfusion imaging or dobutamine echocardiography in asymptomatic patients who are able to exercise and do not have left bundle-branch block or electronically paced ventricular rhythm. (Level of Evidence: C)

▲ Measure #325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a diagnosis of MDD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with major depressive disorder based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], ESRD or congestive heart failure) being treated by another clinician

Definition:
Comorbid condition - For the purposes of this measure, only the following comorbid conditions will be included:

1. Diabetes
2. Coronary artery disease
3. Stroke, including ischemic stroke and intracranial hemorrhage
4. Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease
5. Congestive Heart Failure

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for MDD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
Diagnosis for MDD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
AND
Patient encounter during the reporting period (CPT): 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

AND

Diagnosis for Diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

Diagnosis for Diabetes (ICD-10-CM) [for use 10/01/2014-12/31/2014]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

OR

Diagnosis for CAD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82

Diagnosis for CAD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

OR

Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9

OR

Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.4, 585.5, 585.6

Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.4, N18.5, N18.6

OR

Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9

NUMERATOR:
Medical records of patients with communication to the clinician treating the comorbid condition

Definition:
Communication - Transmission of relevant clinical information which specifies that the patient has MDD.

Numerator Options:
Clinician treating Major Depressive Disorder communicates to clinician treating comorbid condition (G8959)

OR

Clinician treating Major Depressive Disorder did not communicate to clinician treating comorbid condition for specified patient reason (G9232)

OR

Clinician treating Major Depressive Disorder did not communicate to clinician treating comorbid condition, reason not given (G8960)

RATIONALE:
Depressive disorders are more common among persons with chronic conditions (e.g., obesity, cardiovascular disease, diabetes, asthma, arthritis, and cancer) and among those with unhealthy behaviors (e.g., smoking, physical inactivity, and binge drinking). Comorbidities are more common in the elderly. The highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%). The coordination of care for patients with depression and certain comorbid conditions is important for managing both the patient's depression and the other present medical condition. Improvements in the coordination of care between clinicians treating a patient with depression and other clinicians treating comorbid conditions can reduce the symptom exacerbation that depression and other conditions may cause to the other. Any [depression] treatment should be integrated with psychiatric management and any other treatments being provided for other diagnoses.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

In patients with major depressive disorder, it is important to recognize and address the potential interplay between major depressive disorder and any co-occurring general medical conditions. (APA, 2010)

The clinical assessment should include identifying any potential interactions between medications used to treat depression and those used to treat general medical conditions. In addition, the psychiatrist (clinician) should consider the effects of prescribed psychotropic medications on the patient's general medical conditions, as well as the effects of interventions for such disorders on the patient's psychiatric condition. (APA, 2010)

Many patients with major depressive disorder will be evaluated by or receive treatment from other health care professionals in addition to the psychiatrist (clinician). If more than one clinician is involved in providing the care, all treating clinicians should have sufficient ongoing contact with the patient and with each other to ensure that care is coordinated, relevant information is available to guide treatment decisions, and treatments are synchronized. (APA, 2010)

In ruling out general medical causes of depressive symptoms, it is important to ensure that a general medical evaluation has been done. (APA, 2010)

In patients with preexisting hypertension or cardiac conditions, treatment with specific antidepressant agents may suggest a need for monitoring of vital signs or cardiac rhythm (eg, electrocardiogram [ECG] with TCA treatment; heart rate and blood pressure assessment with SNRIs and TCAs). (APA, 2010)
In treating the depressive syndrome that commonly occurs following a stroke, consideration should be given to the potential for interactions between antidepressants and anticoagulating (including antiplatelet) medications. (APA, 2010)

The diagnostic work-up for MDD should include evaluation for existing or emerging medical conditions that may exacerbate the depression. These may include: Cardiovascular diseases, Chronic pain syndrome, Degenerative diseases, Immune disorders, Metabolic endocrine conditions (including kidney and lung diseases), Neoplasms, Trauma. Simultaneous treatment is often required for both the medical problem and psychiatric symptoms and can lead to overall improvement in function. (VA/DoD, 2009)

Indications for referral to a mental health specialist familiar with diabetes management may include gross noncompliance with medical regimen (by self or others), depression with the possibility of self-harm, debilitating anxiety (alone or with depression), indications of an eating disorder, or cognitive functioning that significantly impairs judgment. It is preferable to incorporate psychological assessment and treatment into routine care rather than waiting for identification of a specific problem or deterioration in psychological status. Although the clinician may not feel qualified to treat psychological problems, using the patient-provider relationship as a foundation for further treatment can increase the likelihood that the patient will accept referral for other services. It is important to establish that emotional well-being is part of diabetes management. (ADA, 2010)

Measure #326 (NQF 1525): Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation (AF) or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by $CHADS_2$ risk stratification, who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with nonvalvular AF or atrial flutter seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code(s). All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of nonvalvular AF or atrial flutter whose assessment of the specified thromboembolic risk factors indicate one or more high-risk factors or more than one moderate risk factor, as determined by $CHADS_2$ risk stratification

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for nonvalvular atrial fibrillation or atrial flutter (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 427.31, 427.32
> Diagnosis for nonvalvular atrial fibrillation or atrial flutter (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I48.0, I48.1, I48.2, I48.3, I48.4, I48.91, I48.92
> AND
> Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients who are prescribed warfarin OR another oral anticoagulant drug that is FDA approved for the prevention of thromboembolism

Definition:
Prescribed - May include prescription given to the patient for warfarin OR another oral anticoagulant that is FDA approved for the prevention of thromboembolism at one or more visits in the measurement period OR patient already taking warfarin OR another oral anticoagulant that is FDA approved for the prevention of thromboembolism as documented in current medication list.

The assessment of patients with nonvalvular AF or atrial flutter for thromboembolic risk factors should include the following criteria:

Risk Factors	Weighting
Prior stroke, TIA or systemic embolism	High risk
Age ≥ 75 years	Moderate risk
Hypertension	Moderate risk
Diabetes Mellitus	Moderate risk
Heart failure or impaired left ventricular systolic function	Moderate risk

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Warfarin OR Another Oral Anticoagulant that is FDA Approved Prescribed
*(Two quality-data codes [*G8967 & G8972*] are required on the claim form to submit this numerator option)*
G8967: Warfarin OR another oral anticoagulant that is FDA approved prescribed
AND
G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

OR

Warfarin OR Another Oral Anticoagulant that is FDA Approved not Prescribed for Medical, or Patient Reasons
*(Two quality-data codes [*G896x & G8972*] are required on the claim form to submit this numerator option)*
G8968: Documentation of medical reason(s) for not prescribing warfarin OR another oral anticoagulant that is FDA approved for the prevention of thromboembolism [e.g., patients with mitral stenosis or prosthetic heart valves, patients with transient or reversible causes of AF (eg, pneumonia or hyperthyroidism), postoperative patients, patients who are pregnant, allergy, risk of bleeding, other medical reasons]
OR
G8969: Documentation of patient reason(s) for not prescribing warfarin OR another oral anticoagulant that is FDA approved for the prevention of thromboembolism (eg, economic, social, and/or religious impediments, noncompliance, patient refusal, other patient reasons)
AND
G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

OR

No Risk Factors or One Moderate Risk Factor for Thromboembolism, Patient not Eligible
*(One quality-data code [*G8970*] is required on the claim form to submit this numerator option)*
G8970: No risk factors or one moderate risk factor for thromboembolism

OR

Warfarin OR Another Oral Anticoagulant that is FDA Approved not Prescribed, Reason not Given
*(Two quality-data codes [*G8971 & G8972*] are required on the claim form to submit this numerator option)*
G8971: Warfarin OR another oral anticoagulant that is FDA approved not prescribed, reason not given
AND

G8972: One or more high risk factors for thromboembolism OR more than one moderate risk factor for thromboembolism

RATIONALE:
Anticoagulation should be prescribed for all high risk patients with AF or atrial flutter except those with contraindications to anticoagulation. Aspirin is preferred in patients without risk factors or in those with contraindications to anticoagulation, and is an alternative to anticoagulation in those with only one moderate risk factor.

CLINICAL RECOMMENDATION STATEMENTS:
ACCF/AHA/HRS 2011 Focused Update on the Management of Patients with Atrial Fibrillation (Update on Dabigatran) Emerging Antithrombotic Agents

Class I
Dabigatran is useful as an alternative to warfarin for the prevention of stroke and systemic thromboembolism in patients with paroxysmal to permanent AF and risk factors for stroke or systemic embolization who do not have a prosthetic heart valve or hemodynamically significant valve disease, sever renal failure (Creatinne clearance < 15 mL/min) or advanced liver disease (impaired baseline clotting function) *(Level of Evidence: B)*
2006 ACC/AHA/ESC Guidelines for the Management of Atrial Fibrillation Patients with AF Chronic Anticoagulation Therapy (Recommendations other than those listed below pertain to antithrombotic therapy for patients with AF undergoing cardioversion) (4)

2006 ACC/AHA/ESC Guidelines for the Management of Patients with Atrial Fibrillation
Chronic Anticoagulation Therapy

Class I
1. Antithrombotic therapy to prevent thromboembolism is recommended for all patients with AF, except those with lone AF or contraindications. (Level of Evidence: A)
2. The selection of the antithrombotic agent should be based upon the absolute risks of stroke and bleeding and the relative risk and benefit for a given patient. (Level of Evidence: A)
3. Aspirin, 81–325 mg daily, is recommended as an alternative to vitamin K antagonists in low-risk patients or in those with contraindications to anticoagulation. (Level of Evidence: A)
4. Antithrombotic therapy is recommended for patients with atrial flutter as for those with AF. (Level of Evidence: C)

Antithrombotic Therapy for Patients with Atrial Fibrillation*

	Risk Category	Recommended Therapy
Low Risk	No risk factors	Aspirin, 81 to 325 mg daily
Intermediate Risk	One moderate-risk factor	Aspirin, 81 to 325 mg daily, or warfarin (INR 2.0 to 3.0, target 2.5)
High Risk	Any high-risk factor or more than one moderate-risk factor	Warfarin (INR 2.0 to 3.0, target 2.5)

*Adapted from 2006 ACC/AHA/ESC Guidelines for the Management of Patients with Atrial Fibrillation

▲ Measure #327: Pediatric Kidney Disease: Adequacy of Volume Management

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) undergoing maintenance hemodialysis in an outpatient dialysis facility have an assessment of the adequacy of volume management from a nephrologist

INSTRUCTIONS:
This measure is to be reported each calendar month patients are seen with a diagnosis of ESRD (who are undergoing maintenance hemodialysis in an outpatient dialysis facility) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code(s). All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All calendar months during which patients aged 17 years and younger with a diagnosis of ESRD are undergoing maintenance hemodialysis in an outpatient dialysis facility

Denominator Criteria (Eligible Cases):
Patients aged ≤ 17 years on date of encounter
AND
Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.6
Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.6
AND
Patient encounter during the reporting period (CPT): 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90963, 90964, 90965, 90967, 90968, 90969

NUMERATOR:
Calendar months during which patients have an assessment of the adequacy of volume management from a nephrologist

Definition:

Adequacy of Volume Management – Adequacy of volume management for a patient on dialysis is determined by assessing whether or not the patient achieved a target end dialysis weight after receiving dialysis, by a comparison of the patient-specific target end dialysis weight and the actual post dialysis weight.

NUMERATOR 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:
Most Recent Assessment of the Adequacy of Volume Management
*(Two quality-data codes [*G8955 & G8956*] are required on the claim form to submit this numerator option)*
G8955: Most recent assessment of adequacy of volume management
AND
G8956: Patient receiving maintenance hemodialysis in an outpatient dialysis facility

OR

Patient not Receiving Maintenance Hemodialysis, Patient not Eligible
*(One quality-data code [*G8957*] is required on the claim form to submit this numerator option)*
G8957: Patient not receiving maintenance hemodialysis in an outpatient dialysis facility

OR

Assessment of Adequacy of Volume Management not Performed, Reason not Given
*(Two quality-data codes [*G8958 & G8956*] are required on the claim form to submit this numerator option)*
G8958: Assessment of adequacy of volume management not documented, reason not given
AND
G8956: Patient receiving maintenance hemodialysis in an outpatient dialysis facility

RATIONALE:
Management of hypertension in dialysis patients includes the management of the fluid status. Poor extracellular volume control may exacerbate hypertension and so it is important to optimize ultrafiltration, volume status and dry weight to control blood pressure in an effort to improve patient outcomes. (KDOQI, 2006)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

1.2 The following parameters of nutritional status and growth should be considered in combination for evaluation in children with CKD stages 2 to 5 and 5D. *(B)*
i Dietary intake (3-day diet record or three 24-hour dietary recalls)
ii Length- or height-for-age percentile or standard deviation score (SDS)
iii Length or height velocity-for-age percentile or SDS
iv Estimated dry weight and weight-forage percentile or SDS
v BMI-for-height-age percentile or SDS
vi Head circumference-for-age percentile or SDS (< 3 years old only)
vii Normalized protein catabolic rate (nPCR) in hemodialyzed adolescents with CKD stage 5D. (KDOQI, 2009)

▲ Measure #328 (NQF 1667): Pediatric Kidney Disease: ESRD Patients Receiving Dialysis: Hemoglobin Level < 10 g/dL

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of calendar months within a 12-month period during which patients aged 17 years and younger with a diagnosis of End Stage Renal Disease (ESRD) receiving hemodialysis or peritoneal dialysis have a hemoglobin level < 10 g/dL

INSTRUCTIONS:
This measure is to be reported each calendar month patients are seen with a diagnosis of ESRD (who are on hemodialysis or peritoneal dialysis) during the reporting period. The most recent quality code submitted will be used for performance calculation. It is anticipated that clinicians providing care for patients with ESRD will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All calendar months during which patients aged 17 years and younger with a diagnosis of ESRD are receiving hemodialysis or peritoneal dialysis

> Denominator Criteria (Eligible Cases):
> Patients aged ≤ 17 years on date of encounter
> AND
> Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.6
> Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.6
> AND
> Patient encounter during the reporting period (CPT): 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90963, 90964, 90965, 90967, 90968, 90969

NUMERATOR:
Calendar months during which patients have a hemoglobin level < 10 g/dL

Numerator Instructions: The hemoglobin values used for this measure should be a most recent (last) hemoglobin value recorded for each calendar month.

