

2008 Physician Quality Reporting Initiative Specifications Document

This document contains the complete specifications for the 119 measures that make up the 2008 Physician Quality Reporting Initiative (PQRI). Each measure is assigned a unique number. Measure numbers for 2008 PQRI represent a continuation in numbering from the 2007 PQRI Measures 1 through 74. Gaps in measure numbering reflect those 2007 PQRI measures that are not included for implementation in 2008 PQRI. In general, the quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. These specifications will be updated prior to the beginning of the 2008 PQRI reporting period to reflect any additional edits.

The denominator population is defined by certain ICD-9 and CPT Category I codes specified in the measure that are submitted by eligible professionals as part of a claim for covered services under the Medicare Physician Fee Schedule. Some measure coding specifications are adapted as needed for implementation in PQRI in agreement with the measure developer. For example, CPT codes for non-covered services such as preventive visits are not included in the denominator. If the specified denominator codes for a measure are not included in the patient's claim as submitted, then the patient does not fall into the denominator population, and the PQRI measure does not apply to the patient.

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

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

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

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

The measure specifications are organized to provide the following information:

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

2008 PQRI Measure Specifications Table of Contents

Measure Number	Measure Title	Page
1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus	1
2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus	3
3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus	5
4	Screening for Future Fall Risk	8
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	10
6	Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease	14
7	Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)	17
8	Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction	20
9	Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression	22
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports	25
11	Stroke and Stroke Rehabilitation: Carotid Imaging Reports	28
12	Primary Open Angle Glaucoma: Optic Nerve Evaluation	31
14	Age-Related Macular Degeneration: Dilated Macular Examination	33
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	35
19	Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care	37
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	40
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	45
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)	50
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)	55
24	Osteoporosis: Communication with the Physician Managing Ongoing Care Post-Fracture	60
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	63
30	Perioperative Care: Timing of Prophylactic Antibiotics – Administering Physician	65
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	68
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	70
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	72
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered	74
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	77
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	80
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	82
40	Osteoporosis: Management Following Fracture	85
41	Osteoporosis: Pharmacologic Therapy	89

2008 PQRI Measure Specifications Table of Contents

Measure Number	Measure Title	Page
43	Use of Internal Mammary artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery	92
44	Preoperative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery	94
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	96
46	Medication Reconciliation	99
47	Advance Care Plan	102
48	Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	105
49	Characterization of Urinary Incontinence in Women Aged 65 Years and Older	107
50	Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	109
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	111
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	113
53	Asthma: Pharmacologic Therapy	116
54	Electrocardiogram Performed for Non-Traumatic Chest Pain	119
55	Electrocardiogram Performed for Syncope	121
56	Vital Signs for Community-Acquired Bacterial Pneumonia	123
57	Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia	125
58	Assessment of Mental Status for Community-Acquired Bacterial Pneumonia	127
59	Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	129
64	Asthma Assessment	132
65	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	134
66	Appropriate Testing for Children with Pharyngitis	136
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	139
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	142
69	Multiple Myeloma: Treatment with Bisphosphonates	145
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	147
71	Hormonal Therapy for Stage IC - III ER/PR Positive Breast Cancer	149
72	Chemotherapy for Stage III Colon Cancer Patients	154
73	Plan for Chemotherapy Documented Before Chemotherapy Administered	158
74	Radiation Therapy Recommended for Invasive Breast Cancer Patients who have Undergone Breast Conserving Surgery	160
75	Prevention of Ventilator-Associated Pneumonia – Head Elevation	162
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter Insertion Protocol	165
77	Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD	167
78	Vascular Access for Patients Undergoing Hemodialysis	170
79	Influenza Vaccination in Patients with End Stage Renal Disease (ESRD)	173
80	Plan of Care for ESRD Patients with Anemia	175
81	Plan of Care for Inadequate Hemodialysis in ESRD Patients	178

**2008 PQRI Measure Specifications
Table of Contents**

Measure Number	Measure Title	Page
82	Plan of Care for Inadequate Peritoneal Dialysis	181
83	Testing of Patients with Chronic Hepatitis C (HCV) for Hepatitis C Viremia	184
84	Initial Hepatitis C RNA Testing	187
85	HCV Genotype Testing Prior to Therapy	190
86	Consideration for Antiviral Therapy in HCV Patients	193
87	HCV RNA Testing at Week 12 of Therapy	195
88	Hepatitis A and B Vaccination in Patients with HCV	198
89	Counseling Patients with HCV Regarding Use of Alcohol	201
90	Counseling of Patients Regarding Use of Contraception Prior to Starting Antiviral Therapy	203
91	Acute Otitis Externa (AOE): Topical Therapy	206
92	Acute Otitis Externa (AOE): Pain Assessment	208
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	210
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	212
95	Otitis Media with Effusion (OME): Hearing Testing	214
96	Otitis Media with Effusion (OME): Antihistamines or Decongestants – Avoidance of Inappropriate Use	216
97	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	218
98	Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use	220
99	Breast Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer	222
100	Colorectal Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer	225
101	Appropriate Initial Evaluation of Patients with Prostate Cancer	228
102	Inappropriate Use of Bone Scan for Staging Low-Risk Prostate Cancer Patients	230
103	Review of Treatment Options in Patients with Clinically Localized Prostate Cancer	233
104	Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	236
105	Three-dimensional Radiotherapy for Patients with Prostate Cancer	239
106	Patients who have Major Depressive Disorder who meet DSM IV Criteria	241
107	Patients who have Major Depressive Disorder who are Assessed for Suicide Risks	245
108	Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis	248
109	Patients with Osteoarthritis who have an Assessment of Their Pain and Function	251
110	Influenza Vaccination for Patients \geq 50 Years Old	253
111	Pneumonia Vaccination for Patients 65 years and Older	255
112	Screening Mammography	258
113	Colorectal Cancer Screening	261
114	Inquiry Regarding Tobacco Use	264
115	Advising Smokers to Quit	266
116	Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis	269

