

2009 Physician Quality Reporting Initiative Measure Specifications Manual for Claims and Registry

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

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

Eligible Professionals

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

Reporting Options, Frequency, and Performance Timeframes

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

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

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

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

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

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

Measure Specification Format

Measure title

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

Measure description

Instructions on reporting including frequency, timeframes, and applicability

Numerator coding

Definitions of terms

Coding instructions

Use of CPT Category II exclusion modifiers, where applicable

Denominator coding

Rationale statement for measure

Clinical recommendations or evidence forming the basis or supporting criteria for the measure

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

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

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

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

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

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

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

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

◆ **Measure #9: Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD**

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

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

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

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

AND

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90821, 90822, 90823, 90824, 90829, 90845, 90849, 90853, 90857, 90862, 99078, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99510

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

In recent years, major depression has come to be considered a chronic and/or recurrent, rather than an acute illness. This reevaluation of the disorder has inherent treatment implications because patients with major depression tend to exhibit episodic recurrence and/or chronic residual symptoms. Considering this, the management of depression can be divided into the acute phase (suppression of symptoms to achieve clinical remission), lasting 8 to 12 weeks, and the maintenance phase (prevention of relapse/recurrence), lasting 6 months or longer. Clinical management is an important component of pharmacotherapy; and includes a brief session of psychoeducation and supportive strategies. During the maintenance phase after remission of acute symptoms, all patients should continue the antidepressant dose that induced remission for at least 6 months. The relapse rate is 35% to 60% if antidepressants are discontinued in the first 6 months, compared with 10% to 25% in patients who continue medications. The risk of relapse is particularly high if drug discontinuation occurs in the first few months of response/remission. *Canadian Psychiatric Association, 2001*

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with either a diagnosis of ischemic stroke or transient ischemic attack (TIA) or intracranial hemorrhage or at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage that includes documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

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

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

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Presence/Absence of Hemorrhage, Mass Lesion, and Acute Infarction Documented
(Two CPT II codes [3110F & 3111F] are required on the claim form to submit this numerator option)

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

AND

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

OR

If patient is not eligible for this measure because CT or MRI of the brain was performed greater than 24 hours after arrival to the hospital, report:

(One CPT II code [3112F] is required on the claim form to submit this numerator option)

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

OR

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

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

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

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

AND

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

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

For purposes of this measure, the listed symptoms will be considered "documented symptoms consistent" with ischemic stroke or TIA or intracranial hemorrhage. Each of the listed symptoms corresponds to a specific ICD-9-CM code in the code table below.

Note: Use of symptom codes is limited to the following:

<ul style="list-style-type: none">• Transient visual loss (368.12)• Diplopia (double vision) (368.2)• Vertigo of central origin (386.2)• Transient global amnesia (437.7)• Transient alteration of awareness (780.02)• Lack of coordination (781.3)	<ul style="list-style-type: none">• Transient paralysis of limb (781.4)• Facial weakness (781.94)• Disturbance of skin sensation (782.0)• Aphasia (784.3)• Slurred speech (784.5)
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Diagnosis for ischemic stroke or TIA or intracranial hemorrhage – including symptom codes (line-item ICD-9-CM): 368.12, 368.2, 386.2, 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9, 437.7, 780.02, 781.3, 781.4, 781.94, 782.0, 784.3, 784.5

AND

Patient encounter during the reporting period (CPT): 0042T, 70450, 70460, 70470, 70551, 70552, 70553

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

Preliminary data suggest that specific MRI profiles may identify patients who are particularly likely to benefit from thrombolytic therapy. New MRI techniques including perfusion-weighted and diffusion-weighted may detect ischemic injury in the first hour and may reveal the extent of reversible and irreversible injury. In addition, MRI appears to be highly sensitive for identification of acute brain hemorrhage. (Albers, ACCP, 2004)

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported 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.

Measure Reporting via Claims:

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

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

NUMERATOR:

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

Definition:

Direct or Indirect Reference to Measurements of Distal Internal Carotid Diameter as the Denominator for Stenosis Measurement – Includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (e.g., for duplex ultrasound studies, velocity parameters that correlate the residual internal carotid lumen with methods based on the distal internal carotid lumen)

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

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

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.

3100F with 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.

3100F with 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 Criteria (Eligible Cases):

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

AND

Patient encounter during the reporting period (CPT): 70498, 70547, 70548, 70549, 75660, 75662, 75665, 75671, 75676, 75680, 93880, 93882

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported 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:

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

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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.

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

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

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.

4070F with 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for ischemic stroke or intracranial hemorrhage (line-item ICD-9-CM):

431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

AND

Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99291

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported for patients under active treatment for ischemic stroke or TIA 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:

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

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

NUMERATOR:

Patients who were prescribed antiplatelet therapy at discharge

Definitions:

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

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Antiplatelet Therapy Prescribed

CPT II 4073F: Oral antiplatelet therapy prescribed at discharge

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.

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

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

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.

4073F with 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for ischemic stroke or transient ischemic attack (TIA)

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

AND

Patient encounter during the reporting period (CPT): 99238, 99239, 99251, 99252, 99253, 99254, 99255

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported for patients under active treatment for ischemic stroke or TIA with documented atrial fibrillation 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 Only:

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

NUMERATOR:

Patients who were prescribed an anticoagulant at discharge

Definitions:

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

Paroxysmal Atrial Fibrillation – Recurrent atrial fibrillation, self-terminating

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

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

Numerator Options:

Anticoagulant therapy prescribed at discharge

OR

Anticoagulant therapy not prescribed at discharge for medical reason

OR

Anticoagulant therapy not prescribed at discharge for patient reason

OR

Anticoagulant therapy not prescribed at discharge, reason not specified

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for ischemic stroke or transient ischemic attack (TIA)

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

AND

Diagnosis for atrial fibrillation (line-item ICD-9-CM): 427.31

AND

Patient encounter during the reporting period (CPT): 99238, 99239, 99251, 99252, 99253, 99254, 99255

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

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

Definition:

Patients Considered for t-PA Administration – Includes patients to whom t-PA was given or patients for whom reasons for not being a candidate for t-PA therapy are documented.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

t-PA Administration or Consideration Documented

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

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

AND

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

OR

If patient is not eligible for this measure because ischemic stroke symptom onset \geq 3 hours prior to arrival at hospital, report:

(One CPT II code [1066F] is required on the claim form to submit this numerator option)

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

OR

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

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

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

4077F with 8P: Tissue plasminogen activator (t-PA) administration was 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

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

AND

Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99291

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

It is recommended administration of IV tPA in a dose of 0.9 mg/kg (maximum of 90 mg), with 10% of the total dose given as an initial bolus and the remainder infused over 60 minutes for eligible patients, provided that treatment is initiated within 3 hours of clearly defined symptom onset. It is

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported 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:

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

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

NUMERATOR:

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

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

Definition:

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

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

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 Reasons

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

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

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

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 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

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for ischemic stroke or intracranial hemorrhage (line-item ICD-9-CM):

431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

AND

Patient encounter during the reporting period (CPT): 99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported for patients under active treatment for ischemic stroke or intracranial hemorrhage a minimum of once 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:

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

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

NUMERATOR:

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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.