A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Most Recent Hemoglobin level < 10 g/dL
G8973: Most recent hemoglobin (Hgb) level < 10 g/dL

OR

Hemoglobin Level Measurement not Performed, Reason not Given
G8974: Hemoglobin level measurement not documented, reason not given
OR
Documented Clinical Reason Patient has Hemoglobin Level < 10 g/dL
G8975: Documentation of medical reason(s) for patient having a hemoglobin level < 10 g/dL (eg, patients who have non-renal etiologies of anemia (eg, sickle cell anemia or other hemoglobinopathies, hypersplenism, primary bone marrow disease, anemia related to chemotherapy for diagnosis of malignancy, postoperative bleeding, active bloodstream or peritoneal infection), other medical reasons)

OR

Most Recent Hemoglobin Level ≥ 10.0 g/dL
G8976: Most recent hemoglobin (Hgb) level ≥ 10 g/dL

RATIONALE:
The clinical issues that impact achievement of the target hemoglobin in the pediatric population differ from the adult population. Normative, adult population data should not be used to assess performance in the pediatric population. Consideration(s) should be given to using age-specific normative data across the pediatric age range.

Anemia is a common complication of chronic kidney disease (CKD). The prevalence of anemia varies with the degree of renal impairment in predialysis patients with CKD, but once end-stage kidney failure occurs, all patients are eventually affected. Anemia develops once renal function decreases to < 50% because of a deficiency in endogenous erythropoietin (EPO) production by the kidney, decreased red cell survival, blood losses, and increased red blood cell destruction once the patient begins dialysis treatment, particularly hemodialysis. Anemia reduces physical capacity, well-being, neurocognitive function, and energy level and worsens quality of life both in predialysis and dialysis patients. Anemia also induces adaptive cardiovascular mechanisms to maintain tissue oxygen supply. This leads to left ventricular hypertrophy, left ventricular dilation, and myocardial ischemia, which are risk factors for cardiovascular disease and death. It is plausible that reversing anemia may reduce this risk. (Strippoli et al., 2004)

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

CLINICAL PRACTICE RECOMMENDATIONS FOR ANEMIA IN CHRONIC KIDNEY DISEASE IN CHILDREN:
2.1.2 *(FULLY APPLICABLE TO CHILDREN)* In the opinion of the [KDOQI] Work Group, in pediatric dialysis and nondialysis patients with CKD receiving ESA therapy, the selected Hb target should generally be in the range of 11.0 to 12.0 g/dL. *(Clinical Practice RECOMMENDATION)* (KDOQI, 2007)

▲ Measure #329: Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

This is a two part measure which is paired with Measure #330: Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days. If there is documentation that the patient initiated hemodialysis with a catheter, then Measure #330 *should* also be reported.

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) who initiate maintenance hemodialysis during the measurement period, whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with ESRD who initiated maintenance hemodialysis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, quality-data code and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD who initiate maintenance hemodialysis during the measurement period

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.6, V56.0
> Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.6, Z49.31
> AND
> Patient encounter during reporting period (CPT): 90957, 90958, 90959, 90960, 90961, 90962, 90966, 90970
> AND
> Initiation of maintenance hemodialysis during the reporting/maintenance period

NUMERATOR:
Patients whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated

> Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.
>
> Numerator Options:

Patient whose mode of vascular access is a catheter at the time maintenance hemodialysis is initiated (G9240)

OR

Documentation of reasons for patient initiaiting maintenance hemodialysis with a catheter as the mode of vascular access (e.g., patient has a maturing AVF/AVG, time-limited trial of hemodialysis, patients undergoing palliative dialysis, other medical reasons, patient declined AVF/AVG, other patient reasons, patient followed by reporting nephrologist for fewer than 90 days, other system reasons) (G9239)

OR

Patient whose mode of vascular access is **not** a catheter at the time maintenance hemodialysis is initiated (G9241)

RATIONALE:
Cuffed tunneled central venous catheters should be discouraged as permanent vascular access.

Among vascular access modalities, catheters have the highest rates of infectious complications, thrombosis, risk of permanent central venous stenosis or occlusion.

Patients receiving catheters and grafts have greater mortality risk than patients dialyzed with fistulae.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

A structured approach to the type and location of long-term HD accesses should help optimize access survival and minimize complications. The access should be placed distally and in the upper extremities whenever possible. Options for fistula placement should be considered first, followed by prosthetic grafts if fistula placement is not possible. Catheters should be avoided for HD and used only when other options listed are not available. (KDOQI, 2006)

2.1 The order of preference for placement of fistulae in patients with kidney failure who choose HD as their initial mode of KRT should be (in descending order of preference):
2.1.1 Preferred: Fistulae (B)
2.1.1.1 A wrist (radiocephalic) primary fistula (A)
2.1.1.2 An elbow (brachiocephalic) primary fistula (a)
2.1.1.3 A transposed brachial basilic vein fistula (B)
2.1.2 Acceptable: AVG of synthetic or biological material, such as: (B)
2.1.2.1 A forearm loop graft, preferable to a straight configuration
2.1.2.2 Upper-arm graft
2.1.2.3 Chest wall or “necklace” prosthetic graft or lower-extremity fistula or graft; all upper-arm sites should be exhausted. (KDOQI, 2006)

▲ Measure #330: Adult Kidney Disease: Catheter Use for Greater Than or Equal to 90 Days

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

This is a two part measure which is paired with Measure #329: Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis.
This measure *should* be reported if quality-data code G9240 "Documentation of patient with a catheter at the time maintenance hemodialysis is initiated" is submitted for Measure #329.

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of End Stage Renal Disease (ESRD) receiving maintenance hemodialysis for greater than or equal to 90 days whose mode of vascular access is a catheter

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with ESRD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. NOTE: Include only patients that have catheters at the time of initiation of hemodialysis through September 30 of the reporting period. This will allow the evaluation of at least 90 days of catheter use for hemodialysis within the reporting year.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, quality-data code and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of ESRD receiving maintenance hemodialysis for greater than or equal to 90 days

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 18 years on date of encounter
> AND
> Diagnosis for ESRD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 585.6, V56.0
> Diagnosis for ESRD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: N18.6, Z49.31
> AND
> Patient encounter during reporting period (CPT): 90957, 90958, 90959, 90960, 90961, 90962, 90966, 90970
> AND
> All eligible instances of quality-data code G9240 (Documentation of patient with a catheter at the time maintenance hemodialysis is initiated as applied in the numerator for Measure #329 Adult Kidney Disease: Catheter Use at Initiation of Hemodialysis)

NUMERATOR:
Patients whose mode of vascular access is a catheter

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Patient receiving maintenance hemodialysis for greater than or equal to 90 days with a catheter as the mode of vascular access (G9265)

OR

Documentation of patient receiving maintenance hemodialysis for greater than or equal to 90 days with a catheter for documented reasons (e.g., patient is undergoing palliative dialysis with a catheter, patient approved by a qualified transplant program and scheduled to receive a living donor kidney transplant, other medical reasons, patient declined AVF/AVG, other patient reasons) (G9264)

OR

Patient receiving maintenance hemodialysis for greater than or equal to 90 days without a catheter as the mode of vascular access (G9266)

RATIONALE:

Long-term catheter use without appropriate adjustments in treatment duration can compromise dialysis adequacy. Compromise of dialysis adequacy is associated with increased morbidity and mortality. Long-term catheter access is associated with a risk for central venous stenosis development, which can preclude the establishment of a permanent vascular access for HD.

Data suggest that a change from non-cuffed to long-term cuffed catheters, and the reduction in catheter placement rates, may reflect longer duration of catheter use and longer exposure to potential infections.

The infection rate for long-term cuffed catheters is one episode per 252 catheter days, and their use is associated with lower blood flows, less hemodialysis, and an increased risk of sepsis, endocarditis, and metastatic infections.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

A structured approach to the type and location of long-term HD accesses should help optimize access survival and minimize complications. The access should be placed distally and in the upper extremities whenever possible. Options for fistula placement should be considered first, followed by prosthetic grafts if fistula placement is not possible. Catheters should be avoided for HD and used only when other options listed are not available. (KDOQI, 2006)

2.1 The order of preference for placement of fistulae in patients with kidney failure who choose HD as their initial mode of KRT should be (in descending order of preference):
2.1.1 Preferred: Fistulae (B)
2.1.1.1 A wrist (radiocephalic) primary fistula (A)
2.1.1.2 An elbow (brachiocephalic) primary fistula (a)
2.1.1.3 A transposed brachial basilic vein fistula (B)
2.1.2 Acceptable: AVG of synthetic or biological material, such as: (B)
2.1.2.1 A forearm loop graft, preferable to a straight configuration
2.1.2.2 Upper-arm graft
2.1.2.3 Chest wall or “necklace” prosthetic graft or lower-extremity fistula or graft; all upper-arm sites should be exhausted.
2.1.3 Avoid if possible: Long-term catheters. (B)
2.1.3.1 Short-term catheters should be used for acute dialysis and for a limited duration in hospitalized patients. Noncuffed femoral catheters should be used in bed-bound patients only. (B)

2.1.3.2 Long-term catheters or dialysis port catheter systems should be used in conjunction with a plan for permanent access. Catheters capable of rapid flow rates are preferred. Catheter choice should be based on local experience, goals for use, and cost. (B)
2.1.3.3 Long-term catheters should not be placed on the same side as a maturing AV access, if possible. (B)
Special attention should be paid to consideration of avoiding femoral catheter access in HD patients who are current or future kidney transplant candidates. MRA imaging of both arteries and veins is the diagnostic procedure of choice for evaluating central vessels for possible chest wall construction.(KDOQI, 2006)

▲ Measure #331: Adult Sinusitis: Antibiotic Prescribed for Acute Sinusitis (Appropriate Use)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, aged 18 years and older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms

INSTRUCTIONS:
This measure is to be reported once for each occurrence for patients with acute sinusitis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute sinusitis

Definitions:
Acute Sinusitis/Rhinosinusitis: Up to 4 weeks of purulent nasal drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial pain-pressure-fullness, or both:
Purulent nasal discharge is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection, and may be reported by the patient or observed on physical examination
Nasal obstruction may be reported by the patient as nasal obstruction, congestion, blockage, or stuffiness, or may be diagnosed by physical examination
Facial pain-pressure-fullness may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients prescribed any antibiotic within 7 days of diagnosis or within 10 days after onset of symptoms
Numerator Instructions: The desired performance goal is not an antibiotic prescribing rate of zero. This measure is an overall rate of all patients receiving an antibiotic.

Numerator Options:
Antibiotic regimen prescribed within 7 days of diagnosis or within 10 days after onset of symptoms (G9286)
OR
Antibiotic regimen not prescribed within 7 days of diagnosis or within 10 days after onset of symptoms (G9287)

RATIONALE:
Antibiotic treatment for Sinusitis is indicated for some patients, but overtreatment of acute sinusitis with antibiotics is common and often not indicated. Further, treatment with antibiotics may increase patient harm and can lead to antibiotic resistance.

A Cochrane systematic review was undertaken to quantify the effectiveness of antibiotic therapy for patients diagnosed with acute sinusitis and treated in ambulatory settings. The authors concluded that antibiotics have a small benefit for improving clinical outcomes in patients with uncomplicated acute sinusitis and symptoms lasting more than seven days in a primary care setting. However, 80% of patients treated with a placebo also improved within two weeks.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:
AAO-HNS Sinusitis Guideline (2007)
Observation without use of antibiotics is an option for selected adults with uncomplicated ABRS who have mild illness (mild pain and temperature < 38.3°C or 101°F) and assurance of follow-up.
Option based on double-blind randomized controlled trials with heterogeneity in diagnostic criteria and illness severity, and a relative balance of benefit and risk.
Antibiotics are not recommended for treating viral rhinosinusitis (VRS) because they are ineffective and do not relieve symptoms directly.

▲ Measure #332: Adult Sinusitis: Appropriate Choice of Antibiotic: Amoxicillin Prescribed for Patients with Acute Bacterial Sinusitis

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of acute bacterial sinusitis that were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with acute bacterial sinusitis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute bacterial sinusitis

Definitions:
Acute Sinusitis/Rhinosinusitis: Up to 4 weeks of purulent nasal drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial pain-pressure-fullness, or both:
Purulent nasal discharge is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection, and may be reported by the patient or observed on physical examination
Nasal obstruction may be reported by the patient as nasal obstruction, congestion, blockage, or stuffiness, or may be diagnosed by physical examination
Facial pain-pressure-fullness may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients who were prescribed amoxicillin, with or without clavulanate, as a first line antibiotic at the time of diagnosis

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Amoxicillin, with or without clavulanate, prescribed as a first line antibiotic at the time of diagnosis (G9315)

OR

Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis for documented reason (e.g., cystic fibrosis, immotile cilia disorders, ciliary dyskinesia, immune deficiency, prior history of sinus surgery within the past 12 months, and anatomic abnormalities, such as deviated nasal septum, resistant organisms, allergy to medication, recurrent sinusitis, chronic sinusitis, or other reasons) (G9313)

OR

Amoxicillin, with or without clavulanate, not prescribed as first line antibiotic at the time of diagnosis, reason not given (G9314)

RATIONALE:
The use of broad-spectrum antibiotics as first line treatment have contributed to the rising incidence of drug-resistant strains of bacteria and to increased costs.