2008 PQRI Measure Specifications Table of Contents

Measure Number	Measure Title	Page
117	Dilated Eye Exam in Diabetic Patient	272
118	Angiotensin Converting Enzyme Inhibitor (ACE) or Angiotensin Receptor Blocker (ARB) Therapy for Patients with Coronary Artery Disease and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD)	275
119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	279
120	ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD	282
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH), and Lipid Profile)	284
122	Chronic Kidney Disease (CKD): Blood Pressure Management	287
123	Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)	290
124	HIT- Adoption/Use of Health Information Technology (Electronic Health Records)	294
125	HIT- Adoption/Use of e-Prescribing	297
126	Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation	300
127	Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear	302
128	Universal Weight Screening and Follow-Up	304
129	Universal Influenza Vaccine Screening and Counseling	308
130	Universal Documentation and Verification of Current Medications in the Medical Record	311
131	Pain Assessment Prior to Initiation of Patient Treatment	314
132	Patient Co-Development of Treatment Plan/Plan of Care	317
133	Screening for Cognitive Impairment	321
134	Screening for Clinical Depression	325
	Symbol and Copyright Information	328
	List of Retired PQRI Measures	332

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

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals). This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

Numerator Instructions: Patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year

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

Numerator Coding:

Screening for Future Fall Risk Performed

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

OR

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

OR

Screening for Future Fall Risk not Performed for Medical Reasons

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

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

OR

Screening for Future Fall Risk not Performed, Reason not Specified

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

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

DENOMINATOR:

All patients aged 65 years and older

Denominator Coding:

A CPT code is required to identify patients for denominator inclusion.

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

RATIONALE:

Patients may not volunteer information regarding falls.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using G-codes:

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

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

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

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

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

Numerator Coding:

Acute Treatment with Antidepressant Medication

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

OR

Acute Treatment with Antidepressant Medication not Completed for Documented Reasons

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

OR

Acute Treatment with Antidepressant Medication not Completed

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

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code for MDD and a CPT code are required to identify patients for denominator inclusion.

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

AND

CPT E/M service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

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

NUMERATOR NOTE: *The correct combination of numerator 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 Coding:

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

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

AND

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

OR

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

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

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

OR

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

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

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

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

AND

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

DENOMINATOR:

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

Denominator Coding:

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

<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)
--	---

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

ICD-9 diagnosis and symptom codes: 368.12, 368.2, 386.2, 431, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9, 437.7, 780.02, 781.3, 781.4, 781.94, 782.0, 784.3, 784.5

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

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

Numerator Coding:

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

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

OR

Measurements of Distal Internal Carotid Diameter not Referenced for Medical Reasons

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

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

OR

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

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

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

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

Numerator Coding:

DVT Prophylaxis Received

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

OR

DVT Prophylaxis not Received for Medical or Patient Reasons

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

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

OR

DVT Prophylaxis not Received, Reason not Specified

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

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

Denominator:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

Patients who were prescribed antiplatelet therapy at discharge

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

Numerator Coding:

Antiplatelet Therapy Prescribed

CPT II 4073F: Oral antiplatelet therapy prescribed at discharge

OR

Antiplatelet Therapy Prescription not Prescribed for Medical or Patient Reasons

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

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

OR

Antiplatelet Therapy Prescription not Prescribed, Reason not Specified

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

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

Patients who were prescribed an anticoagulant at discharge

Definitions:

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

Numerator Coding:

Anticoagulant Prescribed

CPT II 4075F: Anticoagulant therapy prescribed at discharge

OR

Anticoagulant Prescription not Received for Medical or Patient Reasons

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

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

OR

Anticoagulant Prescription not Received, Reason not Specified

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

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

ICD-9 diagnosis code: 427.31

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

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

NUMERATOR NOTE: *The correct combination of numerator 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 Coding:

t-PA Administration or Consideration Documented

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

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

AND

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

OR

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

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

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

OR

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

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

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

- **4077F with 8P:** Tissue plasminogen activator (t-PA) administration was not considered, reason not otherwise specified

AND

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

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

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

NUMERATOR NOTE: *The correct combination of numerator 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 Coding:

Dysphagia Screening Conducted

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

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

AND

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

OR

Dysphagia Screening not Conducted for Medical Reasons

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

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

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

AND

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

OR

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

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

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

OR

Dysphagia Screening not Conducted, Reason not Specified

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

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

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

AND

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

INSTRUCTIONS:

This measure is to be reported for patients under active treatment for ischemic stroke or intracranial hemorrhage 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.

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

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

Numerator Coding:

Rehabilitation Services Ordered or Considered

CPT II 4079F: Documentation that rehabilitation services were considered

OR

Rehabilitation Services not Ordered or Considered, Reason not Specified

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

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

DENOMINATOR:

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

Denominator Coding:

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

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

AND

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

*Measure #46: Medication Reconciliation

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported at an office visit occurring within 60 days of each inpatient facility discharge date during the reporting period. There is no diagnosis associated with this measure. If multiple claims are submitted within 60 days of inpatient discharge, only one instance of reporting will be counted. Part B claims data will be analyzed to determine the inpatient facility discharge date. This measure is appropriate for use in the ambulatory setting only. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. 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.

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

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

NUMERATOR NOTE: *The correct combination of numerator 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 Coding:

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

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

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

AND

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

OR

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

OR

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

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

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

- **1111F with 8P:** Discharge medications were not reconciled with the current medication list in outpatient medical record, reason not otherwise specified

AND

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

DENOMINATOR:

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

Denominator Coding:

A CPT E/M service code is required to identify patients for denominator inclusion.