4079F with 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 Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for ischemic stroke or intracranial hemorrhage (line-item ICD-9-CM):

431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

AND

Patient encounter during the reporting period (CPT): 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: Reconciliation After Discharge from an Inpatient Facility**

2009 PQRI REPORTING OPTIONS: REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 65 years and older discharged from any inpatient facility (eg, 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 outpatient visit occurring within 60 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 60 days prior to the outpatient visit.

Measure Reporting via Registry Only:

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

NUMERATOR:

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

Definition:

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

Numerator Options:

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

AND

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

OR

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

OR

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

AND

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

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 65 years on date of encounter

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

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

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

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

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

INSTRUCTIONS:

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

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

NUMERATOR:

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

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

Definition:

Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship

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 Specified

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

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

DENOMINATOR:

All patients aged 65 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 65 years on date of encounter

AND

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

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

Oral statements

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

Instructional advance directives (DNR orders, living wills)

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

Durable power of attorney for health care or health care proxy

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

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

▲ Measure #106: Major Depressive Disorder (MDD): Diagnostic Evaluation

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified during the measurement period

INSTRUCTIONS:

This measure is to be reported a minimum of 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:

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

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

NUMERATOR:

Patients with documented evidence that they met the DSM-IV criteria [At least 5 elements (must include: 1) depressed mood or 2) loss of interest or pleasure) with symptom duration of 2 weeks or longer] during the visit in which the new diagnosis or recurrent episode was identified.

Definitions:

DSM-IV Criteria – Includes presence of depressed mood, marked diminished interest/pleasure, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, diminished ability to concentrate and recurrent suicidal ideation.

Remission – Patient no longer meets DSM-IV criteria

***NUMERATOR NOTE:** PATIENTS WHOSE EPISODE OF MDD BEGAN PRIOR TO THE CURRENT REPORTING PERIOD: The clinician should report that DSM IV criteria was assessed during the visit in which the new diagnosis or recurrent episode was identified.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

DSM-IV Criteria for Major Depressive Disorder Documented

CPT II 1040F: DSM-IV criteria for major depressive disorder documented at the initial evaluation

OR

DSM-IV Criteria for Major Depressive Disorder not Documented, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1040F** report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1040F with 8P: DSM-IV criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for MDD (line-item ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34

AND

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Thorough assessment of depressive symptoms sets the basis for accurate diagnosis and treatment of major depressive disorder.

CLINICAL RECOMMENDATION STATEMENTS:

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient. (APA; Level I Recommendation)

Diagnostic criteria for 296.20-296.24 – Major Depressive Disorder, Single Episode

- A. Presence of a single Major Depressive Episode.
- B. The Major Depressive Episode is not better accounted for by Schizoaffective Disorder and is not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.

Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition. (DSM IV)

Diagnostic criteria for 296.30-296.34 – Major Depressive Disorder, Recurrent

- A. Presence of two or more Major Depressive Episodes.
Note: To be considered separate episodes, there must be an interval of at least 2 consecutive months in which criteria are not met for a Major Depressive Episode.
- B. The Major Depressive Episodes are not better accounted for by Schizoaffective Disorder and are not superimposed on Schizophrenia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder Not Otherwise Specified.
- C. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode.
Note: This exclusion does not apply if all of the manic-like, mixed-like, or hypomanic-like episodes are substance or treatment induced or are due to the direct physiological effects of a general medical condition. (DSM IV)

Criteria for Major Depressive Episode

- A. At least five of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly due to general medical condition or mood-incongruent delusions or hallucinations).
 - 1) Depressed mood most of the day, nearly every day as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
 - 2) Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
 - 3) Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or decrease in appetite nearly every day
 - 4) Insomnia or hypersomnia nearly every day
 - 5) Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 - 6) Fatigue or loss of energy nearly every day
 - 7) Feelings of worthlessness or excessive inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
 - 8) Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others)
 - 9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide
- B. The symptoms do not meet criteria for a mixed episode
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)

- E. The symptoms are not better accounted for by bereavement (i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation). (DSM-IV)

▲ Measure #107: Major Depressive Disorder (MDD): Suicide Risk Assessment

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the measurement period

INSTRUCTIONS:

This measure is to be reported at each visit for a new diagnosis or recurrent episode of MDD, for patients seen individually during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who had suicide risk assessment completed at each visit

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Suicide Risk Assessed

CPT II 3085F: Suicide risk assessed

OR

If patient is not eligible for this measure because MDD is in remission, report:

CPT II 3092F: Major depressive disorder, in remission

OR

Suicide Risk not Assessed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3085F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3085F with 8P: Suicide risk not assessed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older with a new diagnosis or recurrent episode of MDD

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for MDD (line-item ICD-9-CM): 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34

AND

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Research has shown that patients with major depressive disorder are at a high risk for suicide, which makes this assessment an important aspect of care that should be assessed at each visit.

CLINICAL RECOMMENDATION STATEMENTS:

Successful treatment of patients with major depressive disorder is promoted by a thorough assessment of the patient. (APA; Level I Recommendation)

Psychiatric management consists of a broad array of interventions and activities that should be instituted by psychiatrists for all patients with major depressive disorder. (APA; Level I Recommendation)

The components of an evaluation for suicide risk should include:

- 1) An assessment of the presence of suicidal or homicidal ideation, intent, or plans
- 2) Access to means for suicide and the lethality of those means
- 3) Presence of psychotic symptoms, command hallucinations, or severe anxiety
- 4) Presence of alcohol or substance abuse
- 5) History of seriousness of previous attempts
- 6) Family history or recent exposure to suicide (APA)

▲ Measure #114: Preventive Care and Screening: Inquiry Regarding Tobacco Use

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

DESCRIPTION:

Percentage of patients aged 18 years or older who were queried about tobacco use one or more times within 24 months

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period. Tobacco use is to be queried at least once within 24 months prior to the date of service. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who were queried about tobacco use one or more times within 24 months

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Tobacco Use Assessed

(Two CPT II codes [1000F & 103xF] are required on the claim form to submit this numerator option)

CPT II 1000F: Tobacco use assessed

AND

CPT II 1034F: Current tobacco smoker

OR

CPT II 1035F: Current smokeless tobacco user

OR

CPT II 1036F: Current tobacco non-user

OR

Tobacco Use not Assessed, Reason not Specified

(One CPT II code [1000F-8P] is required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **1000F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1000F with 8P: Tobacco use not assessed, reason not otherwise specified

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 90862, 96150, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

RATIONALE:

Tobacco use is one of the leading causes of many preventable diseases, however, not all individuals are screened for tobacco use.