Once antibiotics therapy is initiated due to severity and/or duration of symptoms, the goal is to choose a first-line antibiotic treatment that is efficacious, cost-effective and that results in minimal side effects. The justification for amoxicillin as first-line therapy for most patients with ABRS relates to its favorable adverse effect profile, efficacy, low cost, and narrow microbiologic spectrum.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:
AAO-HNS Sinusitis Guideline (2007)

If a decision is made to treat ABRS with an antibiotic agent, the clinician should prescribe amoxicillin as first-line therapy for most adults.

Recommendation based on randomized controlled trials with heterogeneity and noninferiority design with a preponderance of benefit over harm.

IDSA Clinical Practice Guideline for Acute Bacterial Rhinosinusitis in Children and Adults (2012)

Amoxicillin-clavulanate rather than amoxicillin alone is recommended as empiric antimicrobial therapy for ABRS in adults (weak, low).
Evidence for at least 1 critical outcome from observational studies, from RCTs with serious flaws or indirect evidence.

▲ Measure #333: Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of acute sinusitis who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis

INSTRUCTIONS:
This measure is to be reported once for each occurrence for patients with acute sinusitis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of acute sinusitis

Definitions:
Acute Sinusitis/Rhinosinusitis: Up to 4 weeks of purulent nasal drainage (anterior, posterior, or both) accompanied by nasal obstruction, facial pain-pressure-fullness, or both:
Purulent nasal discharge is cloudy or colored, in contrast to the clear secretions that typically accompany viral upper respiratory infection, and may be reported by the patient or observed on physical examination
Nasal obstruction may be reported by the patient as nasal obstruction, congestion, blockage, or stuffiness, or may be diagnosed by physical examination
Facial pain-pressure-fullness may involve the anterior face, periorbital region, or manifest with headache that is localized or diffuse

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for acute sinusitis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 461.0, 461.1, 461.2, 461.3, 461.8, 461.9
Diagnosis for acute sinusitis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J01.00, J01.10, J01.20, J01.30, J01.40, J01.80, J01.90
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:

Patients who had a computerized tomography (CT) scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis

Numerator Options:
CT scan of the paranasal sinuses ordered at the time of diagnosis or received within 28 days after date of diagnosis (G9349)

OR

CT scan of the paranasal sinuses ordered at the time of diagnosis for documented reasons (e.g., persons with sinusitis symptoms lasting at least 7 to 10 days, antibiotic resistance, immunocompromised, recurrent sinusitis, acute frontal sinusitis, acute sphenoid sinusitis, periorbital cellulitis, or other medical) (G9348)

OR

CT scan of the paranasal sinuses not ordered at the time of diagnosis or received within 28 days after date of diagnosis (G9350)

RATIONALE:
Most cases of uncomplicated acute and subacute sinusitis are diagnosed clinically and should not require any imaging procedure. Sinus CT scanning is of limited value in the routine evaluation of sinusitis due to the high prevalence of abnormal imaging findings. Forty percent of asymptomatic patients and 87 percent of patients with community-acquired colds have sinus abnormalities on sinus CT. Additionally, sinus CT imaging has a high sensitivity but a low specificity for demonstrating acute sinusitis. Furthermore, CT imaging is not recommended for the diagnosis of uncomplicated sinusitis because it is not cost-effective and exposes patients to unnecessary radiation.

Sinusitis cannot be diagnosed on the basis of imaging findings alone. Findings on CT scans should be interpreted in conjunction with clinical and endoscopic findings. Up to 40% of asymptomatic adults have abnormalities on sinus CT scans, as do more than 80% of those with minor upper respiratory tract infections.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:
AAO-HNS Sinusitis Guideline (2007)

Clinicians should not obtain radiographic imaging for patients who meet diagnostic criteria for acute rhinosinusitis, unless a complication or alternative diagnosis is suspected. Recommendation against based on diagnostic studies with minor limitations and a preponderance of benefit over harm.

Radiographic imaging of the paranasal sinuses is unnecessary for diagnosis in patients who already meet clinical diagnostic criteria (Table 5) for acute Rhinosinusitis Imaging modalities for the paranasal sinuses include plain film radiography, computed tomography (CT), and magnetic resonance (MR) imaging. The utility of ultrasound for diagnosis is inconclusive.

Imaging should only be considered for persons with rhinosinusitis symptoms lasting at least 7 to 10 days who have a history of recurrent symptoms or nonresponse to multiple courses of antibiotics in the past.

American College of Radiology ACR Appropriateness Criteria® For Sinonasal Disease (ACR, 2009)
Acute (<4 weeks) and subacute (4-12 weeks) uncomplicated rhinosinusitis.
Radiologic Procedure: CT paranasal sinuses without contrast
Rating: 5
RRL* : 0.1-1 mSv
Comments: Most episodes are managed without imaging as this is primarily a clinical diagnosis. Imaging may be indicated in cases of suspected acute frontal or sphenoid sinusitis or if diagnosis is uncertain.
Radiologic Procedure: MRI head and paranasal sinuses without contrast
Rating: 4

RRL* : 0 mSv
Comments: May be useful as part of a general workup for headache.
Radiologic Procedure: CT paranasal sinuses with contrast
Rating: 2
RRL* : 0.1-1 mSv
Radiologic Procedure: MRI head and paranasal sinuses without and with contrast
Rating: 2
RRL* : 0 mSv
Comments: May be useful as part of a general workup for headache.
Radiologic Procedure: X-ray paranasal sinuses
Rating: 1
RRL* : <0.1 mSv
Rating Scale: 1, 2, 3 Usually not appropriate; 4, 5, 6 May be appropriate; 7, 8, 9 Usually appropriate
*Relative Radiation Level

▲ Measure #334: Adult Sinusitis: More than One Computerized Tomography (CT) Scan Within 90 Days for Chronic Sinusitis (Overuse)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of chronic sinusitis who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after date of diagnosis

INSTRUCTIONS:
This measure is to be reported at each visit for patients with chronic sinusitis during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of chronic sinusitis

Definition:
Chronic Sinusitis/Rhinosinusitis - is defined as twelve (12) weeks or longer of two or more of the following signs and symptoms: mucopurulent drainage (anterior, posterior, or both), nasal obstruction (congestion), facial pain-pressure-fullness, or decreased sense of smell AND inflammation is documented by one or more of the following findings: purulent (not clear) mucus or edema in the middle meatus or ethmoid region, polyps in nasal cavity or the middle meatus, and/or radiographic imaging showing inflammation of the paranasal sinuses.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for chronic sinusitis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 473.0, 473.1, 473.2, 473.3, 473.8, 473.9
Diagnosis for chronic sinusitis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: J32.0, J32.1, J32.2, J32.3, J32.4, J32.8, J32.9
AND
Patient encounter during reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

NUMERATOR:
Patients who had more than one CT scan of the paranasal sinuses ordered or received within 90 days after date of diagnosis

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control. A lower percentage, with a definitional target approaching 0%, indicates appropriate use of CT in cases of chronic sinusitis (eg, not ordering more than one CT scan within 90 days after the date of diagnosis).

Numerator Options:

More than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis, reason not given (G9352)

OR

More than one CT scan of the paranasal sinuses ordered or received within 90 days after the date of diagnosis for documented reasons (e.g., patients with complications, second CT obtained prior to surgery, other medical reasons) (G9353)

OR

One CT scan or no CT scan of the paranasal sinuses ordered within 90 days after the date of diagnosis (G9354)

RATIONALE:

In contrast to acute or isolated cases of sinusitis, chronic or recurrent sinusitis may benefit from additional diagnostic evaluation (eg, CT scan, nasal endoscopy) and management to corroborate a diagnosis and/or investigate for underlying causes. When endoscopic sinus surgery is considered in patients with recurrent or chronic sinusitis, a CT of the paranasal sinuses should be obtained to provide the anatomic detail necessary to guide the surgery. Multiple CT scans, however, are not indicated for chronic sinusitis patients due to risk of radiation overexposure and the fact that sinusitis cannot be diagnosed on the basis of imaging findings alone.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines:
AAO-HNS Sinusitis Guideline (2007)

Diagnostic Testing

The clinician should corroborate a diagnosis and/or investigate for underlying causes of chronic Rhinosinusitis and recurrent acute rhinosinusitis.
Recommendation based on observational studies with a preponderance of benefit over harm.

Radiographic Imaging

The clinician should obtain computed tomography (CT) of the paranasal sinuses in diagnosing or evaluating a patient with chronic rhinosinusitis or recurrent acute Rhinosinusitis (AAO-HNS, 2007).
Recommendation based on diagnostic and observational studies and a preponderance of benefit over harm.
American College of Radiology ACR Appropriateness Criteria®: Sinonasal Disease (ACR, 2009): Recurrent acute or chronic rhinosinusitis (possible surgical candidate)
Radiologic Procedure: CT paranasal sinuses without contrast
Rating: 9
RRL* : 0.1-1 mSv
Comments: Consider using surgical planning protocol.
Radiologic Procedure: CT paranasal sinuses with contrast
Rating: 4
RRL* : 0.1-1 mSv
Radiologic Procedure: MRI head and paranasal sinuses without and with contrast
Rating: 3
RRL* : 0 mSv
Comments: See statement regarding contrast in text under “Anticipated Exceptions.”
Radiologic Procedure: MRI head and paranasal sinuses without contrast
Rating: 2
RRL* : 0 mSv

Radiologic Procedure: X-ray paranasal sinuses
Rating: 1
RRL* : <0.1 mSv
Comments: May be indicated for planning frontal sinus obliteration.
Rating Scale: 1, 2, 3 Usually not appropriate; 4, 5, 6 May be appropriate; 7, 8, 9 Usually appropriate
*Relative Radiation Level

▲ Measure #335: Maternity Care: Elective Delivery or Early Induction Without Medical Indication at ≥ 37 and < 39 Weeks

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, who gave birth during a 12-month period who delivered a live singleton at ≥ 37 and < 39 weeks of gestation completed who had elective deliveries or early inductions without medical indication

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed for patients undergoing elective delivery or early induction during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients, regardless of age, who gave birth during a 12-month period delivering a live singleton at ≥ 37 and < 39 weeks of gestation completed without medical indication for induction

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Live Singleton (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V27.0
Live Singleton (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z37.0
AND
Patient encounter during reporting period (CPT): 59409, 59514, 59612, 59620
AND
Delivery between ≥ 37 and < 39 weeks gestation

NUMERATOR:
Patients who had elective deliveries or early inductions

Numerator Options:
Early elective delivery or early elective induction not performed (≥ 37 and < 39 weeks gestation) (G9355)

OR

Medical indication for induction [Documentation of reason(s) for elective delivery or early induction (e.g., hemorrhage and placental complications, hypertension, preeclampsia and eclampsia, rupture of membranes-premature, prolonged maternal conditions complicating pregnancy/delivery, fetal conditions complicating pregnancy/delivery, malposition and malpresentation of fetus, late pregnancy, prior uterine surgery, or participation in clinical trial)] (G9361)

OR

Early elective delivery or early elective induction performed (≥ 37 and < 39 weeks gestation) (G9356)

RATIONALE:

Elective delivery or early induction often leads to prematurity, increased costs, and an increased incidence of cesarean section. Studies have determined that elective delivery or elective cesarean section prior to the gestational age of 39 weeks may result in significant short term neonatal morbidity (neonatal intensive care unit admission rates of 13-21%). Among women undergoing induction, women with their first pregnancies have a higher rate of cesarean delivery than women with prior vaginal births. Recent research shows that infants born prior to 39 weeks face a higher risk of breathing disorders and other problems than those who remain in the womb longer.

CLINICAL RECOMMENDATION STATEMENTS:

The following evidence statements are quoted verbatim from the referenced clinical guidelines:

ACOG induction of labor guidelines (ACOG, 2009)

The goal of induction of labor is to achieve vaginal delivery by stimulating uterine contractions before the spontaneous onset of labor. Generally, induction of labor has merit as a therapeutic option when the benefits of expeditious delivery outweigh the risks of continuing the pregnancy. The benefits of labor induction must be weighed against the potential maternal and fetal risks associated with this procedure.
"Labor may also be induced for logistic reasons, eg, rapid labor, distance, or psychosocial reasons. In such circumstances, at least 1 of the criteria (for being > 39 weeks) should be met or fetal lung maturity should be established."

Indications for induction of labor are not absolute but should take into account maternal and fetal conditions, gestational age, cervical status, and other factors. Following are examples of maternal or fetal conditions that may be indications for induction of labor:
• Placental abruption
• Chorioamnionitis
• Fetal demise
• Gestational hypertension
• Preeclampsia, eclampsia
• Premature rupture of membranes
• Postterm pregnancy
• Maternal medical conditions (eg, diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome)
• Fetal compromise (eg, severe fetal growth restriction, isoimmunization, oligohydramnios)

The individual patient and clinical situation should be considered in determining when induction of labor is contraindicated. Generally, the contraindications to labor induction are the same as those for spontaneous labor and vaginal delivery. They include, but are not limited to, the following situations:
• Vasa previa or complete placenta previa
• Transverse fetal lie
• Umbilical cord prolapse
• Previous classical cesarean delivery
• Active genital herpes infection
• Previous myomectomy entering the endometrial cavity

▲ Measure #336: Maternity Care: Post-Partum Follow-Up and Care Coordination

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, who gave birth during a 12-month period who were seen for post-partum care within 8 weeks of giving birth who received a breast feeding evaluation and education, post-partum depression screening, post-partum glucose screening for gestational diabetes patients, and family and contraceptive planning

INSTRUCTIONS:
This measure is to be a minimum of once per reporting period for patients seen for post-partum care within 8 weeks of giving birth during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients, regardless of age, who gave birth during a 12-month period seen for post-partum care visit before or at 8 weeks of giving birth

Denominator Criteria (Eligible Cases):
All patients, regardless of age
AND
Patient encounter during reporting period (CPT): 59430, 59510, 59515, 59610, 59614, 59618, 59622
AND
Post-partum Care Visit before or at 8 weeks post-delivery

NUMERATOR:
Patients receiving the following at a post-partum visit:

- Breast feeding evaluation and education, including patient-reported breast feeding
- Post-partum depression screening
- Post-partum glucose screening for gestational diabetes patients and
- Family and contraceptive planning

Definitions:
Breast Feeding Evaluation and Education - Patients who were evaluated for breast feeding before or at 8 weeks post-partum.
Post-Partum Depression Screening - Patients who were screened for post-partum depression before or at 8 weeks post-partum. Questions may be asked either directly by a health care provider or in the form of self-completed paper- or computer administered questionnaires and results should be documented in the medical record. Depression screening may include a self-reported validated depression screening tool (eg, PHQ-2, Beck Depression Inventory, Beck Depression Inventory for Primary Care, Edinburgh Postnatal Depression Scale (EPDS).