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

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

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

DESCRIPTION:

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

INSTRUCTIONS:

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

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

Numerator Coding:

Advance Care Planning Discussed and Documented

CPT II 1123F: Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record

OR

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

OR

Advance Care Planning not Documented, Reason not Specified

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

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

DENOMINATOR:

All patients aged 65 years and older

Denominator Coding:

A CPT E/M service code is required to identify patients for denominator inclusion.

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

Oral statements

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

Instructional advance directives (DNR orders, living wills)

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

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

Durable power of attorney for health care or health care proxy

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

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

▲ Measure #106: Patients who have Major Depression Disorder who meet DSM IV Criteria

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported once for each occurrence of a new diagnosis or recurrent episode of MDD occurring prior to or during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. An occurrence of a new diagnosis or recurrent episode of MDD and DSM-IV™ diagnostic evaluation will be identified through the submission of CPT II code 1040F and G-code G8467 for an individual patient. The CPT II code for diagnostic evaluation should be reported once until remission occurs. At the time of remission, G-code G8466 should be reported to indicate the current occurrence of MDD has been resolved.

This measure is reported using CPT Category II codes and/or G-codes:

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

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

NUMERATOR:

Patients 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.
- Patient is considered to be in remission if he/she no longer meets DSM-IV™ criteria.

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. This includes patients whose occurrences of MDD began prior to the reporting period and are still receiving treatment for an occurrence of MDD.*

Numerator Coding:

DSM-IV™ Criteria for Major Depressive Disorder Documented

(One CPT II code & one G-code [1040F & G8467] are required on the claim form to submit this category)

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

AND

G8467: Documentation of new diagnosis of initial or recurrent episode of major depressive disorder

OR

G8466: Report if patient is not eligible for this measure because their MDD is in remission.

OR

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

(One CPT II code & one G-code [1040F-8P & G8467] are required on the claim form to submit this category)

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

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

AND

G8467: Documentation of new diagnosis of initial or recurrent episode of major depressive disorder

DENOMINATOR:

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

Denominator Coding:

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

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

AND

CPT E/M service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, 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)

A. At least five of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either 1) depressed mood or 2) loss of interest or pleasure (do not include symptoms that are clearly due to general medical condition or mood-incongruent delusions or hallucinations).

1. Depressed mood most of the day, nearly every day as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% body weight in a month), or decrease in appetite nearly every day
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or observed by others)

9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide
- B. The symptoms do not meet criteria for a mixed episode
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism)
- E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation. (DSM-IV)

▲ Measure #107: Patients who have Major Depression Disorder who are Assessed for Suicide Risks

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported at each visit for a new diagnosis or recurrent episode of MDD, for patients seen individually or as a group, during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. An occurrence of a new diagnosis or recurrent episode of MDD will be identified through the submission of CPT II code 3093F for an individual patient. The CPT II code for suicide risk assessment 3085F should be reported at each visit with CPT II code 3093F until remission occurs. At the time of remission, CPT II code 3092F should be reported to indicate the current occurrence of MDD has been resolved.

This measure is reported using CPT Category II codes

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

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

NUMERATOR:

Patients who had suicide risk assessment completed at each visit

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 Coding:

Suicide Risk Assessed

(Two CPT II codes [3085F & 3093F] are required on the claim form to submit this category)

CPT II 3085F: Suicide risk assessed

AND

CPT II 3093F: Documentation of new diagnosis of initial or recurrent episode of major depressive disorder

OR

If patient is not eligible for this measure because MDD is in remission, report:
(One CPT II code [3092F] is required on the claim form to submit this category)

CPT II 3092F: Major depressive disorder, in remission

OR

Suicide Risk not Assessed, Reason not Specified

(Two CPT II codes [3085F-8P & 3093F] are required on the claim form to submit this category)

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

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

AND

CPT II 3093F: Documentation of new diagnosis of initial or recurrent episode of major depressive disorder

DENOMINATOR:

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

Denominator Coding:

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

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

AND

CPT E/M service codes: 90801, 90802, 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: Inquiry Regarding Tobacco Use

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using CPT Category II codes:

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

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

NUMERATOR:

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

NUMERATOR NOTE: *The correct combination of numerator 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 Coding:

Tobacco Use Assessed

(Two CPT II codes [1000F & 10[☒]☒F] are required on the claim form to submit this category)

CPT II 1000F: Tobacco use assessed

AND

CPT II 1034F: Current tobacco smoker

OR

CPT II 1035F: Current smokeless tobacco user

OR

CPT II 1036F: Current tobacco non-user

OR

Tobacco Use not Assessed, Reason not Specified

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

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

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

DENOMINATOR:

All patients aged 18 years and older

Denominator Coding:

A CPT E/M service code is required to identify patients for denominator inclusion.

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

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

◆Measure #115: Advising Smokers to Quit

DESCRIPTION:

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

INSTRUCTIONS:

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

This measure is reported using G-codes:

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

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

Patients who received advice to quit smoking

NUMERATOR NOTE: *The correct combination of numerator 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 Coding:

Identify Tobacco Smokers Receiving Cessation Intervention

(Two G-codes [G8455 & G8402] are required on the claim form to submit this category)

G8455: Current tobacco smoker

AND

G8402: Tobacco (smoke) use cessation intervention, counseling

OR

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

(One G-code [G8456] is required on the claim form to submit this category)

Smokeless Tobacco User

G8456: Current smokeless tobacco user

OR

Tobacco Non-User

G8457: Tobacco non-user

OR

Tobacco Smokers not Advised to Quit, Reason not Specified

(Two G-codes [G8455 & G8403] are required on the claim form to submit this category)

G8455: Current tobacco smoker

AND

G8403: Tobacco (smoke) use cessation intervention not counseled

DENOMINATOR:

All patients aged 18 years and older

Denominator Coding:

A CPT E/M service code is required to identify patients for denominator inclusion.

