

2007 Physician Quality Reporting Initiative Specifications Document

This document contains the complete specifications for the 74 measures that make up the 2007 Physician Quality Reporting Initiative (PQRI). In general, the quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome.

The denominator population is defined by certain ICD-9 and CPT Category I codes specified in the measure that are submitted as part of a claim for Medicare Physician Fee Schedule services by eligible professionals. If the specified denominator codes for a measure are not included in the patient's claim as submitted, then the patient does not fall into the denominator population, and the PQRI measure does not apply to the patient.

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

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

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

Instructions for some measures limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically.

The measure specifications are organized to provide the following information:

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

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

DESCRIPTION:

Percentage of patients aged 65 years and older who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). It is anticipated that clinicians who provide primary care for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

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

When reporting the measure, submit the listed CPT E/M service codes and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

NUMERATOR:

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

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

Definition: A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti).

Numerator Coding:

Screening for Future Fall Risk Performed

CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year

OR

Screening for Future Fall Risk not Performed for Medical Reasons

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

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

OR

Screening for Future Fall Risk not Performed, Reason Not Specified

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

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

DENOMINATOR:

All patients aged 65 years and older

Denominator Coding:

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

CPT E/M service codes: 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404

RATIONALE:

Patients may not volunteer information regarding falls.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported for each occurrence of MDD during the reporting period. It is anticipated that clinicians who provide the primary management of patients with major depressive disorder (MDD) will submit this measure.

This measure can be reported using G-codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate G-code.

NUMERATOR:

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

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

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

Numerator Coding:

Acute Treatment with Antidepressant Medication

G8126: Patient with new episode of MDD documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

OR

Acute Treatment with Antidepressant Medication not Completed for Documented Reasons

G8128: Clinician documented that patient with a new episode of MDD was not an eligible candidate for antidepressant medication treatment or patient did not have a new episode of MDD

OR

Acute Treatment with Antidepressant Medication not Completed

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

In recent years, major depression has come to be considered a chronic and/or recurrent, rather than an acute illness. This reevaluation of the disorder has inherent treatment implications because patients with major depression tend to exhibit episodic recurrence and/or chronic residual symptoms. Considering this, the management of depression can be divided into the acute phase

(suppression of symptoms to achieve clinical remission), lasting 8 to 12 weeks, and the maintenance phase (prevention of relapse/recurrence), lasting 6 months or longer. Clinical management is an important component of pharmacotherapy; and includes a brief session of psychoeducation and supportive strategies. During the maintenance phase after remission of acute symptoms, all patients should continue the antidepressant dose that induced remission for at least 6 months. The relapse rate is 35% to 60% if antidepressants are discontinued in the first 6 months, compared with 10% to 25% in patients who continue medications. The risk of relapse is particularly high if drug discontinuation occurs in the first few months of response/remission. *Canadian Psychiatric Association, 2001*

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

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported each time a CT or MRI is performed in a hospital or outpatient setting during the reporting period for patients with a diagnosis of ischemic stroke, TIA, or intracranial hemorrhage. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for patients with stroke, TIA, or intracranial hemorrhage in the hospital or outpatient setting will submit this measure.

This measure can be reported using CPT Category II codes:

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

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

NUMERATOR:

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

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

Numerator Coding:

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

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

AND

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

OR

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

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

OR

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

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

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

AND

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

DENOMINATOR:

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

Denominator Coding:

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

ICD-9 diagnosis codes: 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

AND

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

RATIONALE:

The CT and MRI findings are critical to initiating care for the patient with stroke. All CT and MRI reports should address the presence or absence of these three important findings. This documentation is particularly vital in the report of the first imaging study performed after arrival at the hospital, on which initial treatment decisions will be based.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

Preliminary data suggest that specific MRI profiles may identify patients who are particularly likely to benefit from thrombolytic therapy. New MRI techniques including perfusion-weighted and diffusion-weighted may detect ischemic injury in the first hour and may reveal the extent of

reversible and irreversible injury. In addition, MRI appears to be highly sensitive for identification of acute brain hemorrhage. (Albers, ACCP, 2004)

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

DESCRIPTION:

Percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed for patients aged 18 years and older with the diagnosis of ischemic stroke or TIA that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

INSTRUCTIONS:

This measure is to be reported each time a carotid imaging study is performed during the reporting period for patients with a diagnosis of ischemic stroke or TIA. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for patients with stroke or TIA in the hospital or outpatient setting will submit this measure.

This measure can be reported using CPT Category II codes:

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

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT procedure codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Final carotid imaging study reports that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

Definition: "Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (eg, for duplex ultrasound studies, velocity parameters that correlate the residual internal carotid lumen with methods based on the distal internal carotid lumen)

Numerator Coding:

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

CPT II 3100F: Carotid image study report includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

OR

Measurements of Distal Internal Carotid Diameter not Referenced for Medical Reasons

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

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

OR

Measurements of Distal Internal Carotid Diameter not Referenced, Reason Not Specified

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

- **8P:** Carotid image study report did not include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement, reason not otherwise specified

DENOMINATOR:

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

Denominator Coding:

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

ICD-9 diagnosis codes: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

AND

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

RATIONALE:

Since the clinical decision-making is based on randomized trial evidence and degree of stenosis is an important element of the decision for carotid intervention, characterization of the degree of stenosis needs to be standardized. Requiring that stenosis calculation be based on a denominator of distal internal carotid diameter or, in the case of duplex ultrasound, velocity measurements that have been correlated to angiographic stenosis calculation based on distal internal carotid diameter, makes the measure applicable to both imaging and duplex studies.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

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

Definition: For purposes of this measure, DVT prophylaxis can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), intravenous Heparin, low-dose subcutaneous heparin, or intermittent pneumatic compression devices.