Post-Partum Glucose Screening for Gestational Diabetes - Patients who were diagnosed with gestational diabetes during pregnancy who were screened with a glucose screen before or at 8 weeks post-partum.
Family and Contraceptive Planning - Patients who were provided family and contraceptive planning and education *(including contraception, if necessary)* before or at 8 weeks post-partum.

Numerator Instruction: To satisfactorily meet the numerator ALL components (breast feeding evaluation and education, post-partum depression screening, family and contraceptive planning and post-partum glucose screening for patients with gestational diabetes) must be performed.

Numerator Options:
Post-partum screenings, evaluations and education performed (G9357)

OR

Post-partum screenings, evaluations and education not performed (G9358)

RATIONALE:
Managing and ensuring concrete post-partum follow up after delivery is a critical challenge to the health care system impacting the quality of care mothers receive. Post-partum follow-up for depression screening, breast feeding evaluation, family planning, and glucose screening are important risk factors to evaluate after childbirth. Maternal depression is one of the most common perinatal complications; however, the disorder remains unrecognized, undiagnosed, and untreated. The various maternal depression disorders are defined by the severity of the depression and the timing and length of the episode. Studies report that three to 25 percent of women experience major depression during the year following childbirth. Establishing the diagnosis of gestational diabetes mellitus offers an opportunity not only to improve pregnancy outcome, but also to decrease risk factors associated with the subsequent development of type 2 diabetes. The American College of Obstetricians and Gynecologists' Committee on Obstetric Practice recommends that all women with gestational diabetes mellitus be screened at 6-12 weeks postpartum and managed appropriately.

This measure is a measure of the adequacy of the care provided for those that come for postpartum care, as patients who do not have post-partum visits are excluded from this measure.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines.

The following should be included in the postpartum visit (VA/DoD Clinical Practice Guideline for Pregnancy Management, 2009):
- Pelvic and breast examinations.
- Cervical smear should be completed as indicated by cervical cancer screening guidelines. [A]
- Initiate or continue the HPV vaccine series for women age < 26 years [C]
- Screening for postpartum depression
- Screening for domestic violence [B]
- Diabetes testing for patients with pregnancies complicated by gestational diabetes. The two-hour 75g oral glucose tolerance test (GTT) is recommended but a fasting glucose can also be done. [B]
- Education about contraception, infant feeding method, sexual activity, weight, exercise and the woman's assessment of her adaptation to motherhood. Pre-existing or chronic medical conditions should be addressed with referral for appropriate follow-up as indicated. [I]

Breast Feeding
The USPSTF recommends interventions during pregnancy and after birth to promote and support breastfeeding.

This recommendation applies to pregnant women, new mothers, and young children. In rare circumstances involving health issues in mothers or infants, such as human immunodeficiency virus (HIV) infection or galactosemia, breastfeeding may be contraindicated and interventions to promote breastfeeding may not be appropriate. Interventions to promote and support breastfeeding may also involve a woman's partner, other family members, and friends.

Depression Screening

Edinburgh Postnatal Depression Scale (EPDS): The 10-question Edinburgh Postnatal Depression Scale (EPDS) is a valuable and efficient way of identifying patients at risk for “perinatal” depression. The EPDS is easy to administer and has proven to be an effective screening tool. Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt during the previous week. In doubtful cases it may be useful to repeat the tool after 2 weeks.

★ Measure #337: Tuberculosis Prevention for Psoriasis and Psoriatic Arthritis Patients on a Biological Immune Response Modifier

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients whose providers are ensuring active tuberculosis prevention either through yearly negative standard tuberculosis screening tests or are reviewing the patient's history to determine if they have had appropriate management for a recent or prior positive test

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with psoriasis and/or psoriatic arthritis seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients with a diagnosis of psoriasis and/or psoriatic arthritis who are on a biologic immune response modifier

Denominator Criteria (Eligible Cases):
All patients seen within reporting year
AND
Diagnosis for psoriasis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 696.1
Diagnosis for psoriasis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: L40.0, L40.1, L40.2, L40.3, L40.4, L40.8, L40.9
AND/OR
Diagnosis for psoriatic arthritis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 696.0
Diagnosis for psoriatic arthritis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: L40.50, L40.51, L40.52, L40.53, L40.54, L40.59
AND/OR
Diagnosis for rheumatoid arthritis (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 714.0, 714.2, 714.81
Diagnosis for rheumatoid arthritis (ICD-10-CM) [for use 10/01/2014-12/31/2014]: M05.10, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519,

M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.621, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821, M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.20, M06.211, M06.212, M06.219, M06.221, M06.222, M06.229, M06.231, M06.232, M06.239, M06.241, M06.242, M06.249, M06.251, M06.252, M06.259, M06.261, M06.262, M06.269, M06.271, M06.272, M06.279, M06.28, M06.29, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

AND

Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:

Patients who have a documented negative annual TB screening or have documentation of the management of a positive TB screening test with no evidence of active tuberculosis, confirmed through use of radiographic imaging (i.e., chest x-ray, CT)

Numerator Options:

Documentation of negative or managed positive TB screen with further evidence that TB is not active (G9359)

OR

No documentation of negative or managed positive TB screen (G9360)

RATIONALE:

The safety of biologics in terms of their long-term adverse events and their use in different types of psoriasis and in different patient populations is important for clinicians to understand and monitor. Biologics have been associated with a variety of serious and "routine" opportunistic infections, particularly tuberculosis. For this reason, anti-tuberculosis testing both prior to the initiation of a biologic therapy and annually during treatment is pertinent.

CLINICAL RECOMMENDATION STATEMENTS:

When planning to initiate treatment of a patient with psoriasis with a biologic it is important to obtain an age appropriate history and physical examination along with an updated medication list. In addition, it is also important to obtain a reliable set of baseline laboratory studies that will allow the clinician to detect and be aware of any underlying conditions or risk factors. This is particularly important because after patients have been initiated on a biologic treatment, they are likely to be treated with other biologics or systemic therapies and it may be useful to have reliable baseline laboratory studies. Tuberculosis testing (PPD) should be performed on all patients who will be treated with TNF inhibitors as there are reports of tuberculosis reactivation in patients treated with this class of drug. (AAD)

∞ Measure #338 (NQF 2082): HIV Viral Load Suppression

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last viral load test during the measurement year

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV 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.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients, regardless of age, with a diagnosis of HIV who were prescribed antiretroviral therapy for at least 6 months and had a viral load test during the reporting period, AND who had at least two medical visits during the reporting period, with at least 60 days between each visit

Denominator Criteria (Eligible Cases):
Patients, regardless of age, who were prescribed antiretroviral therapy for at least 6 months and had a viral load test during the reporting period
AND
Diagnosis for HIV (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 042, V08
Diagnosis for HIV (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B20, Z21
AND
Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Number of patients with a HIV viral load less than 200 copies/mL at last viral load test

Numerator Options:
Documentation of viral load less than 200 copies/mL (G9243)
OR
Documentation of viral load equal to or greater than 200 copies/mL (G9242)

RATIONALE:
Sustained viral load suppression is directly related to reduction in disease progression and to reduction in potential for transmission of infection. Among persons in care, sustained viral load suppression represents the cumulative

effect of prescribed therapy, ongoing monitoring, and patient adherence. The measure will direct providers' attention and quality improvement efforts towards this important outcome.

CLINICAL RECOMMENDATION STATEMENTS:
Plasma HIV RNA (viral load) should be measured in all patients at baseline and on a regular basis thereafter, especially in patients who are on treatment, because viral load is the most important indicator of response to antiretroviral therapy (ART)…Thus, viral load testing serves as a surrogate marker for treatment response and can be useful in predicting clinical progression.

Optimal viral suppression is generally defined as a viral load persistently below the level of detection (<20–75 copies/mL, depending on the assay used). In addition, low-level positive viral load results (typically <200 copies/mL) appear to be more common with some viral load assays than others, and there is no definitive evidence that patients with viral loads quantified as <200 copies/mL using these assays are at increased risk for virologic failure. For the purposes of clinical trials the AIDS Clinical Trials Group (ACTG) currently defines virologic failure as a confirmed viral load >200 copies/mL, which eliminates most cases of apparent viremia caused by blips or assay variability.

Effective treatment reduces HIV-associated morbidity and mortality and reduces transmission of HIV. The mechanism for the impact of treatment is viral load suppression.

Multiple studies demonstrate that viral load suppression is associated with slowing disease progression. Analysis of 18 trials that included more than 5,000 participants with viral load monitoring showed a significant association between a decrease in plasma viremia and improved clinical outcome. Viral load testing serves as a surrogate marker for treatment response and can be useful in predicting clinical progression. As a result, the Department of Health and Human Services (HHS) Guidelines include a recommendation for measuring viral load at baseline and on a regular basis because viral load is the most important predictor of response to therapy. This recommendation is graded AI. The review of the evidence focuses on the evidence for the treatment and prevention recommendations.

∞ Measure #339 (NQF 2083): Prescription of HIV Antiretroviral Therapy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy for the treatment of HIV infection during the measurement year

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with HIV seen during the reporting period. This measure is intended to reflect the quality of services provided for the primary management of patients with HIV. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients, regardless of age, with a diagnosis of HIV with at least one medical visit in the reporting period

Denominator Criteria (Eligible Cases):
Patients, regardless of age
AND
Diagnosis for HIV (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 042, V08
Diagnosis for HIV (ICD-10-CM) [for use 10/01/2014-12/31/2014]: B20, Z21
AND
Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0402

NUMERATOR:
Number of patients prescribed HIV antiretroviral therapy during the reporting period

Numerator Options:
Antiretroviral therapy prescribed (G9245)
OR
Antiretroviral therapy not prescribed (G9244)

RATIONALE:
The primary goal of antiretroviral therapy (ART) is to reduce HIV-associated morbidity and mortality. This is best accomplished by using antiretroviral therapy to maximally inhibit HIV replication, as measured by consistent plasma HIV RNA (viral load) values below the level of detection using commercially available assays.

Measure reflects important aspect of care that significantly impacts survival, mortality and hinders transmission.

CLINICAL RECOMMENDATION STATEMENTS:

Antiretroviral therapy (ART) reduces HIV-associated morbidity and mortality by maximally inhibiting HIV replication (as defined by achieving and maintaining plasma HIV RNA (viral load) below levels detectable by commercially available assays). Durable viral suppression improves immune function and quality of life, lowers the risk of both AIDS-defining and non-AIDS-defining complications, and prolongs life. Emerging evidence also suggests that additional benefits of ART-induced viral load suppression include a reduction in HIV-associated inflammation and possibly its associated complications.

Measures of viral replication are known to predict HIV disease progression. Among untreated HIV-infected individuals, time to clinical progression and mortality is fastest in those with greater viral loads. This finding is confirmed across the wide spectrum of HIV-infected patient populations such as injection drug users (IDUs), women, and individuals with hemophilia. Several studies have shown the prognostic value of pretherapy viral load for predicting post-therapy response. Once therapy has been initiated, failure to achieve viral suppression and viral load at the time of treatment failure is predictive of clinical disease progression.

ART has also been shown to reduce transmission of HIV and increases the length of survival. The risk of sexual HIV transmission is highly correlated with HIV viral load in the blood and genital secretions of the infected individual, and ART reduces HIV blood viral load as well as HIV viral shedding in potentially infectious body fluids including semen, cervicovaginal secretions, and anorectal secretions.

Φ Measure #342 (NQF 0209): Pain Brought Under Control Within 48 Hours

2014 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Patients aged 18 and older who report being uncomfortable because of pain at the initial assessment (after admission to palliative care services) who report pain was brought to a comfortable level within 48 hours

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients admitted for palliative care services during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 and older admitted to palliative care services who communicated and self reported that they were uncomfortable due to pain at the initial assessment (by responding "yes" when asked if they were uncomfortable because of pain)

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT or HCPCS): 99324, 99325, 99326, 99337, 99377 G0182
AND
Patient able to Communicate and Understand the Language of the Person Asking
AND
Patient Self Reported Uncomfortable due to Pain at the Initial Assessment

NUMERATOR:
Patients whose pain was brought to a comfortable level within 48 hours of initial assessment (after admission to palliative care services)

Definition:
Comfortable Level: For the purpose of reporting this measure, achievement of comfort should be assessed as defined by the patient's response (of "yes" or "no" when asked if their pain was brought to a comfortable level within 48 hours after the initial assessment).
Within 48 Hours: The lookback window for the pain management measure question is 48 hours. The follow up measure question should be asked between 48 to 72 hours from the initial evaluation. The follow up question should not be asked prior to 48 hours.

Numerator Options:

Documentation of patient pain brought to a comfortable level within 48 hours from initial assessment (G9250)

OR

Documentation of patient with pain not brought to a comfortable level within 48 hours from initial assessment (G9251)

RATIONALE:

Poorly controlled pain diminishes patient quality of life and functional status, and causes suffering for patients and family caregivers. Pain is highly prevalent in the palliative care population, so the timely evaluation and treatment of pain at the start of palliative services is a priority. This measure is particularly important because it ensures integration of patient choice for desired level of treatment with the care process by incorporating the patient's own pain goals and perception of his or her own degree of comfort. If pain is an individual experience with an individual response, then the decision of what is comfortable should be left up to the individual, not determined arbitrarily by a clinician. It's more consistent with patient-centered care to care to ask the patient to decide how comfortable he/she wants to be, rather than aim for a specific numeric pain intensity rating, even if that rating can be linked to functionality. The Comfortable Dying measure also allows for a broader conceptualization of pain than use of a measure that relies solely on a numeric intensity rating.