CLINICAL RECOMMENDATION STATEMENTS:

Periodic screening for tobacco use is recommended for all patients. (US Department of Health and Human Services, USPSTF)

Tobacco cessation counseling is recommended for all patients who smoke. (USPSTF)

◆ **Measure #115: Preventive Care and Screening: Advising Smokers to Quit**

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

DESCRIPTION:

Percentage of patients aged 18 years and older and are smokers who received advice to quit smoking

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for all patients (whether or not they use tobacco) seen during the reporting period. All patients identified as tobacco smokers at any time during the reporting period should be advised to quit. There is no diagnosis associated with this measure. This measure is appropriate for use in all healthcare settings. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who received advice to quit smoking

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Advising Smoker to Quit

(One G-code and one CPT II code [G8455 & 400x~~F~~] are required on the claim form to submit this numerator option)

G8455: Current tobacco smoker

AND

CPT II 4000F: Tobacco use cessation intervention, counseling

OR

CPT II 4001F: Tobacco use cessation intervention, pharmacologic therapy

OR

If patient is not eligible for this measure because patient is a smokeless tobacco user or a non tobacco user, report:

(One G-code [G845X] is required on the claim form to submit this numerator option)

Smokeless Tobacco User

G8456: Current smokeless tobacco user

OR

Tobacco Non-User

G8457: Current tobacco non-user

OR

Tobacco Smoker not Advised to Quit, Reason not Specified

(One CPT II code and one G-code [4000F-8P & G8455] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **4000F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4000F with 8P: Tobacco use cessation intervention not counseled, reason not otherwise specified

AND

G8455: Current tobacco smoker

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): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Interventions to control smoking are strategically important because smoking is the leading preventable cause of death in the United States, clinical interventions are known to be effective in increasing cessation rates, and quitting smoking has been shown to improve health outcomes. (Fiore, 2000)

CLINICAL RECOMMENDATION STATEMENTS:

The Clinical Practice Guidelines: Treating tobacco use and dependence published by USDHHS Public Health Service (Fiore, 2002) provide convincing empirical support for providing advice to and assistance with quitting smoking for patients who smoke. Specifically, these guidelines recommend:

- 1) repeated advice and support at all or most visits, and
- 2) delivery of cessation assistance and follow-up at all or most visits.

There have been more than 12 million premature deaths attributable to smoking since the first published Surgeon General's report on smoking and health in 1964. Smoking remains the leading preventable cause of premature death in the United States.

Nearly every organ in the body is affected by smoking (USDHHS, 2004). Smoking causes many diseases and reduces the health of smokers in general. The list of diseases caused by smoking has been expanded to include abdominal aortic aneurysm, acute myeloid leukemia, cataract, cervical cancer, kidney cancer, pancreatic cancer, pneumonia, periodontitis, and stomach cancer (USDHHS, 2004).

In the US in 2003, 45.4 million adults (21.6 percent) were current smokers—24.1 percent of men and 19.2 percent of women (CDC, 2005a). An estimated 70% of these smokers said they wanted to quit (CDC, 2005a).

An estimated 45.9 million adults were former smokers in 2003, representing 50.3 percent of those who had ever smoked (CDC, 2005a). For the second consecutive year, more adults had quit than were still smoking. A large number of clinical trials have demonstrated the effectiveness of counseling in increasing cessation rates, and the effectiveness of bupropion and NRT has been demonstrated (Fiore, 2000). A meta-analysis of 7 studies found that physician advice to quit is associated with a 30% increase in cessation rates (Fiore, 2000). Counseling and medication are each associated with a doubling of cessation rates (Fiore, 2000).

Measure #124: Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR)

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and be using a certified/qualified EHR

INSTRUCTIONS:

This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted and are using certified/qualified health information technology.

Measure Reporting via Claims:

CPT codes, HCPCS (D- or G-) codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT codes, HCPCS codes, and the appropriate numerator G-code. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

NUMERATOR:

Patient encounter documentation substantiates use of certified/qualified EHR

Definitions:

Health Information Technology (HIT) – A system that incorporates both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Basic Privacy and Security Elements – Basic privacy and security elements include the following:

- Ability to audit the date/time and user of each time patient chart printed
- Ability to archive and retrieve health record information

CCHIT – The Certification Commission for Healthcare Information Technology – an independent, nonprofit organization that has been recognized by the federal government as an official certification body for electronic health record products.

Certified/Qualified Electronic Health Record – A certified/qualified EHR can be any of the following:

- Certification Commission for Healthcare Information Technology (CCHIT) certified EHR at the time of measurement
- If CCHIT certification is available (in primary care or a specialty) on or before August 1, 2008, but the system in use is not CCHIT certified, the EHR must meet the following criteria:
 - Ability to manage a medication list

- Ability to manage a problem list
- Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
- Ability to meet basic privacy and security elements

AND

the EHR (above) must be CCHIT certified on or before August 1, 2011, or another CCHIT certified product must be in use for compliance after August 1, 2011

- If CCHIT certification is not available for a specialty on August 1, 2008, the EHR must have the following capabilities to be qualified:
 - Ability to manage a medication list
 - Ability to manage a problem list
 - Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
 - Ability to meet basic privacy and security elements

Note: For providers having CCHIT certified EHR products available (according to specialty) on or before August 1, 2008, an extended time parameter has been placed in this measure of August 1, 2011 in order to allow for a period of time for providers to transition to a CCHIT certified product if necessary. After August 1, 2011, these providers will no longer meet the performance requirement of the measure without a CCHIT certified EHR in use.

Manage a Medication List – Create, maintain and display a patient specific medication list

Manage a Problem List – Create, maintain and display a patient specific problem list

Discrete Searchable Data Elements – Laboratory data that can be recorded in predefined fields in predefined formats within the EHR that allow for reports to be generated, such as trends of a specific element over time. This cannot be easily done if data is entered via a free text format or by merely scanning a report into the EHR.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Encounter Documented Using Certified/Qualified EHR

G8447: Patient encounter was documented using a CCHIT certified EHR

OR

G8448: Patient encounter was documented using a qualified (non-CCHIT certified) EHR

DENOMINATOR:

All patient encounters

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92548, 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92569, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586,

92587, 92588, 92601, 92602, 92603, 92604, 92620, 92621, 92625, 92626, 92627, 92640, 95920, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, D7140, D7210, G0101, G0108, G0109, G0270, G0271

RATIONALE:

The need for clinical information systems to provide high-quality, safe care is a well recognized fact. This need was well publicized by Dr. Ed Wagner in his “Chronic Care Model” as one of the key elements to provide high-quality care. To quote from the Improving Chronic Care Web site, “Effective chronic illness care is virtually impossible without information systems that assure ready access to key data on individual patients as well as populations of patients. A comprehensive clinical information system can enhance the care of individual patients by providing timely reminders about needed services and summarized data to track and plan care. At the practice population level, they identify groups of patients needing additional care, as well as facilitate performance monitoring and quality improvement efforts.” To be able to take advantage of many of the more advanced applications of health information technology, the facility must first implement an EMR and use it to document patient encounters.

Although some health plans and provider incentive programs do reward facilities for EMR adoption, our analysis did not reveal any established consensus-endorsed measure that measures adoption of technology and defines it in the way described above.