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

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

An estimated 45.9 million adults were former smokers in 2003, representing 50.3 percent of those who had ever smoked (CDC, 2005a). For the second consecutive year, more adults had quit than were still smoking. A large number of clinical trials have demonstrated the effectiveness of

counseling in increasing cessation rates, and the effectiveness of bupropion and NRT has been demonstrated (Fiore, 2000). A meta-analysis of 7 studies found that physician advice to quit is associated with a 30% increase in cessation rates (Fiore, 2000). Counseling and medication are each associated with a doubling of cessation rates (Fiore, 2000).

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

DESCRIPTION:

Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted a qualified electronic medical record (EMR). For the purpose of this measure, a qualified EMR can either be a Certification Commission for Healthcare Information Technology (CCHIT) certified EMR or, if not CCHIT certified, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

INSTRUCTIONS:

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

This measure is reported using G-codes:

CPT E/M codes, CPT service codes, CPT procedure codes, HCPCS D-codes and HCPCS G-codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

Patient encounter documentation substantiates use of certified/qualified EMR

Definitions:

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

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

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

Numerator Coding:

Encounter Documented Using CCHIT Certified or Qualified EMR

G8447: Patient encounter was documented using a CCHIT certified EMR

OR

G8448: Patient encounter was documented using a non-CCHIT certified EMR. To qualify, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

OR

Encounter not Documented Using CCHIT Certified or Qualified EMR for System Reasons

G8449: Patient encounter was not documented using an EMR due to system reasons such as, the system being inoperable at the time of the visit. Use of this code implies that an EMR is in place and generally available

DENOMINATOR:

All patients aged 18 years and older

Denominator Coding:

A CPT service code, CPT E/M code, HCPCS D-code or HCPCS G-code is required to identify patients for denominator inclusion.

CPT service codes, CPT E/M codes, HCPCS D-codes or HCPCS G-codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, D7140, D7210, G0101, G0108, G0109, G0270, G0271

RATIONALE:

The need for clinical information systems to provide high-quality, safe care is a well recognized fact, as publicized by Dr. Ed Wagner in his Chronic Care Model. A comprehensive clinical information system can enhance the care of individual patients by:

- Providing timely reminders about needed services
- Summarizing data to track and plan care
- Identifying groups of patients needing additional care
- Facilitating performance monitoring and quality improvement efforts

While it is preferable to encourage adoption of CCHIT certified EMRs, it became apparent during measure field testing that CCHIT certified EMRs are not currently available for all provider settings and specialty groups that may report this measure. Therefore, additional numerator coding was added to enable providers who have adopted a non-CCHIT certified product, which meets a set of standards, to also report this measure. The following is an excerpt taken from the CCHIT website:

The 2006 Ambulatory EHR Criteria represent basic requirements that the Commission and its Workgroups believe are appropriate for many common ambulatory care settings. CCHIT acknowledges that these Criteria may not be suitable for settings such as behavioral health, emergency departments, or specialty practices and our current certification makes no representation for these. Purchasers should not interpret a lack of CCHIT Certification as being of

significance for specialties and domains not yet addressed by CCHIT Criteria. (excerpt from www.cchit.org)

Evidence Supporting the Criterion of the Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: better patient care management, higher patient satisfaction, reduction of adverse drug events, better quality performance, and improved patient safety, but not consistently high quality evidence

Committee on Quality Health Care in America (2001). Crossing the Quality Chasm: A new health system for the 21st century. Washington, D.C., National Academy Press.

This report explains the difficulty managing a patient's care using a written medical record, which can be cumbersome to navigate through, as well as illegible. Not only would an EMR be consistent and legible, it can provide reminders and prompts, allowing better management of patient care. In addition, patients who can access their provider using e-mail can have their needs met more quickly and cost effectively.

Study quality level 2 (limited-quality patient-oriented evidence)

Hillestad, R., et al. (2005). "Can electronic medical record systems transform health care? Potential health benefits, savings and costs." Health Affairs 24(5): 1103-1117.

This article concludes that two-thirds of the approximately 8 million adverse drug events that occur in the outpatient setting would be avoided through the widespread use of computerized physician order entry (CPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Jha, A. K., et al. (2003). "Effect of the transformation of the Veterans Affairs Health Care System on quality of care." NEJM 348(22): 2218-2227.

The Veterans Health Administration medical system uses an EMR system-wide. The authors attribute the VHA's superior quality performance in part to "an emphasis on the use of information technology."

Study quality level 2 (limited-quality patient-oriented evidence)

Middleton, B. (2005). The value of health information technology in clinical practice. Pennsylvania eHealth Initiative, Harrisburg.

This article highlights the impact that various components of HIT and EMR will have on improving patient safety. Additionally, Dr. Middleton enumerates the cost benefits of ambulatory computerized physician order entry (ACPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Mitchell, E., Sullivan, F. (2001). "A descriptive feast but an evaluative famine: systematic review of published articles on primary care computing during 1980-1997." BMJ 322(7281): 279-282.

This older systematic review documents the value of using ECI in a variety of primary care situations.

Study quality level 2 (limited-quality patient-oriented evidence; systematic review but older)

◆Measure #125: HIT - Adoption/Use of e-Prescribing

DESCRIPTION:

Documents whether provider has adopted a qualified e-Prescribing system and the extent of use in the ambulatory setting. To qualify this system must be capable of **ALL** of the following:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks (defined below)
- Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan

INSTRUCTIONS:

This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted a qualified e-Prescribing system.