CLINICAL RECOMMENDATION STATEMENTS:

This measure is designed to evaluate the effectiveness and timeliness of initial pain management after the start of palliative care services. Pain control may be immediate but pain management occurs over time. Therefore, the look-back window for follow-up after the initial pain assessment is 48 hours. The clinician should contact the patient the number of times and at intervals as clinically appropriate for good pain management practice.

But the patient should not be asked the follow-up question for the purpose of data collection to inform the measure

numerator until at least 48 hours after the initial assessment.

β Measure #343: Screening Colonoscopy Adenoma Detection Rate

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
The percentage of patients age 50 years or older with at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy

INSTRUCTIONS:
This measure is to be reported each time
a screening colonoscopy for colorectal cancer is performed during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients age 50 years or older undergoing a screening colonoscopy

Definitions:
Colorectal Cancer Precursor Lesions: Based on pathologic diagnosis, colorectal cancer precursor lesions include: adenomatous polyps [tubular, tubulovillous, villous] and traditional serrated adenomas, sessile serrated polyps and sessile serrated adenomas.

Denominator Criteria (Eligible Cases):
Patients 50 years of age or older on date of encounter
AND
Risk factors for colorectal cancer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: V16.0, V18.51, V76.51
Risk factors for colorectal cancer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: Z12.11, Z80.0, Z83.71
AND
Patient encounter during reporting period (CPT or HCPCS): 45378, 45380, 45381, 45383, 45384, 45385, G0121
WITHOUT
CPT Category I Modifiers: 52, 53, 73, 74

NUMERATOR:
Number of patients age 50 years or older with at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy

Numerator Options:
Adenoma(s) or other neoplasm detected during screening colonoscopy (G9252)
OR

Adenoma(s) or other neoplasm not detected during screening colonoscopy (G9253)

RATIONALE:
The removal of adenomatous polyps during a screening colonoscopy is associated with a lower risk of subsequent colorectal cancer incidence and mortality. Higher adenoma detection rates (> 20% in a mixed gender population) are associated with significant protection against incident colorectal cancer in the five years following screening colonoscopy. Up to 30% of colorectal cancers arise from serrated neoplasms including sessile serrated polyps, sessile serrated adenomas and traditional serrated adenomas.

CLINICAL RECOMMENDATION STATEMENTS:
The United States Preventive Services Task Force has recommended screening colonoscopy for adults, beginning at age 50 and continuing until age 75 (Grade A recommendation) Screening exams are those performed to detect lesions in the absence of signs, symptoms, or personal history of colon neoplasia. The adenoma detection rate is an independent predictor of risk of developing colorectal cancer between screening colonoscopies. However, studies have documented wide variation in adenoma detection rates, illustrating the need for measuring and monitoring this metric for endoscopists. Some studies have identified variation due to the location of adenomas (lesions in the colon's right side are more difficult to detect). Procedure length has also been found in some, but not all, studies to correlate with adenoma detection rate. The adenoma detection rate varies between genders, with a lower rate demonstrated in women. Multi-specialty and stakeholder guidelines support the importance of measuring the adenoma detection rate in the prevention of colorectal cancer. Guidelines and the supporting literature consistently recommend an adenoma detection rate of at least 15% in women and at least 25% in men. . Multi-specialty guidelines support the detection and complete removal of serrated colorectal neoplasms and surveillance of individuals with these lesions.

✦ Measure #344: Rate of Carotid Artery Stenting (CAS) for Asymptomatic Patients, Without Major Complications (Discharged to Home by Post-Operative Day #2)

2014 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CAS who are discharged to home no later than post-operative day #2

INSTRUCTIONS:
This measure is to be reported each time a CAS is performed during the reporting period. It is anticipated that clinicians who provide services of CAS, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 and older who are asymptomatic undergoing CAS

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT or HCPCS): 37215
AND NOT
Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure: 9006F
OR
Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke: 9007F

NUMERATOR:
Patients discharged to home no later than post-operative day 2 following CAS

Definition:
Home – For purposes of reporting this measure, home is the point of origin prior to hospital admission prior to procedure. For example, if the patient comes from a skilled facility and returns to the skilled facility, this would meet criteria for discharged to home.

Numerator Options:
Documentation of patient discharged to home no later than post-operative day 2 following CAS (G9255)
OR

Documentation of patient discharged to home later than post-operative day 2 following CAS (G9254)

RATIONALE:
Surgeons performing CAS on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. Discharge to home within two days of the procedure is an indicator of patients who were not frail prior to the procedure and who did not experience a major complication (e.g., disabling stroke, myocardial infarction). The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATIONS STATEMENTS:
Percutaneous carotid intervention is a rapidly emerging field. Published trial results have established carotid stenting (CAS) in high risk surgical patients to be an effective alternative to carotid endarterectomy (CEA). It is well established that CEA benefits patients with asymptomatic >60% stenosis only if performed with a high degree of technical proficiency on appropriately selected patients. The same is proposed to hold true for CAS. This is particularly important when considering an asymptomatic population where the relative risk reduction with intervention is narrow when compared to medical management. Numerous publications have noted variation in the combined endpoint of stroke and death following carotid angioplasty and stent placement with embolic protection (Percutaneous Transluminal Angioplasty, Cochrane Database Syst Rev 2007). Adoption of this outcome measure in the United States would likely disclose disparate results between hospitals and between providers, and lead to quality improvement when this information was provided to individual providers and participating centers. The SVS Vascular Registry has shown that outcome results are good for CAS, but variations exist between interventionalists and centers. Postoperative stroke or death is the accepted outcome parameter for this procedure, and its measurement and reporting would demonstrate variation and opportunity for improvement. CAS is an elective procedure in nearly all cases. Patients can be referred or transferred to a center with the personnel and experience to perform this procedure with a high level of competence and any procedure that has "stroke" as a potential risk should be performed only by individuals with appropriate training and experience. (Carotid Artery Angioplasty, J Vasc Interv Radiol 2003)

✦ Measure #345: Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS)

2014 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CAS who experience stroke or death following surgery while in the hospital

INSTRUCTIONS:
This measure is to be reported each time a CAS is performed during the reporting period. It is anticipated that clinicians who provide services of CAS, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 and older who are asymptomatic undergoing CAS

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT): 37215
AND NOT
Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure: 9006F
OR
Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke: 9007F

NUMERATOR:
Patients who experience stroke or death in the hospital following CAS

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
Documentation of patient stroke following CAS (G9257)
OR
Documentation of patient death following CAS (G9256)

OR

Documentation of patient survival and absence of stroke following CAS (G9259)

RATIONALE:
Surgeons performing CAS on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
Updated Society for Vascular Surgery guidelines for management of extracranial carotid disease. Ricotta et al, J Vasc Surg, 54:3, 2011

Neurologically asymptomatic patients with ≥ 60% diameter stenosis should be considered for CAS for reduction of long-term risk of stroke, provided the patient has a 3- to 5-year life expectancy and perioperative stroke/death rates can be ≤ 3% (GRADE 1, Level of Evidence A).

✦ Measure #346: Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Endarterectomy (CEA)

2014 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percent of asymptomatic patients undergoing CEA who experience stroke or death following surgery while in the hospital

INSTRUCTIONS:
This measure is to be reported each time a CEA is performed during the reporting period. It is anticipated that clinicians who provide services of CEA, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 and older who are asymptomatic undergoing CEA

Denominator Criteria (Eligible Cases):
Patients aged 18 and older
AND
Patient encounter during reporting period (CPT): 35301
AND NOT
Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure: 9006F
OR
Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke: 9007F

NUMERATOR:
Patients who experience stroke or death in the hospital following CEA

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:
Documentation of patient stroke following CEA (G9258)
OR
Documentation of patient death following CEA (G9260)

OR

Documentation of patient survival and absence of stroke following CEA (G9261)

RATIONALE:
Surgeons performing CEA on asymptomatic patients must select patients at low risk for morbidity and perform the procedure with a very low complication rate in order to achieve benefit. The proposed measure will therefore serve as an indicator of both appropriateness and overall outcome.

CLINICAL RECOMMENDATION STATEMENTS:
Updated Society for Vascular Surgery guidelines for management of extracranial carotid disease. Ricotta et al, J Vasc Surg, 54:3, 2011

Neurologically asymptomatic patients with ≥ 60% diameter stenosis should be considered for CEA for reduction of long-term risk of stroke, provided the patient has a 3- to 5-year life expectancy and perioperative stroke/death rates can be ≤ 3% (GRADE 1, Level of Evidence A).

✦ Measure #347: Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured Abdominal Aortic Aneurysms (AAA) Who Die While in Hospital

2014 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percent of patients undergoing endovascular repair of small or moderate abdominal aortic aneurysms (AAA) who die while in the hospital

INSTRUCTIONS:
This measure is to be reported each time an EVAR is performed during the reporting period. It is anticipated that clinicians who provide services of EVAR, as described in the measure, based on the services provided and the measure-specific denominator coding will report this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients aged 18 and older with infrarenal non-ruptured endovascular AAA repairs

> Denominator Criteria (Eligible Cases):
> Patients aged 18 and older
> AND
> Patient encounter during reporting period (CPT): 34800, 34802
> AND NOT
>
> *For women:*
> Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9003F
> OR
> Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F
> OR
> *For men:*
> Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT: 9004F

NUMERATOR:
Patients who die in the hospital following endovascular AAA repair

> Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Numerator Options:

Documentation of patient death in the hospital following endovascular AAA repair (G9262)

OR

Documentation of patient survival in the hospital following endovascular AAA repair (G9263)

RATIONALE:

Elective repair of a small or moderate sized AAA is a prophylactic procedure and the mortality/morbidity of the procedure must be contrasted with the risk of rupture over time. Surgeons should select patients for intervention who have a reasonable life expectancy and who do not have a high surgical risk.

CLINICAL RECOMMENDATION STATEMENTS:

The care of patients with an abdominal aortic aneurysm: The Society for Vascular Surgery practice guidelines. Chaikof et al, J Vasc Surg, 50:4, supplement, 2009.

Elective repair is recommended for patients that present with a fusiform AAA ≥5.5 cm in maximum diameter, in the absence of significant co-morbidities.

Surveillance is recommended for most patients with a fusiform AAA in the range of 4.0 cm to 5.4 cm in maximum diameter.

£ Measure #348: HRS-3 Implantable Cardioverter-Defibrillator (ICD) Complications Rate

2014 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Patients with physician-specific risk-standardized rates of procedural complications following the first time implantation of an ICD

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with a first time implantation of an ICD during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. NOTE: Include only patients that have had first time implantation through November 30 for evaluation of complications for 30 days and September 30 for evaluation of complications for 90 days post procedure within the reporting period. This will allow the evaluation of ICD implant complications within the reporting year.

This is a risk adjusted measure. Please refer to the "Hierarchical logistic regression" at the end of this specification.

There are 2 rates to be calculated for this measure:

1) Complications or mortality at 30 days
   OR
2) Complications at 90 days

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

There are two reporting criteria for this measure:
(1) Patients with first time implants with one or more complications or mortality within 30 days

OR

(2) Patients with first time implants with one or more complications within 90 days

The eligible professional should submit data on both reporting criteria 1 and 2 for a patient that meets the denominator.

REPORTING CRITERIA 1: All patients with first time implants with one or more of the identified complications or mortality within 30 days

DENOMINATOR (REPORTING CRITERIA 1):
Patients with a first time implantation of an ICD

Denominator Instructions: Include patients with procedures that are performed ≥ 31 days prior to the end of the reporting period. Denominator patients can be identified using the following ICD-9 or ICD-10 codes.

Denominator Criteria (Eligible Cases):
Patient aged ≥ 65 years on date of encounter
AND
Implantation of ICD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 00.50, 00.51, 00.52, 00.53, 00.54, 37.94
Implantation of ICD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: OJH607Z, OJH637Z, OJH807Z, OJH837Z, OJH608Z, OJH638Z, OJH808Z, OJH838Z, OJH609Z, OJH639Z, OJH809Z, OJH839Z
AND/OR
Patient encounter during reporting period (CPT): 33216, 33217, 33218, 33220, 33223, 33240, 33241, 33249
AND NOT
OJPT0PZ, OJPT3PZ

NUMERATOR (REPORTING CRITERIA 1):
Number of patients with one or more of the following complications or mortality within 30 days (depending on the complication) following ICD implantation

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.
Definitions:
Complications measured for 30 days:
1. Death
2. Pneumothorax or hemothorax plus a chest tube
3. Hematoma plus a blood transfusion or evacuation
4. Cardiac tamponade or pericardiocentesis

Numerator Options:
Documentation of patient with one or more complications or mortality within 30 days (G9267).

OR

Documentation of patient without one or more complications and without mortality within 30 days (G9269).

REPORTING CRITERIA 2: All patients with first time implants with one or more of the identified complications within 90 days

DENOMINATOR (REPORTING CRITERIA 2):
Patients with a first time implantation of an ICD

Denominator Instructions: Include patients with procedures that are performed ≥ 91 days prior to the end of the reporting period. Denominator patients can be identified using the following ICD-9 or ICD-10 codes.

Denominator Criteria (Eligible Cases):
Patient aged ≥ 65 years on date of encounter
AND
Implantation of ICD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 00.50, 00.51, 00.52, 00.53, 00.54, 37.94
Implantation of ICD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: OJH607Z, OJH637Z, OJH807Z, OJH837Z, OJH608Z, OJH638Z, OJH808Z, OJH838Z, OJH609Z, OJH639Z, OJH809Z, OJH839Z
AND/OR
Patient encounter during reporting period (CPT): 33216, 33217, 33218, 33220, 33223, 33240, 33241, 33249

AND NOT
OJPT0PZ, OJPT3PZ

NUMERATOR (REPORTING CRITERIA 2):
Number of patients with one or more of the following complications within 90 days (depending on the complication) following ICD implantation

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control.