While it is preferable to encourage adoption of CCHIT certified EMRs, it became apparent during measure field testing that CCHIT certified EMRs are not currently available for all provider settings and specialty groups that may report this measure. Therefore, additional numerator coding was added to enable providers who have adopted a non-CCHIT certified product, which meets a set of standards, to also report this measure. The following is an excerpt taken from the CCHIT website: *“The 2006 Ambulatory EHR Criteria represent basic requirements that the Commission and its Workgroups believe are appropriate for many common ambulatory care settings. CCHIT acknowledges that these Criteria may not be suitable for settings such as behavioral health, emergency departments, or specialty practices and our current certification makes no representation for these. Purchasers should not interpret a lack of CCHIT Certification as being of significance for specialties and domains not yet addressed by CCHIT Criteria.”*

Measure #126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months

INSTRUCTIONS:

This measure is to reported a minimum of 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 categorization and follow up treatment plan should be done according to the following table:

Risk Categorization System:

Category	Risk Profile	Evaluation Frequency
0	Normal	Annual
1	Peripheral Neuropathy (LOPS)	Semi-annual
2	Neuropathy, deformity, and/or PAD	Quarterly
3	Previous ulcer or amputation	Monthly to quarterly

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

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients who had a lower extremity neurological exam performed at least once within 12 months

Definition:

Lower Extremity Neurological Exam – Consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Lower Extremity Neurological Exam Performed

G8404: Lower extremity neurological exam performed and documented

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons

G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure

OR

Lower Extremity Neurological Exam not Performed

G8405: Lower extremity neurological exam not performed

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for diabetes (line-item ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

AND

Patient encounter during the reporting period (CPT): 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

RATIONALE:

Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. Other forms of neuropathy may also play a role in foot ulcerations. Motor neuropathy resulting in anterior crural muscle atrophy or intrinsic muscle wasting can lead to foot deformities such as foot drop, equinus, and hammertoes. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

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 #128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented

Parameters: Age 65 and older BMI ≥ 30 or < 22

Age 18 – 64 BMI ≥ 25 or < 18.5

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. The most recent quality code submitted will be used for performance calculation. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. BMI measured and documented in the medical record may be reported if done in the provider's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the provider. The documentation of a follow up plan should be based on the most recently calculated BMI.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients with BMI calculated within the past six months or during the current visit and a follow-up plan documented if the BMI is outside of parameters

Definitions:

BMI – Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems. BMI is calculated by dividing a person's weight (in kilograms) by his/her height (in meters, squared). BMI can also be calculated by multiplying weight (in pounds) by 705, then dividing by height (in inches) twice. A simpler method to calculate the BMI involves the use of a chart. The weight is plotted on one axis and the height is plotted on the other axis. The BMI can then be read where the two points intersect. Example BMI charts are widely available via the internet.

Calculated BMI – Requires that both the height and weight are actually measured. Values merely reported by the patient cannot be used.

Follow-up Plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education, referral, prescription/administration of medications/dietary supplements, etc.

Terminal Illness – Life expectancy is 6 months or less

Not Eligible/Not Appropriate for BMI Measurement – Patients can be considered not eligible in the following situations:

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness
- If the patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented

G8420: Calculated BMI within normal parameters and documented

OR

G8417: Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record

OR

G8418: Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record

OR

Patient not Eligible for BMI Calculation for Documented Reasons

G8422: Patient not eligible for BMI calculation

OR

BMI not Performed and/or Calculated BMI Outside of Normal Parameters, Follow-up Plan not Documented, Reason not Specified

G8421: BMI not calculated

OR

G8419: Calculated BMI outside normal parameters, no follow-up plan documented in the medical record

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01632, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01953, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01968, 01969, 01990, 01991, 01992, 01996, 01999, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0108, G0270

RATIONALE:

Of the Medicare population, 37 percent are overweight, and 18 percent are obese. Between 1991 and 1998, the prevalence of obesity among persons age 60-69 increased by 45 percent (American Obesity Association).

The economic impact of obesity and its related conditions in the U.S. economy is staggering and has been estimated at about \$117 billion according to the Midcourse Review of Healthy People 2010.

A recent study predicts that by 2020 there will be an 18 percent to 22 percent increase in the prevalence of Americans between the ages of 50 and 69 who have difficulty bathing, dressing or walking across a room if the current rate of weight increase for this age group continues. According to a 1998 survey, only 52 percent of adults age 50 or older reported being asked during routine medical check-ups about physical activity or exercise. The likelihood of being asked about exercise during a routine check-up declined with age (Center for the Advancement of Health, 2004).

Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In one study it was found that a BMI of less than 22 kg per m² in women and less than 23.5 in men is associated with increased mortality. In another study it was found that the optimal BMI in the elderly is 24 to 29 kg per m². (Huffman, G. B., Evaluation and Treatment of Unintentional Weight Loss in the Elderly, American Family Physician, 2002 Feb, 4:640-650.)

A tremendous gap still exists between our knowledge of malnutrition and its sequelae and our actions in preventing and treating it. To date professionals in various disciplines have applied their own approaches to solving the problem. Yet the causes of malnutrition are multi-factorial and the solutions demand an integration of knowledge and expertise from the many different disciplines involved in geriatric care. Older people have special nutritional needs due to age and disease processes. Professionals of all disciplines need to help older individuals improve their oral health, mental health, medication use, food choices, economic situation, functional status and medical condition and thereby improve both nutritional status and quality of life (American Dietetic Association, Nutrition Screening Initiative, 2002).

A Web search of the National Quality Measures Clearinghouse on the key words of BMI, body mass index, produced three measures, all focused on possible follow-up for overweight and obesity for a broader age range. There were no measures that focused on underweight or a follow-up plan.

CLINICAL RECOMMENDATION STATEMENTS:

The USPSTF recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults. (Level of Evidence = B, USPSTF)

The clinical guideline for obesity recommends assessment of BMI at each encounter (National Heart, Lung and Blood Institute).

Validated measure of nutrition status serves as an indicator of over-nourishment and under-nourishment. Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

The NSI-suggested BMI range is 22-27 (values outside this range indicate overweight or underweight for elderly) Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

Interventions can be grouped into six primary categories: Social Services, Oral Health, Mental Health, Medication Use, Nutritional Education and Counseling, and Nutritional Support. For further detail on any of the potential interventional strategies, see the Nutritional Interventions Manual for

Professionals Caring for Older Americans, 2002. Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

📌 **Measure #130: Documentation and Verification of Current Medications in the Medical Record**

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative is documented by the provider

INSTRUCTIONS:

This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

Current medications with dosages and verification with patient or authorized representative is documented by the provider

Definitions:

Authorized Representative – A person who is acting on the patient's behalf and who does not have a conflict of interest with the patient, when the patient is temporarily or permanently unable to act for him or herself. This person should have the patient's best interests at heart and should be reasonably expected to act in a manner that is protective of the person and the rights of the patient. Preferably, the patient appoints this individual.

Current Medications – All medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) a patient may be taking routinely and/or on a PRN basis

Verification – Documentation of acknowledgment by the patient and/or authorized representative or provider that signifies discussion, assessment, or review to confirm accuracy of information.

Not Eligible – A patient is not eligible if one or more of the following condition(s) exist:

- Patient refuses to participate
- Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Patient cognitively impaired and no authorized representative available

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Current Medications with Dosages AND Verification Documented

G8427: List of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative documented by the provider

OR

Current Medications with Dosages not Documented, Patient not Eligible

G8430: Provider documentation that patient is not eligible for medication assessment

OR

Current Medications with Dosages Documented, Patient Verification not Documented, Patient not Eligible

G8507: Provider documentation that patient is not eligible for patient verification of current medications

OR

Current Medications with Dosages Documented, Patient Verification not Documented, Reason not Specified

G8428: Provider documentation of current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) without documented patient verification

OR

Current Medications with Dosages not Documented, Reason not Specified

G8429: Incomplete or no provider documentation that the patient's current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were assessed

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190,

01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01632, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01953, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01968, 01969, 01990, 01991, 01992, 01996, 01999 90801, 90802, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92569, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0270

RATIONALE:

Adverse drug events (ADEs) are one of the leading causes of hospitalizations and deaths in the U.S. Specifically, data suggests that ADEs are an important problem among outpatients, with 13% of events occurring in patients with a prior or documented allergy/reaction to the reactive drug. Using a medication list in the office setting promotes patient safety and reduces medical errors, both by improving documentation in general and, specifically, by improving communication between patients and providers.