This measure is reported using G-codes:

CPT E/M codes, CPT service codes and HCPCS G-codes are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

A qualified e-Prescribing system has been adopted capable of generating a medication list and selecting/printing/transmitting/performing safety checks of prescriptions

Definitions:

Qualified e-Prescribing system – an e-Prescribing system that is capable of **ALL** of the following:

- Generating a complete active medication list incorporating electronic data received from applicable pharmacy drug plan(s) if available
- Selecting medications, printing prescriptions, electronically transmitting prescriptions, and conducting all safety checks (defined below)
- Providing information related to the availability of lower cost, therapeutically appropriate alternatives (if any)
- Providing information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan

e-Prescribing – Entering a prescription for a medication into an automated data entry system that generates a prescription electronically instead of handwriting the prescription on paper

Safety checks – Automated prompts that offer the provider information on the drug being prescribed, potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions

Numerator Coding:

Prescriptions Generated via Qualified e-Prescribing System

G8443: All prescriptions created during the encounter were generated using a qualified e-Prescribing system

OR

Qualified e-Prescribing System Available, Prescription(s) not Generated or not Generated Via Qualified e-Prescribing System for System/Patient Reasons

G8445: No prescriptions were generated during the encounter. Provider does have access to a qualified e-Prescribing system

OR

G8446: Some or all prescriptions generated during the encounter were handwritten or phoned in due to one of the following: required by state law, patient request, or qualified e-Prescribing system being temporarily inoperable

DENOMINATOR:

All patients aged 18 years and older

Denominator Coding:

A CPT service code, CPT E/M code, or G-code is required to identify patients for denominator inclusion.

CPT service codes, CPT E/M codes, or HCPCS G-codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0109

RATIONALE:

Automation of the ambulatory prescribing process has many potential benefits including:

- Patient safety through computerized transmission of legible prescriptions directly to the pharmacy and checks for harmful interactions.
- Patient satisfaction in a process that results in fewer errors and less waiting time
- Avoidance of unnecessary phone calls for clarification between Providers and Pharmacies.
- Easier data collection of physician prescribing patterns and improved formulary compliance for Health plans, pharmacy benefit managers and employers.

Evidence Supporting the Criterion of the Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: reduction of adverse drug events, reduction of unnecessary utilization, and improved patient safety, but not consistently high quality evidence

Corley, S. T. (2003). "Electronic prescribing: a review of costs and benefits." Topics in Health Information Management 24(1): 29-38.

Corley estimated cost savings from reduction of adverse drug events following implementation of electronic prescribing.

Study quality level 2 (limited-quality patient-oriented evidence)

Hillestad, R., et al. (2005). "Can electronic medical record systems transform health care? Potential health benefits, savings and costs." Health Affairs 24(5): 1103-1117.

This article concludes that two-thirds of the approximately 8 million adverse drug events that occur in the outpatient setting would be avoided through the widespread use of computerized order entry (CPOE).

Study quality level 2 (limited-quality patient-oriented evidence)

Kohn, L., et al. (1999). To err is human: Building a safer health system. Washington, D.C., National Academy Press.

This report concluded, from a case analysis, that there is supporting evidence to show that adverse drug events (ADE) resulted in an increase in physician office and emergency department visits, and of those physician office visits, more than 50% were "judged to be unnecessary and potentially avoidable." Additionally, the report stated, "Physicians do not routinely screen for potential drug interactions, even when medication history information is readily available."

Study quality level 2 (limited-quality patient-oriented evidence)

Middleton, B. (2005). The value of health information technology in clinical practice. Pennsylvania eHealth Initiative, Harrisburg.

Dr. Middleton discusses the value of ambulatory computerized order entry (ACPOE). A model was developed based on data derived from HIT implementation in the Partners Healthcare System. When applied nationally, this model predicts a potential savings of \$44 billion and the prevention of 2 million adverse drug events per year.

Study quality level 2 (limited-quality patient-oriented evidence)

Shekelle, P., Morton, S., Keeler, E. (2006). Costs and benefits of health information technology. Evidence Report/Technology Assessment, AHRQ. 132.

Electronic prescribing is widely believed to improve accuracy of the prescription process and thereby reduce potential for medical errors and increase health care quality. Shekelle et al. observe that EMRs with electronic prescribing improve patient safety by reducing adverse drug events in the inpatient setting.

Study quality level 2 (limited-quality patient-oriented evidence)

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

DESCRIPTION:

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

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:

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

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

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

Definition: A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection.

Numerator Coding:

Lower Extremity Neurological Exam Performed

G8404: Lower extremity neurological exam performed and documented

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons

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

OR

Lower Extremity Neurological Exam not Performed

G8405: Lower extremity neurological exam not performed

DENOMINATOR:

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

Denominator Coding:

An ICD-9 diagnosis code for diabetes mellitus and a CPT code are required to identify patients for denominator inclusion.

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

AND

CPT codes: 10060, 10061, 10180, 11000, 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

RATIONALE:

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

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: Universal Weight Screening and Follow-Up

DESCRIPTION:

Percentage of patients aged 65 years and older with a calculated Body Mass Index (BMI) within the past six months or during the current visit that is documented in the medical record and if the most recent BMI is ≥ 30 or < 22 , a follow-up plan is documented

INSTRUCTIONS:

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

This measure is reported using G-codes:

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

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

Patients with BMI calculated within the past six months or during the current visit and a follow up plan documented if the BMI is ≥ 30 or < 22

Definitions:

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

http://www.healthdiscovery.net/links/calculators/body_massindex_chart.htm for an example of a widely available BMI chart.