Definitions:
Complications measured for 90 days:
1. Mechanical complications requiring a system revision
2. Device related infection
3. Additional ICD implantation

Numerator Options:
Documentation of patient with one or more complications within 90 days (G9268)
OR
Documentation of patient without one or more complications within 90 days (G9270)

RATIONALE:
The proposed measure of ICD complications has the potential to significantly improve the quality of care delivered to patients with advanced heart disease. The model used for risk adjustment meets recognized standards for outcomes measurement and was developed with extensive input from stakeholders with a broad range of expertise and perspectives. The study sample is appropriately defined, consisting of an ICD population that has distinct outcomes that will allow for valid comparisons of physician quality. The definition of the complications, the complication-specific period of assessment, and the risk-adjustment variables all have strong face validity, which may facilitate physician acceptance. We excluded covariates that we would not want to adjust for in a quality measure.

In summary, we present an ICD complications measure that is suitable for public reporting. The proposed measure capitalizes on the National Cardiovascular Data Registry (NCDR) ICD Registry data already collected as part of an ongoing collaboration between CMS and NCDR. Accordingly, the incremental burden of data collection on physicians would be minimal and the proposed measure could be implemented by using the direct patient identifiers already being collected by CMS.

CLINICAL RECOMMENDATION STATEMENTS:
ICD implantation is an expensive procedure performed on patients with advanced cardiovascular disease and, often, significant comorbidities. Despite improvements in technology and increasing experience with device implantation, the procedure carries a significant risk of complications (Hammill, Curtis, 2008).

- Roughly 150,000 ICDs are implanted each year and approximately two thirds of implantations are performed on Medicare patients.

- Direct total medical cost per device (2005) (Sanders, Hlatky et al. 2005) is $68,000-$100,000. The total national costs range from $10-$15 billion, of which $7-$10 billion represents fee-for-service Medicare.

- Complications are expensive and, in one study (Reynolds et al, 2006), associated with increased length of stay (1-10 days) and costs $5,000 – 20,000 (mean $7,251), adding roughly $80 million in Medicare costs.

- Reported complication rates following ICD implantation vary from 4% to 30%, depending largely on how complications are defined and the period of assessment. In the NCDR ICD Registry, the incidence of in-

hospital complications is approximately 4%. However, complications such as device infection, malfunction, or cardiac tamponade are not fully captured by the registry since they may only become evident following hospital discharge.

- Al-Khatib et al (2008) analyzed administrative claims data and found overall rates of complication within 90 days of ICD implantation ranged from 18.8% in 2002 to 14.2% in 2005 (Al-Khatib et al, 2005).

We analyzed Medicare FFS administrative claims to assess complications rates following ICD implantation. From 2006 through 2009, a total of 105,575 implants performed by 3,488 physicians met inclusion/exclusion criteria and were included in the analysis. The number of eligible implants increased over time from 22,931 in 2006 to 28,383. The overall complication rate decreased modestly over this time period, from 8.60% to 7.55%. The rate of mechanical complications requiring system revision had the largest decrease over time (0.78%), but similar relative declines were seen across all complications. As expected, the characteristics of patients with and without adverse events differed significantly. Most notably, patients receiving a CRT-D device had a significantly higher complication rate than patients receiving a single and dual chamber device (8.09%, 6.30%, and 5.33% respectively). These results demonstrate an opportunity to improve physician-level performance.

Hierarchical logistic regression

The specification is designed to align with the NQF-endorsed *Hospital Risk-Standardized Complication Rate following Implantation of Implantable Cardioverter-Defibrillator* performance measure (NQF #0694).

The variables apply to both the 30 and 90 day outcomes, but how the variables are to be utilized within the performance calculation is part of a risk model developed by Yale.

𝄞 Measure #349 (NQF 0076): Optimal Vascular Care Composite

2014 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES
REGISTRY ONLY

DESCRIPTION:
Percent of patients aged 18 to 75 with ischemic vascular disease (IVD) who have optimally managed modifiable risk factors demonstrated by meeting all of the numerator targets of this patient level all-or-none composite measure: LDL less than 100, blood pressure less than 140/90, tobacco-free status, and daily aspirin use

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with IVD during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. All components of this composite must be documented with the specified outcomes in order to meet performance of the measure.

Each component within this composite measure should be reported in order to calculate the reporting rate and performance rate for the overall percentage of patients that meet performance for ALL targets indicated. Reporting and performance rates will be required for each component of this composite measure.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

This measure will be calculated with 5 performance rates:
1) Overall percentage for patients that meet performance for ALL targets indicated
2) The most recent LDL test during the measurement period including the last 3 months of the prior measurement period with a value of <100
3) Percentage of patients with most recent blood pressure in the measurement period that have a systolic value of <140 and a diastolic value of <90 (BOTH values must be less than)
4) Percentage of patients with documentation in the chart that the patient is currently a non-tobacco user
5) Percentage of patients with documentation in the measurement period that the patient is on daily aspirin or has documentation of a valid contraindication to aspirin

DENOMINATOR:
Patients aged 18 through 75 with the diagnosis of IVD. Eligible patients are those that have two or more face-to-face visits for IVD in the last two years and at least one visit for any reason in the last 12 months.

DENOMINATOR NOTE: In order for the patient to be included in the denominator criteria, the patient must have two denominator eligible encounters within the current measurement period and prior measurement period AND at least one visit for any reason in the current measurement period.

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75

AND

Diagnosis for IVD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.30, 440.31, 440.32, 440.4, 444.0, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

Diagnosis for IVD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I23.0, I23.1, I23.2, I23.3, I23.4, I23.5, I23.6, I23.7, I23.8, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.3, I25.41, I25.42, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I65.01, I65.02, I65.03, I65.09, I65.1, I65.21, I65.22, I65.23, I65.29, I65.8, I65.9, I66.01, I66.02, I66.03, I66.09, I66.11, I66.12, I66.13, I66.19, I66.21, I66.22, I66.23, I66.29, I66.3, I66.8, I66.9, I67.2, I70.0, I70.1, I70.201, I70.202, I70.203, I70.208, I70.209, I70.211, I70.212, I70.213, I70.218, I70.219, I70.221, I70.222, I70.223, I70.228, I70.229, I70.231, I70.232, I70.233, I70.234, I70.235, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.261, I70.262, I70.263, I70.268, I70.269, I70.291, I70.292, I70.293, I70.298, I70.299, I70.301, I70.302, I70.303, I70.308, I70.309, I70.311, I70.312, I70.313, I70.318, I70.319, I70.321, I70.322, I70.323, I70.328, I70.329, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.361, I70.362, I70.363, I70.368, I70.369, I70.391, I70.392, I70.393, I70.398, I70.399, I70.401, I70.402, I70.403, I70.408, I70.409, I70.411, I70.412, I70.413, I70.418, I70.419, I70.421, I70.422, I70.423, I70.428, I70.429, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.461, I70.462, I70.463, I70.468, I70.469, I70.491, I70.492, I70.493, I70.498, I70.499, I70.501, I70.502, I70.503, I70.508, I70.509, I70.511, I70.512, I70.513, I70.518, I70.519, I70.521, I70.522, I70.523, I70.528, I70.529, I70.531, I70.532, I70.533, I70.534, I70.535, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.548, I70.549, I70.55, I70.561, I70.562, I70.563, I70.568, I70.569, I70.591, I70.592, I70.593, I70.598, I70.599, I70.601, I70.602, I70.603, I70.608, I70.609, I70.611, I70.612, I70.613, I70.618, I70.619, I70.621, I70.622, I70.623, I70.628, I70.629, I70.631, I70.632, I70.633, I70.634, I70.635, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.648, I70.649, I70.65, I70.661, I70.662, I70.663, I70.668, I70.669, I70.691, I70.692, I70.693, I70.698, I70.699, I70.701, I70.702, I70.703, I70.708, I70.709, I70.711, I70.712, I70.713, I70.718, I70.719, I70.721, I70.722, I70.723, I70.728, I70.729, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744, I70.745, I70.748, I70.749, I70.75, I70.761, I70.762, I70.763, I70.768, I70.769, I70.791, I70.792, I70.793, I70.798, I70.799, I70.8, I70.90, I70.91, I70.92, I73.9, I74.01, I74.09, I74.10, I74.11, I74.19, I74.2, I74.3, I74.4, I74.5, I74.8, I74.9, I75.011, I75.012, I75.013, I75.019, I75.021, I75.022, I75.023, I75.029, I75.81, I75.89; I76

AND

Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99455, 99456, G0402

AND

Two Denominator Eligible Visits and at Least One Visit for Any Reason

AND NOT

Patient Died Prior to the End of the Measurement Period

OR

Patient was a Permanent Nursing Home Resident

OR

Patient was in Palliative Care Services at any time During the Measurement Period

NUMERATOR (All or Nothing):
The number of IVD patients aged 18 to 75 years who met ALL of the following targets:

- The most recent LDL test in the measurement period has a value <100
- The most recent Blood Pressure in the measurement period has a systolic value of <140 and a diastolic value of <90 (BOTH values must be less than)
- There is documentation in the chart that the patient is currently a non-tobacco user
- There is documentation in the measurement period that the patient is on daily aspirin or has documentation of a valid contraindication to aspirin

Numerator Options:
Each component should be reported in order to determine the reporting and performance rate for the overall percentage of patients that meet ALL targets represented as the numerator.

COMPONENT 1:
The most recent LDL test during the measurement period including the last 3 months of the prior measurement period with a value of <100

Component Options:
LDL value <100 (G9271)
OR
LDL value ≥ 100 (G9272)

AND

COMPONENT 2:
Patients with most recent blood pressure in the measurement period that have a systolic value of <140 and a diastolic value of <90 (BOTH values must be less than)

Component Options:
Blood Pressure has a systolic value of <140 and a diastolic value of < 90 (G9273)
OR
Blood Pressure has a systolic value of ≥140 and a diastolic value of ≥ 90 OR systolic value < 140 and diastolic value ≥ 90 OR systolic value ≥ 140 and diastolic value < 90 (G9274)

AND

COMPONENT 3:
Documentation in the chart that the patient is currently a non-tobacco user

Component Options:
Documentation that patient is a current non-tobacco user (G9275)
OR
Documentation that patient is a current tobacco user (G9276)

AND

COMPONENT 4:
Documentation in the measurement period that the patient is on daily aspirin or has documentation of a valid contraindication to aspirin

Component Options:
Documentation that the patient is on daily aspirin or has documentation of a valid contraindication to aspirin
Automatic contraindications include anti-coagulant use, allergy, and history of gastrointestinal bleed. Additionally, any reason documented by the physician as a reason for not taking daily aspirin is acceptable (examples include non-steroidal anti-inflammatory agents, risk for drug interaction, or uncontrolled hypertension defined as > 180 systolic or > 110 diastolic) (G9277)
OR
Documentation that the patient is not on daily aspirin regimen (G9278)

RATIONALE:
According to the Minnesota Department of Health, vascular disease is a high impact clinical condition in Minnesota. Approximately 20% of all deaths in Minnesota are due to heart disease and approximately 5% are due to stroke, making them the second and fourth leading causes of death, respectively, in the state behind cancer. Inpatient hospitalization charges alone in Minnesota were $1.79 billion for heart disease patients and $367 million for stroke patients in 2009. Prevalence of risk factors reported by Minnesotans include 34% high cholesterol, 22% high blood pressure, 17% cigarette smoke, 5% diabetes, 63% overweight or obese, and 16% physical inactivity. According to the American Heart Association (2013) Heart Disease and Stoke Statistics, more than 83 million Americans have one or more types of cardiovascular disease. In 2009 the overall death rate attributable to CVD was 236.1 per 100,000. From 1999 to 2009, the relative rate of death attributable to CVD declined by 32.7%, yet still accounted for 32.3% or one of every three deaths in the United States.

CLINICAL RECOMMENDATION STATEMENTS:
Guidelines referenced include the ICSI Institute for Clinical Systems Improvement and the American Heart Association. [https://www.icsi.org/_asset/t6bh6a/SCAD.pdf, http://circ.ahajournals.org/content/126/25/e354]

ICSI Stable Coronary Artery Disease 2014

Hyperlipidemia

A fasting lipid profile should be evaluated for appropriate patients with stable coronary artery disease. Secondary prevention is important in these patients, who should be treated aggressively for hyperlipidemia. Many patients will require both pharmacologic and non-pharmacologic interventions to reach target goals. Target goals for hyperlipidemic patients with coronary artery disease include:

LDL – less than 100 mg/dL for all patients, ideal less than 70 mg/dL especially for high-risk patients

HDL – 40 mg/dL or greater

Triglycerides – less than 150 mg/dL

Hypertension

General health measures include the treatment of hypertension, which is not only a risk factor for development and progression of atherosclerosis, but also causes cardiac hypertrophy, augments myocardial oxygen requirements, and thereby intensifies myocardial ischemia in patients with obstructive coronary disease.

Please refer to the ICSI Hypertension Diagnosis and Treatment guideline for recommendations regarding blood pressure management. The recommended target blood pressure is 140/90 mmHg or less. Based on current evidence, pursuing blood pressure goals lower than < 140/90 should be considered on an individual patient basis based on clinical judgment and patient preference *(ACCORD Study Group, 2010 [High Quality Evidence], Cooper-DeHoff, 2010 [Meta-analysis]).* Please see ICSI Hypertension Diagnosis and Treatment guideline for more information.

Smoking

Cigarette smoking may cause an acute cardiac ischemic event and may interfere with the efficacy of medications to relieve angina.

Aspirin and Anti-platelet Therapy

Recommendation: The use of one aspirin tablet daily (81 mg) is strongly recommended unless there are medical contraindications.