The need for this measure is important because no similar measure has been identified through review of literature, the AHRQ National Quality Measures Clearinghouse, and relevant specialty society web sites.

CLINICAL RECOMMENDATION STATEMENTS:

In addition, as part of its efforts to promote patient safety and reduce the growing incidence of medical errors in the office setting, the Institute for Healthcare Improvement created a recommended medication list for patients and their families to carry with them to medical appointments to help providers reconcile medications during medical visits. [Institute for Healthcare Improvement. Medication List For Patients and Families. Massachusetts Coalition for the Prevention of Medical Error (in collaboration with the Massachusetts Medical Society)]

🏠 Measure #134: Screening for Clinical Depression and Follow-Up Plan

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool AND follow-up plan documented

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

NUMERATOR:

Patient's screening for clinical depression using a standardized tool AND follow-up plan is documented

Definitions:

Screening – Testing done on people at risk of developing a certain disease, even if they have no symptoms. Screening tests can predict the likelihood of someone having or developing a particular disease. This measure looks for the test being done in the practitioner's office that is filing the code.

Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some depression screening tools include: Patient Health Questionnaire (PHQ9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), GDS – Short Version, Hopkins Symptom Checklist (HSCL), The Zung Self-Rating Depression Scale (SDS), and Cornell Scale Screening (this is a screening tool which is used in situations where the patient has cognitive impairment and is administered through the caregiver).

Follow-Up Plan – Proposed outline of treatment to be conducted as a result of clinical depression screen. Such follow-up must include further evaluation if screen is positive and may include documentation of a future appointment, education, additional evaluation and/or referral to a practitioner who is qualified to diagnose and treat depression, and/or notification of primary care provider.

Not Eligible/Not Appropriate – A patient is not eligible if one or more of the following conditions exist:

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases
- Patient was referred with a diagnosis of depression
- Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Positive Screen for Clinical Depression, Follow-up Plan Documented

G8431: Positive screen for clinical depression using a standardized tool and a follow-up plan documented

OR

Negative Screen for Clinical Depression Documented, Patient not Eligible/Appropriate for Follow-up Plan

G8510: Negative screen for clinical depression using standardized tool, patient not eligible/appropriate for follow-up plan documented

OR

Screening for Clinical Depression not Documented, Patient not Eligible/Appropriate

G8433: Screening for clinical depression using a standardized tool not documented, patient not eligible/appropriate

OR

Screening for Clinical Depression not Documented, Reason not Specified

G8432: No documentation of clinical depression screening using a standardized tool

OR

Screening for Clinical Depression Documented, Follow-Up Plan not Documented, Reason not Specified

G8511: Screen for clinical depression using a standardized tool documented, follow-up plan not documented, reason not specified

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92557, 92567, 92568, 92625, 97003

RATIONALE:

The World Health Organization identified major depression as the fourth leading cause of worldwide disease in 1990, causing more disability than either ischemic heart disease or cerebrovascular disease. In primary care settings, the point prevalence of major depression ranges from 5 to 9 percent among adults, and up to 50 percent of depressed patients are not recognized. Depressive disorders are also relatively common in younger persons, with estimated prevalence of 0.8 to 2.0 percent in children and 4.5 percent in adolescents.

U.S. Preventive Services Task Force compared the effects of integrated recognition and management depression screening programs with “usual care” in community primary care practices. Results showed significantly improved patient outcomes.

The National Center for Policy Analysis and the U.S. Surgeons General, among others, estimate the direct and indirect costs of depression to American businesses ranging from \$36.2 billion to \$80 billion annually.

Major depression is “ranked second only to ischemic heart disease in magnitude of disease burden in established market economies” and “is the leading cause of *disability* (measured by the number of years *lived* with a disabling condition) worldwide among persons age 5 and older.” Murray CJL, Lopez AD, eds. The Global Burden Of Disease And Injury Series, Volume 1: A Comprehensive Assessment Of Mortality And Disability From Diseases, Injuries, And Risk Factors In 1990 And Projected To 2020. Cambridge, MA: Published by the Harvard School of Public Health on behalf of the World Health Organization and the World Bank, Harvard University Press, 1996.

A search of the literature in PubMed concerning social workers and depression screening showed nothing to indicate that these practitioners are routinely screening their patients for depression.

A search of the National Quality Measures Clearinghouse database found no depression screening measures that address Medicare eligible patients and there was only one measure from the Physician Consortium for Performance Improvement addressing screening for patients aged 18 years and older with suspected major depressive disorder.

CLINICAL RECOMMENDATION STATEMENTS:

USPSTF recommends screening adults for depression in clinical practices that have systems in place to assure accurate diagnosis, effective treatment, and follow-up. Small benefits have been observed in studies that simply feed back screening results to clinicians. Larger benefits have been observed in studies in which the communication of screening results is coordinated with effective follow-up and treatment. (Evidence: B)

The Canadian Task Force on Preventive Health Care used the rigorous USPSTF 2002 systematic review to update their recommendations regarding depression screening. The Canadian task force arrived at the same practice recommendations as USPSTF.

◆ **Measure #148: Back Pain: Initial Visit**

2009 PQRI REPORTING OPTIONS: MEASURES GROUP ONLY - BACK PAIN

DESCRIPTION:

The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who had back pain and function assessed during the initial visit to the clinician for the episode of back pain

INSTRUCTIONS:

REFER TO THE 2009 PQRI MEASURES GROUPS SPECIFICATIONS MANUAL FOR REPORTING OF THIS MEASURE.

NUMERATOR:

Patients who had all five of the following components assessed at the initial visit to the clinician for an episode of back pain: pain assessment, functional status, patient history (including notation of presence or absence of warning signs), assessment of prior treatment and response, and employment status

Definitions:

Pain Assessment – Must use any of the following assessment tools:

- SF-36
- Oswestry Low Back Pain Disability Questionnaire
- Roland-Morris Disability Questionnaire
- Quebec Pain Disability Scale
- Sickness Impact Profile
- Multidimensional Pain Inventory

OR

If none of the above tools are used, documentation of any of the following pain scales is acceptable:

- McGill Pain Questionnaire
- Visual analog scale
- Brief pain inventory
- Chronic pain grade
- Neuropathic pain scale
- Numerical rating scale (e.g., pain intensity 1–10)
- Verbal descriptive scale (e.g., pt. report: “burning, shooting, stabbing”)
- Faces pain scale

Functional Status Assessment – Must use any of the following assessment tools:

- SF-36
- Oswestry Low Back Pain Disability Questionnaire
- Roland-Morris Disability Questionnaire
- Quebec Pain Disability Scale