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

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

Not eligible for BMI measurement – Patients can be considered not eligible in the following situations:

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

Numerator Coding:

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

G8420: BMI < 30 AND \geq 22 was calculated and documented

OR

G8417: BMI \geq 30 was calculated and a follow-up plan was documented in the medical record

OR

G8418: BMI < 22 was calculated and a follow-up plan was documented in the medical record

OR

Patient not Eligible for BMI Calculation for Documented Reasons

G8422: Patient not eligible for BMI calculation

OR

BMI not Performed and/or Calculated BMI \geq 30 or < 22, Follow-up Plan not Documented, Reason not Specified

G8421: BMI not calculated

OR

G8419: BMI \geq 30 OR < 22 was calculated, but no follow-up plan documented in the medical record

DENOMINATOR:

Patients aged 65 years and older

Denominator Coding:

A CPT procedure code, CPT service code, CPT E/M code, HCPCS D-code or HCPCS G-code is required to identify patients for denominator inclusion.

CPT procedure codes, CPT service codes, CPT E/M codes, HCPCS D-codes or

HCPCS G-codes: 00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 97001, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0108, G0270

RATIONALE:

Of the Medicare population, 37 percent are overweight and 18 percent are obese, the economic impact of which has been estimated at \$117 billion in the U.S. Additionally, elderly patients with unintentional weight loss are at higher risk for infection, depression and death. Older people have special nutritional needs due to age and disease processes and professionals of all disciplines need to help older individuals modify their nutritional status, thereby improving quality of life (American Dietetic Association, Nutrition Screening Initiative, 2002).

CLINICAL RECOMMENDATION STATEMENTS:

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

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

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

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

Interventions can be grouped into six primary categories: Social Services, Oral Health, Mental Health, Medication Use, Nutritional Education and Counseling, and Nutritional Support. For further detail on any of the potential interventional strategies, see the Nutritional Interventions Manual for Professionals Caring for Older Americans, 2002. Nutrition Screening Initiative: "Nutrition Interventions Manual for Professionals Caring for Older Americans," 2002 (Co-sponsored by American Dietetic Association (ADA), AAFP and National Council on Aging, Inc.).

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved clinical outcomes, including improved blood pressure, lipid levels, and glucose metabolism, decreased diabetes incidence, and reduced mortality, but not consistently high quality evidence

Callee, E. E., Thun, M.J., Petrelli, J.M., Rodriguez, C., Heath, C.W., Jr. (1999). "Body-mass index and mortality in a prospective cohort of U.S. adults." New England Journal of Medicine 341: 1097-1105.

BMI of less than 22 kg per m² in women and less than 23.5 kg per m² in men is associated with increased mortality.

Study quality level 2 (limited-quality patient-oriented evidence)

Corrada, M. M., et al. (2006). "Association of body mass index and weight change with all-cause mortality in the elderly." American Journal of Epidemiology 163(10): 938-949.

The study explored the relation of BMI and weight change to all-cause mortality in the elderly. Results highlight the influence on older-age mortality risk of being underweight or obese later in life.

Study quality level 2 (limited-quality patient-oriented evidence)

Flegal, K. M., et al. (2005). "Excess deaths associated with underweight, overweight, and obesity." JAMA 293: 1861-1867.

This study sought to estimate deaths associated with underweight (BMI < 18.5), overweight (BMI 25 to < 30), and obesity (BMI ≥ 30) in the United States in 2000. Underweight was associated with 33,746 excess deaths. Underweight and obesity, particularly higher levels of obesity, were associated with increased mortality relative to the normal weight category.

Study quality level 2 (limited-quality patient-oriented evidence)

Jain, M. G., et al. (2005). "Body mass index and mortality in women: Follow-up of the Canadian national breast screening study cohort." International Journal of Obesity 29: 792-797.

A study designed to examine the relationship between obesity and all-cause mortality in women confirms the association of high BMI with increased all-cause mortality in women.

Study quality level 2 (limited-quality patient-oriented evidence)

McTigue, K. M., et al. (2003). "Screening and interventions for obesity in adults: Summary of the evidence for the U.S. preventive services task force." Annals of Internal Medicine 139(11): 933-949.

This meta-analysis concludes that counseling and pharmacotherapy can promote modest sustained weight loss, improving clinical outcomes. Weight reduction improved blood pressure, lipid levels, and glucose metabolism and decreased diabetes incidence.

Study quality level 1 (good-quality patient-oriented evidence)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with written provider documentation that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative

INSTRUCTIONS:

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

This measure is reported using G-codes:

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

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

Verification of patient's current medications with dosages is documented

Definitions:

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

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

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

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

Numerator Coding:

Current Medication Verification Documented

G8427: Written provider documentation was obtained confirming that current medications with dosages (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) were verified with the patient or authorized representative or patient assessed and is not currently on any medications.

OR

Current Medications not Documented, Patient not Eligible

G8430: Documentation that patient is not eligible for medication assessment

OR

Current Medications not Documented and/or Patient Verification not Documented, Reason not Specified

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

OR

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

DENOMINATOR:

Patients aged 18 years and older

Denominator Coding:

A CPT procedure code, CPT service code, or HCPCS G-code is required to identify patients for denominator inclusion.

CPT procedure codes, CPT service codes, or HCPCS G-codes: 00140, 00142, 00170, 00400, 00402, 00810, 00832, 00851, 00910, 00920, 01380, 01382, 01400, 01732, 01810, 01820, 01829, 90801, 90802, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, G0101, G0108, G0270

RATIONALE:

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

CLINICAL RECOMMENDATION STATEMENTS:

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

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved patient safety, reduced adverse drug events, reduced hospitalizations and death, and reduced costs, but not consistently high quality evidence

Ghandi, T., et al. (2000). "Drug complications in outpatients." Journal of General Internal Medicine 15: 149-154.