Antiplatelet Therapy

The use of one aspirin tablet daily (81 mg) is strongly recommended unless there are medical contraindications *(Kurth, 2003 [High Quality Evidence]; CAPRI, 1996 [High Quality Evidence]; Antiplatelet Trialists' Collaboration, 1994 [High Quality Evidence]; Fuster, 1993 [Low Quality Evidence]; Juul-Möller, 1992 [High Quality Evidence]; Ridker, 1991 [High Quality Evidence])*.

The Antithrombotic Trialists' Collaboration is a meta-analysis that analyzed 287 studies involving 135,000 patients for different aspects of antiplatelet therapy. When comparing the 500-1,500 mg versus 160-325 mg versus 75-150 mg daily regimens of aspirin in multiple trials, there was a trend of reduction in vascular events with decreased dose (odds reduction: 19% versus 26% versus 32%, respectively) *(Antithrombotic Trialists Collaboration, 2002 [Meta-analysis])*. Although the meta-analysis concludes that risk of gastrointestinal bleed was similar among doses 325 mg or less, other studies such as the CURE study showed increased bleeding risk.

ACCF/AHA/AATS/PCNA/SCAI/ STS: Guideline for the Diagnosis and Management of Patients With Stable Ischemic Heart Disease 2012

Lipid Management:

Epidemiological studies have established serum cholesterol as an important coronary heart disease risk factor. The Framingham Heart Study, Multiple Risk Factor Intervention trial, and the Lipid Research Clinics trials all found a continuous, graded increase in coronary events with increasing LDL cholesterol in men and women who were initially free of IHD. A similar relationship has been observed among patients with SIHD. The association between LDL cholesterol and cardiovascular risk is curvilinear, or log-linear, meaning that the decrease in RR for a given 1-mg/dL decrease in LDL cholesterol seems to be the same at any level of baseline LDL cholesterol. An update of the ATP-III report recommends treatment to an LDL cholesterol level _100 mg/dL in patients with established CAD or other high-risk features, with an LDL cholesterol goal of 70 mg/dL as a therapeutic option in patients at very high risk.

Blood Pressure Management

1. All patients should be counseled about the need for lifestyle modification: weight control; increased physical activity; alcohol moderation; sodium reduction; and emphasis on increased consumption of fresh fruits, vegetables, and low-fat dairy products.(Level of Evidence: B)
2. In patients with SIHD with BP 140/90 mm Hg or higher, antihypertensive drug therapy should be instituted in addition to or after a trial of lifestyle modifications.538–543 (Level of Evidence: A)
3. The specific medications used for treatment of high BP should be based on specific patient characteristics and may include ACE inhibitors and/or beta blockers, with addition of other drugs, such as thiazide diuretics or calcium channel blockers, if needed to achieve a goal BP of less than 140/90 mm Hg.544,545 (Level of Evidence: B)

Smoking Cessation Counseling

Smoking cessation and avoidance of exposure to environmental tobacco smoke at work and home should be encouraged for all patients with SIHD. Follow-up, referral to special programs, and pharmacotherapy are recommended, as is a stepwise strategy for smoking cessation (Ask, Advise, Assess, Assist, Arrange, Avoid).650–652 (Level of Evidence: B)

Antiplatelet Therapy

1. Treatment with aspirin 75 to 162 mg daily should be continued indefinitely in the absence of contraindications

in patients with SIHD. (*Level of Evidence: A*)
2. Treatment with clopidogrel is reasonable when aspirin is contraindicated in patients with SIHD. (*Level of Evidence: B*)

Measure #358: Patient-centered Surgical Risk Assessment and Communication

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients who underwent a non-emergency surgery who had their personalized risks of postoperative complications assessed by their surgical team prior to surgery using a clinical data-based, patient-specific risk calculator and who received personal discussion of those risks with the surgeon

INSTRUCTIONS:
This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo non-emergency surgical procedures. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
The total number of adult patients (age 18 and over) having had non-emergency surgery

Denominator Instructions: CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population. Both surgeons participating in PQRS will be fully accountable for the clinical action described in the measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Non-emergency surgery
AND
Patient encounter during the reporting period (CPT): Listed below are surgical procedures.

List of Eligible CPT Codes for This Measure

Specialty	Surgical Procedure	CPT code
General Surgery		

	Abdomen, Peritoneum & Omentum	20102, 44111, 49000, 49002, 49010, 49020, 49040, 49060, 49062, 49203, 49204, 49205, 49215, 49220, 49250, 49255, 49321, 49322, 49323, 49324, 49325, 49329, 49402, 49418, 49419, 49421, 49422, 49425, 49426, 49505, 49507, 49520, 49521, 49525, 49540, 49550, 49553, 49555, 49557, 49560, 49561, 49565, 49566, 49570, 49572, 49580, 49582, 49585, 49587, 49590, 49600, 49606, 49650, 49651, 49652, 49653, 49654, 49655, 49656, 49657, 49659, 49900, 49904, 49905, 49906, 49999
	Anorectal	0184T, 45000, 45005, 45020, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45190, 45395, 45397, 45400, 45402, 45499, 45500, 45505, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 45905, 45910, 45999, 46020, 46030, 46040, 46045, 46060, 46080, 46250, 46255, 46257, 46258, 46260, 46261, 46262, 46270, 46275, 46280, 46285, 46288, 46700, 46705, 46706, 46710, 46712, 46715, 46730, 46735, 46740, 46744, 46748, 46750, 46753, 46760, 46761, 46762, 46924, 46930, 46940, 46942, 46945, 46946, 46947, 46999
	Appendix and Meckel's Diverticulum	44800, 44820, 44850, 44899, 44900, 44950, 44960, 44970, 44979
	Bariatric	43644, 43645, 43770, 43771, 43772, 43773, 43774, 43775, 43843, 43845, 43846, 43847, 43848, 43886, 43887, 43888
	Biliary	47420, 47425, 47460, 47480, 47490, 47560, 47561, 47562, 47563, 47564, 47570, 47579, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 47999
	Breast	11960, 19020, 19101, 19110, 19120, 19125, 19296, 19297, 19298, 19300, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 19499
	Colon	44025, 44110, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44188, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44238, 44320, 44322, 44340,44345, 44346, 44604, 44605, 44620, 44625, 44626, 44660, 44661, 44680, 44799
	Endocrine	60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60500, 60502, 60505, 60540, 60545, 60650, 60659, 60699
	Esophagus	43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43279, 43280, 43281, 43282, 43289, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496

	Integumentary	10121, 10140, 10160, 10180, 11000, 11001, 11004, 11005, 11006, 11010, 11011, 11042, 11043, 11044, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11440, 11441, 11442, 11443, 11444, 11446, 11601, 11602, 11603, 14301, 15040, 15150, 15155, 15200, 15220, 15240, 15260, 15570, 15572, 15574, 15576, 15600, 15610, 15620, 15630, 15650, 15731, 15732, 15734, 15736, 15738, 15740, 15750, 15756, 15757, 15758, 15760, 15770, 15830, 15920, 15922, 15931, 15933, 15934, 15935, 15936, 15937, 15940, 15941, 15944, 15945, 15946, 15950, 15951, 15953, 15956, 15958, 20005, 20922, 20926, 20938, 21011, 21012, 21013, 21014, 21015, 21016, 21501, 21502, 21510, 21552, 21554, 21555, 21556, 21557, 21558, 21920, 21925, 21930, 21931, 21932, 21933, 21935, 21936, 22900, 22901, 22902, 22903, 22904, 22905, 22999, 23030, 23071, 23073, 23075, 23076, 23077, 23078, 24065, 24066, 24071, 24073, 24075, 24076, 24077, 24079, 25065, 25066, 25071, 25073, 25075, 25076, 25077, 25078, 26111, 26113, 26115, 26116, 26117, 26118, 26990, 27040, 27041, 27043, 27045, 27047, 27048, 27049, 27059, 27301, 27327, 27328, 27329, 27337, 27339, 27364, 27365, 27603, 27615, 27616, 27618, 27619, 27632, 27634, 28039, 28041, 28043, 28045, 28046, 28047
	Liver	47010, 47015, 47100, 47120, 47122, 47125, 47130, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47379, 47380, 47381, 47382, 47399, 47400
	Mediastinum and Diaphragm	39501, 39503, 39540, 39541, 39545, 39560, 39561, 39599
	Pancreas	48000, 48020, 48100, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48548, 48999
	Small intestine	44005, 44010, 44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 44186, 44187, 44202, 44310, 44312, 44314, 44316, 44602, 44603, 44615, 44640, 44650, 44700, 48547
	Spleen & Lymph nodes	38100, 38101, 38115, 38120, 38129, 38305, 38308, 38380, 38381, 38382, 38542, 38550, 38555, 38562, 38564, 38570, 38571, 38572, 38589, 38700, 38720, 38724, 38740, 38745, 38760, 38765, 38770, 38780, 38999
	Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43651, 43652, 43659, 43800, 43810, 43820, 43825, 43832, 43840, 43850, 43855, 43860, 43865, 43870, 43880, 43999, 64752, 64755, 64760
ENT		
	Laryngectomy	31360, 31365, 31367, 31370, 31375, 31380, 31382, 31390, 31395

	ENT - other	20100, 21025, 21026, 21034, 21040, 21044, 21045, 21046, 21047, 21048, 21049, 21139, 21154, 21235, 21299, 21360, 21395, 21462, 21465, 21499, 31300, 31320, 31400, 31420, 31580, 31587, 31590, 31599, 31611, 31614, 40812, 40814, 40816, 41000, 41005, 41007, 41008, 41009, 41016, 41017, 41018, 41110, 41112, 41113, 41114, 41116, 41120, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 41599, 41806, 41820, 41822, 41823, 41825, 41826, 41830, 41850, 42104, 42106, 42107, 42120, 42140, 42145, 42160, 42300, 42305, 42330, 42335, 42340, 42408, 42409, 42410, 42415, 42420, 42425, 42426, 42440, 42450, 42500, 42505, 42507, 42665, 42699, 42700, 42720, 42725, 42808, 42810, 42815, 42821, 42826, 42831, 42836, 42842, 42844, 42845, 42870, 42890, 42892, 42894, 42950, 42953, 42955, 42960, 42961, 42962, 42972, 42999, 60280, 60281, 60520, 69511, 69530, 69601, 69602, 69603, 69604, 69610, 69631, 69632, 69633, 69635, 69636, 69637, 69642, 69644, 69645, 69646, 69801
Gynecologic Surgery		
	Hyst/Myomectomy	58140, 58145, 58146, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 58541, 58542, 58543, 58544, 58545, 58546, 58548, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573, 58940, 58943, 58950, 58951, 58952, 58953, 58954, 58956
	Gynecologic reconstruction	57260, 57265, 57268, 57270, 57280, 57282, 57283, 57291, 57292
	Gynecology - other	56405, 56420, 56440, 56501, 56515, 56620, 56625, 56630, 56631, 56632, 56633, 56634, 56637, 56640, 56740, 56800, 56810, 57000, 57010, 57065, 57106, 57107, 57109, 57110, 57120, 57130, 57135, 57200, 57210, 57240, 57250, 57284, 57285, 57295, 57296, 57300, 57305, 57307, 57308, 57335, 57423, 57425, 57522, 57530, 57531, 57540, 57550, 57555, 57556, 57720, 58120, 58356, 58400, 58520, 58540, 58578, 58579, 58700, 58720, 58740, 58750, 58752, 58760, 58770, 58800, 58805, 58820, 58822, 58825, 58920, 58925, 58957, 58958, 58960, 59120, 59121, 59130, 59136, 59140, 59150, 59151, 59350
	Urogynecology	51990, 51992, 57288, 57289, 57310, 57311, 57320, 57330
Urology		
	Cystectomy	51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597
	Nephrectomy	50220, 50225, 50230, 50234, 50236, 50240, 50543, 50545, 50546, 50548
	Prostatectomy	55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866
	TURP	52601, 52630, 52647, 52648, 52649
	Urogynecology	51990, 51992, 57288, 57289, 57310, 57311, 57320, 57330