- Sickness Impact Profile
- Multidimensional Pain Inventory

OR

If none of the above tools are used, there must be documentation that activities of daily living (ADL) were assessed. Assessment of all of the following ADLs must be documented:

- Eating
- Bathing
- Using the toilet
- Dressing
- Getting up from bed or a chair

Patient History – Documentation necessary to satisfy assessment for red flags, which can include the following:

- Indication/notation of presence or absence of red flags
- Notation of specific symptoms that may indicate the presence of red flags (examples noted below)
 - “Red Flags” include:
 - History of cancer or unexplained weight loss
 - Current infection or immunosuppression
 - Fracture or suspected fracture
 - Motor vehicle accident or industrial injury with suspicion of fracture
 - Major fall with suspicion of fracture
 - Cauda equina syndrome or progressive neurologic deficit
 - Saddle anesthesia
 - Recent onset bladder dysfunction (urine retention, increased frequency, overflow incontinence)
 - Recent onset fecal incontinence (loss of bowel control)
 - Major motor weakness

Assessment of Prior Treatment and Response – If applicable, documentation that patient has been queried about back pain episode(s), treatment and response. Notation could include the following:

- No prior back pain
- Diagnosis and dates of back pain reports for the previous two years, or as far back as the patient is able to provide information
- Report from referring physician with summary of back pain history
- Patient report of history and attempted treatments, including diagnostic tests (e.g., imaging)

Employment Status – Use of either of the following assessment tools will satisfy this requirement:

- Sickness Impact Profile
- Multidimensional Pain Inventory

OR

Variables of an employment assessment can count. These variables must include documentation of the following:

- Type of work, including job tasks that may affect back pain management
- Work status (e.g., out of work, part-time work, work with or without limitations)
- If patient is not working or limited in work capacity, length of time for work limitations
- Workers' compensation or litigation involvement

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first claim for back pain diagnosis. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain.

Initial Visit – First visit to the clinician for an episode of back pain. This measure may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Back Pain and Function Assessed

CPT II 1130F: Back pain and function assessed, including all of the following: Pain assessment AND functional status AND patient history, including notation of presence or absence of “red flags” (warning signs) AND assessment of prior treatment and response, AND employment status

OR

If patient is not eligible for this measure because back pain episode began prior to the reporting period, report:

CPT II 0526F: Subsequent visit for episode

OR

Back Pain and Function not Assessed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1130F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1130F with 8P: Back pain and function was not assessed during the initial visit, reason not otherwise specified

DENOMINATOR:

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

Denominator Criteria (Eligible Cases):

Patients aged 18 through 79 years on date of encounter

AND

Diagnosis for back pain (line-item ICD-9-CM): 721.3 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

AND

Patient encounter during the reporting period (CPT) - Service codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

Patient encounter during the reporting period (CPT) - Procedure: 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200

RATIONALE:

Pain Assessment: The initial assessment should occur with each new episode of pain and should focus on identifying the cause of the pain and developing a pain management plan. Subsequent assessments should evaluate the effectiveness of the plan and, if pain is unrelieved, determine whether the cause is related to the progression of disease, a new cause of pain, or the treatment.

Functional Status: Spinal disorders involve a complex interaction of physiologic, psychological and social factors that are difficult to evaluate through traditional biomedical techniques. As a consequence of this complexity, both clinicians and researchers have acknowledged the evaluation of functional status as essential in the treatment of chronic disabling musculoskeletal conditions because pain and disability are the most important endpoints for patients.

Patient History: Identifying the presence or absence of red flags is necessary to determine if there are signs of serious underlying conditions that require specific treatment.

Assessment of Prior Treatment and Response: Information about the patient's history of back pain and response to previous therapy are important in the care of back problems. A variety of treatments may be appropriate. Failure to respond to treatment may indicate the need to try other approaches.

Employment Status: Investigation of employment status and patient-perceived barriers (psychosocial, workplace, management issues) assists physicians in gaining an understanding of how to best alter a patient's back pain or disability trajectory and encourage return to work or full work status.

CLINICAL RECOMMENDATION STATEMENTS:

Guidelines are consistent in recommendations that diagnostic procedures should focus on the identification of red flags and exclusion of specific diseases.

- American Academy of Orthopedic Surgeons (2002)
- North American Spine Society (2000)
- International Guideline Comparison (2001)
- ICSI (2005)
- University of Michigan Health System (2003)

◆ **Measure #149: Back Pain: Physical Exam**

2009 PQRI REPORTING OPTIONS: MEASURES GROUP ONLY - BACK PAIN

DESCRIPTION:

Percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received a physical examination at the initial visit to the clinician for the episode of back pain

INSTRUCTIONS:

REFER TO THE 2009 PQRI MEASURES GROUPS SPECIFICATIONS MANUAL FOR REPORTING OF THIS MEASURE.

NUMERATOR:

Patients who had a physical examination at the initial visit to the clinician for a new episode of back pain

Definitions:

Physical Examination – For patients with radicular symptoms, documentation of physical exam must include the following, at a minimum:

- Indication of straight leg raise test

AND

- Notation of completion of neurovascular exam (a neurovascular exam must include ankle and knee reflexes; quadriceps; ankle and great toe dorsiflexion strength; plantar flexion; muscle strength; motor testing; pulses in lower extremities; and sensory exam)

For patients **without** radicular symptoms, documentation of physical exam must include the following:

- Documentation of straight leg raise, neurovascular exam or clear notation of absence or presence of neurologic deficits

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first claim for back pain diagnosis. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain.

Initial Visit – First visit to the clinician for an episode of back pain. This measure may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Physical Exam Performed

CPT II 2040F: Physical examination on the date of the initial visit for low back pain performed, in accordance with specifications

OR

If patient is not eligible for this measure because back pain episode began prior to the reporting period, report:

CPT II 0526F: Subsequent visit for episode

OR

Physical Exam not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2040F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2040F with 8P: Physical exam was not performed during the initial visit, reason not otherwise specified

DENOMINATOR:

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

Denominator Criteria (Eligible Cases):

Patients aged 18 through 79 years on date of encounter

AND

Diagnosis for back pain (line-item ICD-9-CM): 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

AND

Patient encounter during the reporting period (CPT) - Service codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

Patient encounter during the reporting period (CPT) - Procedure codes: 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200

RATIONALE:

The physical exam is an integral component of identifying the source and mechanism of back pain and provides the physician with the information necessary to determine the next steps for diagnosis and treatment.

CLINICAL RECOMMENDATION STATEMENTS:

The types of physical examination and physical tests that are recommended show some variation. Neurologic screening, which is largely based on the straight leg raising test, plays an important role in most guidelines.

Physical exam components may differ by diagnosis or suspected diagnosis. For example, straight-leg raise should be performed on patients with sciatica or pseudoclaudication, but may be negative in patients with spinal stenosis.

◆ **Measure #150: Back Pain: Advice for Normal Activities**

2009 PQRI REPORTING OPTIONS: MEASURES GROUP ONLY - BACK PAIN

DESCRIPTION:

The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice for normal activities at the initial visit to the clinician for the episode of back pain

INSTRUCTIONS:

REFER TO THE 2009 PQRI MEASURES GROUPS SPECIFICATIONS MANUAL FOR REPORTING OF THIS MEASURE.