A total of 75% of office visits to primary care providers involve the initiation or continuation of drug therapy and estimates of the proportion of outpatients experiencing an ADE per year range from 5-35%, with 13% of events occurring in patients with a prior or documented allergy/reaction to the causative drug. There is need for improved physician-patient communication and documentation of medications in the outpatient setting.
Study quality level 2 (limited-quality patient-oriented evidence)

Gurwitz, J., et al. (2003). "Incidence and preventability of adverse drug events among older persons in the ambulatory setting." JAMA 289: 1107-1116.

ADEs were identified as one of the most serious concerns regarding medication use in older persons cared for in the ambulatory setting. The authors recommend prevention strategies that target the prescribing and monitoring stages of pharmaceutical care and interventions focused on improving patient compliance and monitoring of prescribed medications.

Study quality level 2 (limited-quality patient-oriented evidence)

Kaufman, D., et al. (2002). "Recent patterns of medication use in the ambulatory adult population of the United States." JAMA 287: 337 - 344.

ADEs are among the leading cause of hospitalizations and death in the U.S. The substantial overlap between use of prescription medicine and use of herbals/supplements raises concerns about unintended interactions. Therefore, the authors recommend documentation of usage patterns to provide a basis for improving the safety of medication use.

Study quality level 2 (limited-quality patient-oriented evidence)

Simmonds, M. (2000). "Anesthetists' records of pre-operative assessment." Clinical Performance and Quality Health Care 8(1): 22-27.

Previous anesthesia, drug history, and allergies were recorded in only one to two-thirds of patient charts, thus identifying this as an opportunity for improvement, given the safety and subsequent cost implications.

Study quality level 2 (limited-quality patient-oriented evidence)

Wilson, I. B., et al. (2007). "Physician-patient communication about prescription medications non-adherence." Journal of General Internal Medicine 22(1).

There is a wide communication gap between physicians and elderly patients: one-third of all seniors surveyed and 24% of those with three or more chronic conditions did not talk to their doctors about all of their medicines in the past 12 months.

Study quality level 2 (limited-quality patient-oriented evidence)

♣Measure #133: Screening for Cognitive Impairment

DESCRIPTION:

Percentage of patients aged 65 years and older who have documentation of results of a screening for cognitive impairment using a standardized tool

INSTRUCTIONS:

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

This measure is reported using G-codes:

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

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

Patient's screening for cognitive impairment is documented

Definitions:

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

Standardized tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Some examples of cognitive impairment screening tools include: Clinical Dementia Rating Scale, Mini Mental Status Examination (MMSE), Global Deterioration Scale, Short Portable Mental Status Questionnaire, Clock Drawing Test, Modified MMSE, Mini-Cog, Hopkins Verbal Learning Test, and 7-Minute Screen.

Cognitive impairment – Impairment of mental activities associated with thinking, learning, and memory.

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

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Patient was referred with a diagnosis of cognitive impairment
- Patient has been participating in on-going treatment with screening of cognitive impairment in a preceding reporting period

- Patient is not appropriate for cognitive impairment screening due to physical capacity

Numerator Coding:

Screening for Cognitive Impairment Documented

G8434: Documentation of cognitive impairment screening using a standardized tool

OR

Screening for Cognitive Impairment not Documented, Patient not Eligible/not Appropriate

G8436: Patient not eligible/not appropriate for cognitive impairment screening

OR

Screening for Cognitive Impairment not Documented, Reason not Specified

G8435: No documentation of cognitive impairment screening using a standardized tool

DENOMINATOR:

Patients aged 65 years and older

Denominator Coding:

A CPT service code is required to identify patients for denominator inclusion.

CPT service codes: 90801, 90802, 96150, 97003

RATIONALE:

As many as 6.8 million people in the U.S. have dementia, and at least 1.8 million of those are severely affected. The U.S. Preventive Services Task Force (USPSTF) reported that Alzheimer's Disease and cerebrovascular ischemia (vascular dementia) are the two most common causes of dementia, with estimated economic costs of Alzheimer's Disease (AD) in the U.S. totaling at least \$100 billion annually. The National Institute of Neurological Disorders and Stroke contends that accurate diagnosis of dementia is important for patients and their families because it allows early treatment of symptoms.

CLINICAL RECOMMENDATION STATEMENTS:

The American Psychiatric Association (APA) states that the core of the treatment of demented patients is psychiatric management, through psychiatric, neurological, and general medical evaluations of the nature and cause of cognitive deficits, while the American Academy of Neurology (AAN) states there is good evidence to support the use of general cognitive screening instruments.

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved early detection and initiation of treatment for dementia that may delay further progression; reduced iatrogenic illness, unnecessary workups driven by vague symptoms, and inappropriate and costly utilization of hospital and emergency room care; and improved outcomes, but not consistently high quality evidence

American Academy of Neurology (AAN)

A guideline revised in 2004 includes the identification and monitoring of Mild Cognitive Impairment (MCI) patients for progression to Alzheimer's disease. It also states there is good evidence to support the use of general cognitive screening instruments.

In a second guideline developed in 2001, it states that general cognitive screening instruments, which include the Mini Mental Status Exam (MMSE), Kokmen Short Test of Mental Status, the 7-Minute Screen, or the Memory Impairment Screen, are useful for the detection of dementia when used in patient populations with an elevated prevalence of cognitive impairment either due to age or presence of memory dysfunction.

A third guideline developed in 2001 on the early detection of dementia included a review of the evidence on mild cognitive impairment. It reported that studies indicated that individuals characterized as being cognitively impaired, but not meeting clinical criteria for Alzheimer's disease (mild cognitive impairment), have a high risk of progressing to dementia or Alzheimer's disease. It further reported that, if the figures for incident Alzheimer's disease from the general population are used, one could see that the rates range from 0.2% in the 65-69 year age group to 3.9% in the 85-89 year age group. Finally, it reported that studies of mild cognitive impairment indicate that the rate of progression to dementia or Alzheimer's disease is between 6% and 25% per year.