Numerator Coding:

DVT Prophylaxis Received

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

OR

DVT Prophylaxis not Received for Medical or Patient Reasons

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

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

OR

DVT Prophylaxis not Received, Reason Not Specified

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

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

Denominator:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed antiplatelet therapy at discharge

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

Numerator Coding:

Antiplatelet Therapy Prescribed

CPT II 4073F: Oral antiplatelet therapy prescribed at discharge

OR

Antiplatelet Therapy Prescription not Prescribed for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **4073F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not prescribing oral antiplatelet therapy at discharge
- **2P:** Documentation of patient reason(s) for not prescribing oral antiplatelet therapy at discharge

OR

Antiplatelet Therapy Prescription not Prescribed, Reason Not Specified

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

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

DENOMINATOR:

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

Denominator Coding:

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

ICD-9 diagnosis codes: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reasons not otherwise specified.

NUMERATOR:

Patients who were prescribed an anticoagulant at discharge

Definitions:

- Persistent Atrial Fibrillation: recurrent atrial fibrillation, not self-terminating or terminated electrically or pharmacologically
- Paroxysmal Atrial Fibrillation: recurrent atrial fibrillation, self-terminating
- Permanent Atrial Fibrillation: long-standing atrial fibrillation (>1 year), cardioversion failed or not attempted

Numerator Coding:

Anticoagulant Prescribed

CPT II 4075F: Anticoagulant therapy prescribed at discharge

OR

Anticoagulant Prescription not Received for Medical or Patient Reasons

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

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

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

OR

Anticoagulant Prescription not Received, Reason Not Specified

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

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

DENOMINATOR:

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

Denominator Coding:

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

ICD-9 diagnosis codes: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9

AND

ICD-9 diagnosis code: 427.31

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure can be reported using CPT Category II codes:

ICD 9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

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

NUMERATOR:

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

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

Numerator Coding:

t-PA Administration or Consideration Documented

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

AND

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

OR

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

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

OR

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

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

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

AND

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

We recommend administration of IV tPA in a dose of 0.9 mg/kg (maximum of 90 mg), with 10% of the total dose given as an initial bolus and the remainder infused over 60 minutes for eligible patients, provided that treatment is initiated within 3 hours of clearly defined symptom onset. We recommend strict adherence to eligibility criteria for the use of IV tPA based on the NINDS trial protocol. (Inclusion Criteria: Age \geq 18 years, clinical diagnosis of stroke with a clinically meaningful neurologic deficit, clearly defined time of onset of $<$ 180 minutes before treatment, and a baseline CT showing no evidence of intracranial hemorrhage. (Albers, ACCP, 2001) (Grade 1A)

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes, and the appropriate CPT Category II codes **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reasons not otherwise specified.

NUMERATOR:

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

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

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

Numerator Coding:

Dysphagia Screening Conducted

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

AND

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

OR

Dysphagia Screening not Conducted for Medical Reasons

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

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

AND

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

OR

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

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

OR

Dysphagia Screening not Conducted, Reason Not Specified

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

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

AND

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure can be reported using CPT Category II codes:

ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

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

NUMERATOR:

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

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

Numerator Coding:

Rehabilitation Services Ordered or Considered

CPT II 4079F: Documentation that rehabilitation services were considered

OR

Rehabilitation Services not Ordered or Considered, Reason Not Specified

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

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

***Measure #46: Medication Reconciliation**

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure can be reported using CPT Category II codes:

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

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

NUMERATOR:

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

Definition: The medical record must indicate that the clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.

Numerator Coding:

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

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

AND

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

OR

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

OR

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

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

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

AND

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

DENOMINATOR:

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

Denominator Coding:

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

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

First, a medication list must be collected. It is important to know what medications the patient has been taking or receiving prior to the outpatient visit in order to provide quality care. This applies regardless of the setting from which the patient came — home, long-term care, assisted living, etc..

The medication list should include all medications (prescriptions, over-the-counter, herbals, supplements, etc..) with dose, frequency, route, and reason for taking it. It is also important to verify whether the patient is actually taking the medication as prescribed or instructed, as sometimes this is not the case.

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

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is appropriate for use in all healthcare settings. It is anticipated that clinicians who provide primary care services for the patient will submit this measure.

This measure can be reported using CPT Category II codes:

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

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

NUMERATOR:

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

Numerator Coding:

Surrogate Decision Maker or Advance Care Plan Documented

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

OR

Surrogate Decision Maker or Advance Directive not Documented for Patient Reasons

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

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

OR

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

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

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

DENOMINATOR:

All patients aged 65 years and older

Denominator Coding:

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

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

Oral statements

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

Instructional advance directives (DNR orders, living wills)

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

Durable power of attorney for health care or health care proxy

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

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

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