NUMERATOR:

Patients with documentation of advice to maintain or resume normal activities at the initial visit to the clinician for a new episode of back pain

Definitions:

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first claim for back pain diagnosis. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain.

Initial Visit – First visit to the clinician for an episode of back pain. This measure may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Advice for Normal Activities Performed

CPT II 4245F: Patient counseled during the initial visit to maintain or resume normal activities

OR

If patient is not eligible for this measure because back pain episode began prior to the reporting period, report:

CPT II 0526F: Subsequent visit for the episode

OR

Advice for Normal Activities not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4245F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4245F with 8P: Advice for normal activities was not performed during the initial visit, reason not otherwise specified

DENOMINATOR:

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

Denominator Criteria (Eligible Cases):

Patients aged 18 through 79 years on date of encounter

AND

Diagnosis for back pain (line-item ICD-9-CM): 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

AND

Patient encounter during the reporting period (CPT) – Service codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

Patient encounter during the reporting period (CPT) – Procedure codes: 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200

RATIONALE:

In cases of low back pain, patients should be encouraged to maintain or resume their normal activities as early as possible in the course of the symptoms.

For most patients, the best recommendation is a rapid return to normal activities as tolerated and encouraged ambulation. This recommendation must be tempered by consideration of the patient's usual job or life demands. Heavy lifting, trunk twisting and bodily vibrations should be avoided in the acute phase.

CLINICAL RECOMMENDATION STATEMENTS:

Evidence Level: Moderate—important clinical benefit of functional activities on return to work (acute low back pain only).

Acute: Nine RCTs comparing bed rest with other treatments; either no difference was found or bed rest resulted in worse outcomes in pain, functional status, recovery and sick leave. Advice to continue ordinary activity can give equivalent or faster symptomatic recovery from the acute attack and lead to less chronic disability and less time off work.

Chronic: No RCTs for advice to stay active or bed rest.

Guideline Support:

- Clinical Evidence (review) (2004)
- Philadelphia Panel Evidence Based Guidelines (2001)
- Cochrane Review: Bed Rest (2004)
- ICSI
- University of Michigan Health System

◆ **Measure #151: Back Pain: Advice Against Bed Rest**

2009 PQRI REPORTING OPTIONS: MEASURES GROUP ONLY - BACK PAIN

DESCRIPTION:

The percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice against bed rest lasting four days or longer at the initial visit to the clinician for the episode of back pain

INSTRUCTIONS:

REFER TO THE 2009 PQRI MEASURES GROUPS SPECIFICATIONS MANUAL FOR REPORTING OF THIS MEASURE.

NUMERATOR:

Patients with documentation of advice against bed rest lasting four days or longer at the initial visit to the clinician for a episode of back pain

Definitions:

Episode – A patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first claim for back pain diagnosis. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain.

Initial Visit – First visit to the clinician for an episode of back pain. If the patient's initial visit for this episode of back pain occurred prior to the beginning of the reporting period, report that this is a subsequent visit for the episode.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Advice Against Bed Rest Performed

CPT II 4248F: Patient counseled during the initial visit for an episode of back pain against bed rest lasting 4 days or longer

OR

If patient is not eligible for this measure because back pain episode began prior to the reporting period, report:

CPT II 0526F: Subsequent visit for episode

OR

Advice Against Bed Rest not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4248F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4248F with 8P: Advice against bed rest was not performed during the initial visit, reason not otherwise specified

DENOMINATOR:

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

Denominator Criteria (Eligible Cases):

Patients aged 18 through 79 years on date of encounter

AND

Diagnosis for back pain (line-item ICD-9-CM): 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

AND

Patient encounter during the reporting period (CPT) – Service codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

Patient encounter during the reporting period (CPT) – Procedure codes: 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200

RATIONALE:

For most patients, the best recommendation is a rapid return to normal activities and avoidance of bed rest. This recommendation must be tempered by consideration of the patient's usual job or life demands. Heavy lifting, trunk twisting and bodily vibrations should be avoided in the acute phase.

CLINICAL RECOMMENDATION STATEMENTS:

Evidence Level: Moderate—important clinical benefit of functional activities on return to work (acute LBP only).

Acute: Nine RCTs comparing bed rest with other treatments; either no difference was found or bed rest resulted in worse outcomes in pain, functional status, recovery and sick leave. Advice to continue ordinary activity can give equivalent or faster symptomatic recovery from the acute attack and lead to less chronic disability and less time off work.
Chronic: No RCTs for advice to stay active or bed rest.

Guideline Support:

- Clinical Evidence (review) (2004)
- Philadelphia Panel Evidence Based Guidelines (2001)
- Cochrane Review: Bed Rest (2004)
- ICSI
- University of Michigan Health System

*** Measure # 154: Falls: Risk Assessment**

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 *should* also be reported.

DESCRIPTION:

Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months

INSTRUCTIONS:

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

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

NUMERATOR:

Patients who had a risk assessment for falls completed within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:

Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Risk Assessment – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months.

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

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

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 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

DENOMINATOR:

All patients aged 65 years and older who have a history of falls

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter

AND

Patient encounter during the reporting period (CPT): 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

RATIONALE:

Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.

CLINICAL RECOMMENDATION STATEMENTS:

Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C) Multifactorial assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person's perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence

- assessment of home hazards
- cardiovascular examination and medication review (NICE) (Grade C)

A falls risk assessment should be performed for older persons who present for medical attention because of a fall, report recurrent falls in the past year, report difficulties in walking or balance or fear of falling, or demonstrate unsteadiness or difficulty performing a gait and balance test.

The falls risk evaluation should be performed by a clinician with appropriate skills and experience. [C]

A falls risk assessment is a clinical evaluation that should include the following, but are not limited to:

- a history of fall circumstances
- review of all medications and doses
- evaluation of gait and balance, mobility levels and lower extremity joint function
- examination of vision
- examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function
- cognitive evaluation
- screening for depression
- assessment of postural blood pressure
- assessment of heart rate and rhythm
- assessment of heart rate and rhythm, and blood pressure responses to carotid sinus stimulation if appropriate
- assessment of home environment

The falls risks assessment should be followed by direct intervention on the identified risk. [A] (AGS)

*** Measure #155: Falls: Plan of Care**

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment. This measure *should* be reported if CPT II code 1100F “Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year” is submitted for Measure #154.

DESCRIPTION:

Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months

INSTRUCTIONS:

This measure is to be reported a minimum of 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 SAME CLAIM.

NUMERATOR:

Patients with a plan of care for falls documented within 12 months

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Definitions:

Plan of Care – Must include: 1) consideration of appropriate assistance device AND 2) balance, strength, and gait training.

Consideration of Appropriate Assistance Device – Medical record must include: documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device

Balance, Strength, and Gait Training – Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait
Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Plan of Care Documented

CPT II 0518F: Falls plan of care documented

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 Specified

Append a reporting modifier (**8P**) to CPT Category II code **0518F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0518F with 8P: Plan of care not documented, reason not otherwise specified

DENOMINATOR:

All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

Denominator Criteria (Eligible Cases):

All eligible instances when **CPT II code 1100F** (Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154.