	Urology - other	50010, 50020, 50060, 50065, 50075, 50120, 50130, 50135, 50205, 50250, 50280, 50290, 50389, 50400, 50405, 50500, 50540, 50541, 50542, 50544, 50549, 50610, 50630, 50650, 50660, 50700, 50715, 50725, 50727, 50728, 50740, 50750, 50760, 50770, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50825, 50830, 50840, 50845, 50860, 50900, 50940, 50945, 50947, 50948, 50949, 51040, 51045, 51050, 51060, 51065, 51080, 51500, 51525, 51530, 51535, 51800, 51820, 51840, 51841, 51845, 51860, 51865, 51880, 51900, 51920, 51960, 51980, 51999, 52234, 52235, 52240, 52320, 52341, 52342, 52344, 52345, 52346, 52400, 52402, 52450, 52500, 52640, 52700, 53000, 53010, 53040, 53210, 53220, 53215, 53230, 53235, 53240, 53260, 53265, 53400, 53405, 53410, 53415, 53420, 53425, 53431, 53440, 53442, 53444, 53445, 53446, 53447, 53449, 53450, 53460, 53505, 53510, 53520, 53852, 53899, 54015, 54050, 54057, 54065, 54110, 54111, 54112, 54115, 54120, 54125, 54130, 54135, 54300, 54308, 54324, 54326, 54340, 54344, 54348, 54352, 54360, 54420, 54430, 54435, 54440, 54520, 54522, 54530, 54535, 54550, 54600, 54620, 54640, 54650, 54660, 54670, 54680, 54690, 54692, 54840, 54860, 54861, 54901, 55040, 55041, 55060, 55100, 55110, 55120, 55150, 55175, 55180, 55200, 55530, 55535, 55540, 55550, 55600, 55680, 55862, 55873, 55876, 55899
Hand		
	Hand	25000, 25001, 25040, 25085, 25101, 25105, 25107, 25110, 25111, 25112, 25115, 25116, 25118, 25130, 25135, 25136, 25145, 25210, 25215, 25240, 25260, 25263, 25265, 25270, 25274, 25275, 25280, 25290, 25295, 25301, 25310, 25312, 25320, 25332, 25337, 25430, 25431, 25440, 25442, 25445, 25446, 25447, 25449, 25607, 25608, 25609, 25628, 25645, 25652, 25670, 25676, 25685, 25695, 26350, 26352, 26356, 26357, 26358, 26370, 26372, 26373, 26390, 26392, 26410, 26415, 26418, 26420, 26426, 26433, 26434, 26437, 26440, 26442, 26445, 26449, 26450, 26455, 26460, 26471, 26477, 26478, 26480, 26483, 26485, 26489, 26490, 26492, 26496, 26497, 26498, 26500, 26502, 26510, 26520, 26525, 26530, 26531, 26535, 26536, 26540, 26541, 26542, 26545, 26546, 26548, 26561, 26565, 26567, 26568, 26587, 26591, 26593, 26615, 26650, 26665, 26676, 26685, 26686, 26715, 26727, 26735, 26746, 26765, 26776, 26785, 26989, 29844, 29846, 29847, 29904, 35207
Neurological Surgery		
	Brain tumor	61510, 61512, 61518, 61519, 61520, 61521, 61526, 61530, 61545, 61546
	Neurosurgery - other	61304, 61305, 61312, 61313, 61314, 61315, 61320, 61321, 61322, 61323, 61330, 61332, 61333, 61340, 61343, 61345, 61450, 61458, 61460, 61490, 61500, 61501, 61514, 61516, 61522, 61524, 61531, 61533, 61534, 61535, 61536, 61537, 61538, 61539, 61540, 61541, 61548, 61556, 61557, 61566, 61570, 61575, 61590, 61680, 61682, 61684, 61686, 61690, 61692, 61697, 61698, 61700, 61702, 61703, 61705, 61710, 61711, 61860, 61875, 61880, 61885, 61886, 61888, 62000, 62005, 62010, 62100, 63700, 63707, 63709, 64702, 64704, 64708, 64713, 64722, 64727, 64804, 64809, 64818, 64856, 64862

Orthopaedics		
	Amputation of lower extremity	27295, 27590, 27591, 27592, 27594, 27596, 27598, 27880, 27881, 27882, 27884, 27886, 27888, 27889, 28800, 28805, 28810, 28820, 28825
	Foot and Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737
	Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
	Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447, 27486, 27487
	Trauma (Fractures)	27202, 27226, 27227, 27228, 27235, 27236, 27244, 27245, 27248, 27254, 27269, 27758, 27759, 27766, 27769, 27792, 27814
	Orthopaedics - other	20103, 20150, 20696, 20900, 20902, 20910, 20955, 20956, 20999, 23000, 23020, 23031, 23035, 23040, 23044, 23101, 23106, 23107, 23120, 23125, 23130, 23140, 23146, 23150, 23156, 23170, 23180, 23182, 23184, 23190, 23195, 23200, 23210, 23220, 23395, 23397, 23400, 23405, 23410, 23412, 23415, 23420, 23430, 23440, 23450, 23455, 23460, 23462, 23465, 23466, 23470, 23472, 23480, 23485, 23491, 23515, 23530, 23532, 23550, 23552, 23585, 23615, 23616, 23630, 23660, 23670, 23680, 23800, 23802, 23900, 23920, 23929, 23935, 24000, 24006, 24102, 24105, 24116, 24120, 24125, 24130, 24134, 24136, 24140, 24145, 24149, 24150, 24152, 24201, 24301, 24310, 24320, 24330, 24332, 24340, 24341, 24342, 24344, 24345, 24346, 24358, 24359, 24360, 24361, 24363, 24365, 24366, 24400, 24430, 24435, 24495, 24498, 24515, 24516, 24538, 24545, 24546, 24575, 24579, 24586, 24587, 24615, 24635, 24665, 24666, 24685, 24800, 24802, 24900, 24920, 24925, 24999, 25020, 25023, 25024, 25025, 25120, 25125, 25150, 25151, 25170, 25230, 25248, 25315, 25350, 25355, 25360, 25375, 25390, 25391, 25392, 25400, 25405, 25415, 25420, 25443, 25490, 25515, 25525, 25526, 25545, 25574, 25575, 25900, 25905, 25909, 25920, 25927, 25999, 26117, 26121, 26123, 26130, 26145, 26180, 26952, 26991, 26992, 27000, 27001, 27005, 27006, 27025, 27027, 27030, 27033, 27035, 27036, 27054, 27057, 27060, 27062, 27065, 27066, 27070, 27071, 27075, 27076, 27077, 27078, 27080, 27086, 27087, 27097, 27110, 27120, 27122, 27140, 27146, 27147, 27151, 27156, 27158, 27161, 27165, 27170, 27176, 27177, 27179, 27181, 27187, 27238, 27253, 27258, 27259, 27267, 27280, 27290, 27299, 27303, 27305, 27307, 27310, 27331, 27332, 27333, 27334, 27335, 27340, 27345, 27347, 27350, 27355, 27356, 27357, 27360, 27365, 27372, 27380, 27381, 27385, 27386, 27390, 27392, 27403, 27405, 27407, 27409, 27412, 27415, 27416, 27418, 27420, 27422, 27424, 27425, 27427, 27428, 27429, 27430, 27435, 27437, 27438, 27448, 27450, 27454, 27455, 27457, 27465, 27466, 27468, 27470, 27472, 27477, 27485, 27488, 27495, 27496, 27497, 27498, 27499, 27506, 27507, 27509, 27511, 27513, 27514, 27519, 27524, 27535, 27536, 27540, 27556, 27557, 27566, 27580, 27599, 27600, 27601, 27602, 27604, 27605, 27606, 27607, 27610, 27612, 27620, 27625, 27626, 27630, 27635, 27637, 27638, 27640, 27641, 27645, 27646, 27647, 27650, 27652, 27654, 27656, 27658, 27659, 27664, 27665, 27675, 27676, 27680, 27681, 27685, 27686, 27687, 27695, 27696, 27698, 27700, 27705, 27707, 27709, 27715,

		27720, 27722, 27724, 27725, 27726, 27745, 27756, 27784, 27822, 27823, 27826, 27827, 27828, 27829, 27832, 27846, 27848, 27892, 27893, 27894, 27899, 28002, 28003, 28446, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29827, 29828, 29834, 29835, 29837, 29838, 29850, 29855, 29862, 29866, 29867, 29868, 29871, 29873, 29874, 29875, 29876, 29877, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, 29891, 29893, 29895, 29897, 29898, 29905, 29906, 29907, 29914, 29915, 29916, 29999, 38230
Spine		
	Spine	0202T, 22010, 22015, 22100, 22101, 22102, 22110, 22112, 22114, 22206, 22207, 22210, 22212, 22214, 22220, 22222, 22224, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 22532, 22533, 22548, 22551, 22554, 22556, 22558, 22586, 22590, 22595, 22600, 22610, 22612, 22630, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22841, 22849, 22850, 22852, 22855, 22856, 22857, 22861, 22862, 22864, 22865, 22899, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63040, 63042, 63045, 63046, 63047, 63050, 63051, 63055, 63056, 63064, 63075, 63077, 63081, 63085, 63087, 63088, 63090, 63101, 63102, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63300, 63301, 63302, 63303, 63304, 63305, 63306, 63307
Thoracic		
	Lung resection	32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32503, 32504, 32505, 32663, 32666, 32669, 32670, 32671, 32672
	Thoracic - other	19260, 19271, 19272, 20101, 21620, 21627, 21630, 21632, 21685, 21740, 21742, 21743, 21750, 21805, 21810, 21825, 21899, 31750, 31755, 31760, 31775, 31780, 31781, 31785, 31786, 31800, 31820, 31825, 31899, 32035, 32036, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32151, 32160, 32200, 32215, 32220, 32225, 32310, 32320, 32540, 32560, 32650, 32651, 32652, 32653, 32654, 32655, 32656, 32658, 32659, 32661, 32662, 32664, 32665, 32800, 32810, 32815, 32820, 32900, 32905, 32906, 32940, 32999, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 39000, 39010, 39200, 39220, 39400, 39499, 40510, 40520, 40525, 40530, 40650, 40652, 40800, 40801, 40810, 41006, 42210, 60521, 60522
Vascular		
	Abdominal aortic aneurysm	34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 35081, 35082, 35091, 35092, 35102, 35103,
	Aortoiliac	0236T, 0238T 35331, 35351, 35355, 35361, 35363, 35472, 35521, 35533, 35537, 35538, 35539, 35540, 35558, 35563, 35565, 35621, 35623, 35637, 35638, 35646, 35647, 35654, 35661, 35663, 35665, 37220, 37221
	Carotid artery	35301, 37215

	Lower extremity	35556, 35566, 35571, 35583, 35585, 35587, 35656, 35666, 35671, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231
	Varicose veins	36475, 36478, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37785
	Vascular - other	21600, 21615, 21616, 21700, 21705, 33875, 33877, 33880, 33881, 33883, 33886, 33889, 33891, 34001, 34051, 34101, 34111, 34151, 34201, 34203, 34401, 34421, 34451, 34471, 34490, 34501, 34502, 34510, 34520, 34530, 34812, 34820, 34833, 34834, 34900, 35001, 35002, 35005, 35011, 35013, 35021, 35045, 35111, 35112, 35121, 35122, 35131, 35132, 35141, 35142, 35151, 35152, 35184, 35189, 35190, 35201, 35206, 35211, 35216, 35221, 35226, 35231, 35236, 35246, 35251, 35256, 35261, 35266, 35271, 35281, 35286, 35302, 35303, 35304, 35305, 35311, 35321, 35341, 35371, 35372, 35471, 35501, 35506, 35508, 35509, 35510, 35512, 35515, 35516, 35518, 35522, 35523, 35525, 35526, 35531, 35535, 35536, 35560, 35570, 35601, 35606, 35612, 35616, 35626, 35631, 35632, 35633, 35634, 35636, 35642, 35645, 35650, 35691, 35693, 35694, 35695, 35701, 35721, 35741, 35761, 35800, 35820, 35840, 35860, 35870, 35875, 35876, 35879, 35881, 35883, 35884, 35901, 35903, 35905, 35907, 36818, 36819, 36820, 36821, 36825, 36830, 36838, 37140, 37160, 37180, 37181, 37500, 37565, 37605, 37607, 37615, 37616, 37617, 37618, 37650, 37660, 37718, 37780, 37799, 60600, 60605, 61613

NUMERATOR:
Documentation of empirical, personalized risk assessment based on the patient's risk factors with a validated risk calculator using multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient and/or family

Numerator Instructions: The number of adult patients (age 18 and over) having had non-emergency surgery as defined by CPT codes during the reporting period who had their personalized risk of procedure-specific, 30-day postoperative complications assessed and documented by their surgeon prior to surgery using a clinical data-based, patient-specific risk-calculator* and who had a documented personal discussion with their surgeon about these risks.

The procedure-specific, patient-specific, data-based risk calculator should be based on a validated, risk-adjusted statistical model predicting 30-day postoperative complications (detailed below) for the procedure that the patient is to undergo. Risk calculations should be based on preoperative patient-specific clinical data, and should include the following groups of variables: patient demographic characteristics (e.g., age, gender); relevant lifestyle and clinical risk factors (e.g., smoking status, American Society of Anesthesiologists class, body mass index); patient comorbidities (e.g., diabetes; neurologic event/disease; disseminated cancer); and procedure type.

Postoperative complications should include 30-day risk-adjusted mortality, 30-day risk-adjusted overall morbidity (superficial surgical site infection, deep incisional surgical site infection, wound dehiscence, pneumonia, deep venous thrombosis; pneumonia; renal failure; urinary tract infection; prolonged ventilator dependence; bleeding complications; sepsis; and pulmonary embolism), serious complications (cardiac arrest; myocardial infarction, pneumonia; progressive renal insufficiency; acute renal failure; pulmonary embolism; deep venous thrombosis; return to the operating room deep incisional surgical site infection; organ space surgical site infection; systemic sepsis; unplanned intubation; urinary tract infection; and wound dehiscence), surgical site infection, and average length of stay.

Risk calculators based on multi-institutional, validated clinical data are acceptable for this measure. ACS NSQIP now offers a risk calculator which can be used for operations in every surgical subspecialty (http://www.riskcalculator.facs.org). Examples of other risk calculators acceptable for this measure include, but are not limited to the ACS NSQIP pancreatectomy risk calculator; the ACS NSQIP colorectal surgery risk calculator; and a recent bariatric surgery risk calculator based on ACS NSQIP data. Other risk calculators are available from the Society of Thoracic Surgery.

Numerator Options:
Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family (G9316)

OR

Documentation of patient-specific risk assessment with a risk calculator based on multi-institutional clinical data, the specific risk calculator used, and communication of risk assessment from risk calculator with the patient or family not completed (G9317)

RATIONALE:
Preoperative risk assessment and communication between surgeons and patients is critical for effective informed consent and shared decision making in surgical care. Shared decision-making is considered an integral component of patient-centered care, especially for preference-sensitive issues. Evidence suggests that there is room for improving communication and the informed consent/shared decision-making processes between physicians and patients. Use of a risk calculator helps improve the quality of the informed consent/shared decision-making process by providing a personalized, customized, empirically-based estimate of a patient's risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers.

CLINICAL RECOMMENDATION STATEMENTS:
Preoperative risk assessment and communication between surgeons and patients is critical for effective informed consent and shared decision making in surgical care. Shared decision-making is considered an integral component of patient-centered care, especially for preference-sensitive issues. Evidence suggests that there is room for improving communication and the informed consent/shared decision-making processes between physicians and patients. Use of a risk calculator helps improve the quality of the informed consent/shared decision-making process by providing a personalized, customized, empirically-based estimate of a patient's risk of post-operative complications. Moreover, evidence suggests that sharing numeric estimates of patient-specific risk may enhance patient trust in providers.

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