RATIONALE:

Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

CLINICAL RECOMMENDATION STATEMENTS:

Among community-dwelling older persons (i.e., those living in their own homes), multifactorial interventions should include:

- gait training and advice on the appropriate use of assistive devices (Grade B)
- review and modification of medication, especially psychotropic medication (Grade B)
- exercise programs, with balance training as one of the components (Grade B)
- treatment of postural hypotension (Grade B)
- modification of environmental hazards (Grade C)
- treatment for cardiovascular disorders (Grade D) (AGS/BGS/AAOS)

🏠 Measure #181: Elder Maltreatment Screen and Follow-Up Plan

2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY

DESCRIPTION:

Percentage of patients age 65 years and older with documentation of a screen for elder maltreatment AND documented follow-up plan

INSTRUCTIONS:

This measure is to be reported for each initial patient evaluation during the reporting period. When reporting CPT service code 96116, 97803, and G0270 the measure is to be reported each time the code is submitted. The not eligible code can be used to report if it is not an initial evaluation with screening for elder maltreatment. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

NUMERATOR:

Patients with a documented screen for elder maltreatment and follow-up plan

Definitions:

Documented – Evidenced in the clinical record. Such evidence can include narrative notes, a formal screen and/or an assessment and treatment plan tool/form, copy of a documented plan or referral request for further evaluation, etc.

Screen for Elder Maltreatment – The screen includes a review of the following components: (1) physical abuse, (2) emotional or psychological abuse, (3) neglect, (4) sexual abuse, (5) abandonment, (6) financial or material exploitation, (7) self-neglect, and (8) unwanted control. (Institute of Medicine 2002)

Physical Abuse – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking or other actions that result in harm. (Institute of Medicine, 2002)

Emotional or Psychological Abuse – Involves psychological abuse, verbal abuse, or mental injury and includes act or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.

Neglect – Involves attitudes of others or actions caused by others-such as family members, friends, or institutional caregivers-that have an extremely detrimental effect upon well-being. (Reyes-Ortiz 2001)

Active – Behavior that is willful, the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts. (NCPEA)

Passive – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources. (NCPEA)

Sexual Abuse – Involves adults who are unable to fully comprehend and/or give informed consent in sexual activities that violate the taboos of society. (Institute of Medicine 2002)

Abandonment – Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder. (NCPEA)

Financial or Material Exploitation – Taking advantage of a person for monetary gain or profit. (Institute of Medicine 2002)

Self-Neglect – Self-imposed attitudes or actions that contribute to decline in the persons overall health and well being, may be associated with an inappropriate or nontraditional lifestyle. Other names used may include Diogenes syndrome (DS), aged reclusion, social breakdown, and squalor syndrome. (Reyes-Ortiz 2001)

Unwarranted Control – Controlling a person's ability to make choices about living situations, household finances, and medical care. (Institute of Medicine 2002)

Follow-Up Plan – May include but is not limited to documentation of a referral or discussion with other providers, ongoing monitoring or assessment, and/or a direct intervention.

Not Eligible – A patient is not eligible if the following condition(s) exist:

- Patient refuses to participate.
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
- Patient elder maltreatment screen was negative and no further follow-up required.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Elder Maltreatment Screen and Follow-Up Plan Documented

G8534: Documentation of an elder maltreatment screen and follow-up plan

OR

Elder Maltreatment Screen Documented, Follow-Up Plan not Documented, Patient not Eligible

G8537: Elder maltreatment screen documented, follow-up plan not documented, patient not eligible

OR

Elder Maltreatment Screen not Documented, Patient not Eligible

G8535: No documentation of an elder maltreatment screen, patient not eligible

OR

Elder Maltreatment Screen not Documented, Reason not Specified

G8536: No documentation of an elder maltreatment screen, reason not specified

OR

Elder Maltreatment Screen Documented, Follow-Up Plan not Documented, Reason not Specified

G8538: Elder maltreatment screen documented, follow-up plan not documented, reason not specified

DENOMINATOR:

All patients 65 years of age and older

Denominator Criteria (Eligible Cases):

Patients aged \geq 65 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 96116*, 96150, 97003, 97802, 97803*, G0270*

Note: **When reporting CPT code 96116, 97803, and G0270, the measure is to be reported each time the code is submitted.*

RATIONALE:

Elder abuse is the infliction of physical, emotional, or psychological harm on an older adult, but also can take the form of financial exploitation or intentional or unintentional neglect of an older adult by the caregiver. Over the past ten years there has been an increase in elder abuse, which is not being picked up and reported to appropriate authorities. The reasons for underreporting are two-fold: health care professionals don't ask patients if they are being abused and patients don't tell, for fear of retaliation by their caregivers. In the American Psychological Association's "Elder Abuse and Neglect: In Search of Solutions," found on their website, it is reported that every year an estimated 2.1 million older Americans are victims of physical, psychological, or other forms of abuse and neglect and that for every reported case of elder abuse and neglect, it is estimated that there may be as many as five unreported cases. Recent research suggests that elders who have been abused tend to die earlier than those who are not abused, even in the absence of chronic conditions or life threatening disease.

It is difficult to obtain accurate information on the extent of elder abuse and neglect in the United States. Studies often focus on reports of selected populations and many cases are unreported. Victims may be embarrassed, intimidated and overwhelmed by the situation. They may be fearful of reprisals or unaware of the availability of help. In some cases, victims may be unable to report maltreatment or do not realize that they are being maltreated. Finally, health professionals may ignore the signs and symptoms of elder maltreatment because they are unaware of the extent of the problem and uncomfortable with the responsibility of further assessment and action.

The extent to which elder maltreatment affects the health care system is largely unknown. Common clinical findings associated with maltreatment include bruises, lacerations, abrasions, head injury, fractures, dehydration, and malnutrition. These injuries commonly result in hospitalization. In one descriptive study that tracked the emergency department utilization of known elderly victims of physical abuse identified through adult protective services, 114 individuals had 628 emergency department visits during a 5-year window surrounding the referral; 30 percent of these visits resulted in hospital admission. (Institute of Medicine 2002)

Studies do indicate that the effects of elder maltreatment increase the medical needs of victims. One longitudinal study of elderly victims of maltreatment documented a threefold increased risk of death in the 3-year period following maltreatment, after adjusting for comorbidity and other factors that predict death in older cohorts (Lachs 1998). In addition, maltreatment may exacerbate or interfere with the treatment of other medical and psychosocial conditions. For example, angina pectoris, emphysema, diabetes mellitus, and arthritis are much more challenging to treat in an abusive environment (Lachs 1997). No studies of the costs associated with these increased medical needs have been published. (Institute of Medicine 2002)

Website searches of the National Quality Measures Database (NQMC) using the keywords Elder Abuse and Elder Neglect resulted in 9 measures. The measures only pertain to intimate partner violence and not the broader topic of elder maltreatment. One measure was focused on preventive counseling on violence and abuse, which is not the measure focus.

CLINICAL RECOMMENDATION STATEMENTS:

Every clinical setting should have a protocol for the detection and assessment of elder maltreatment. This may be a narrative, a checklist, or some other type of standardized form that enables all providers in that practice setting to rapidly assess for elder maltreatment and document it in a way that allows clinicians to look at patterns over time. (Aravanis and Adelman 1993)

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