Study quality level 2 (limited-quality patient-oriented evidence)

Geriatric Nursing Academic Institution

This 2003 guideline, developed by a group of nursing experts from across the country as a part of the Nurses Improving Care for Health System Elders (NICHE) Project, supports the use of standardized instruments for cognitive testing.

Study quality level 2 (limited-quality patient-oriented evidence)

Chow, T. W. (2001). "Quality indicators for dementia in vulnerable community dwelling and hospitalized elders." Annals of Internal Medicine 135: 668-676.

A review of 30 quality indicators for dementia resulted in 14 being judged to be valid by the expert panel process. These included five dealing with dementia screening and diagnosis. The cognitive and functional screening indicator states that, if a vulnerable elder is admitted to the hospital or is new to a physician practice, the multidimensional assessment of cognitive ability and assessment of functional status should be documented because screening for dementia can lead to early detection and initiation of treatment that may delay further progression.

Study quality level 2 (limited-quality patient-oriented evidence)

National Chronic Care Consortium (2003). Tools for the early identification, assessment and treatment for people with Alzheimer's disease and dementia. Bloomington, National Chronic Care Networks for Alzheimer's Disease initiative.

Dementia is very prevalent among the elderly, but is often overlooked even by skilled clinicians. Unrecognized dementia may lead to iatrogenic illness, unnecessary workups driven by vague symptoms, inappropriate and costly utilization of hospital and emergency room care, and poor outcomes. Improving our ability to recognize dementia is a key first step toward improving this widespread situation. The Chronic Care Networks for

Alzheimer's disease early identification process uses two tools to identify people who may have dementia and should receive a full assessment. These tools include education and awareness materials/triggers and a family questionnaire.

Study quality level 2 (limited-quality patient-oriented evidence)

Kawas, C. H. (2006). "Alzheimer's and dementia in the oldest-old: A century of challenges." Current Alzheimer Research 3(5): 411-419.

Alzheimer's disease (AD) is the most common type of dementia in the U.S. and much of the world with rates increasing exponentially from age 65. Increases in life expectancy in the last century have resulted in a large number of people living to old age and will result in a quadrupling of AD cases by the middle of the century. Preventing or delaying the onset of AD could have a huge impact in the number of cases expected to develop. The oldest-old are the fastest growing segment of the population and are estimated to account for 12% of the population over 65.

Study quality level 2 (limited-quality patient-oriented evidence)

♣Measure #134: Screening for Clinical Depression

DESCRIPTION:

Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool

INSTRUCTIONS:

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

This measure is reported using G-codes:

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

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

NUMERATOR:

Patient's screening for clinical depression is documented

Definitions:

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

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

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

- Patient refuses to participate
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- Situations where the patient's motivation to improve may impact the accuracy of results of nationally recognized standardized depression assessment tools. For example: certain court appointed cases

- Patient was referred with a diagnosis of depression
- Patient has been participating in on-going treatment with screening of clinical depression in a preceding reporting period
- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example: cases such as delirium or severe cognitive impairment, where depression cannot be accurately assessed through use of nationally recognized standardized depression assessment tools

Numerator Coding:

Screening for Clinical Depression Documented

G8431: Documentation of clinical depression screening using a standardized tool

OR

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

G8433: Patient not eligible/not appropriate for clinical depression screening

OR

Screening for Clinical Depression not Documented, Reason not Specified

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

DENOMINATOR:

Patients aged 18 years and older

Denominator Coding:

A CPT service code is required to identify patients for denominator inclusion.

CPT service codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97003

RATIONALE:

Major depression was the fourth leading cause of worldwide disease in 1990, with estimated direct and indirect costs to American businesses ranging from \$36.2 to \$80 billion annually. The U.S. Preventive Services Task Force compared the effects of integrated recognition and management depression screening programs with “usual care” in community primary care practices, and the results showed significantly improved patient outcomes.

CLINICAL RECOMMENDATION STATEMENTS:

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

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

Evidence Supporting the Criterion of Quality Measure:

Overall Evidence Grading: SORT Strength of Recommendation B: considerable patient-oriented evidence, i.e., re: improved recognition and diagnosis of depression, and improved depression outcomes, but not consistently high quality evidence

Ell, K. (2006). "Depression care for the elderly: Reducing barriers to evidence based practice." Home Health Care Services Quarterly 25: 115 - 148.

This review provides an overview of evidence identifying use of health services for depression, effective interventions, barriers to depression care, strategies to reduce barriers, and translating research into practice. There is strong empirical support for implementing strategies to improve depression care for older adults, and there is recent encouraging evidence from Medicare data that older adults may be more willing to seek and accept antidepressant treatment.

Study quality level 2 (limited-quality patient-oriented evidence)

Hickie, I. B., et al. (2002). "Screening for depression in general practice and related medical settings." The Medical Journal of Australia 177: S111-116.

This meta-analysis included reviews found by searching MEDLINE, Cochrane, and other databases. It found that screening increases the recognition and diagnosis of depression and, when integrated with a commitment to provide coordinated and prompt follow-up of diagnosis and treatment, clinical outcomes are improved.

Study quality level 1 (good quality patient-oriented evidence)

Kirkcaldy, R. D., Tynes, L.L. (2006). "Depression screening in a VA primary care clinic." Psychiatric Services 57: 1694 - 1696.

In 1998, the U.S. Department of Veterans Affairs (VA) mandated annual depression screening at all VA primary care clinics. This article reports on an evaluation of the screening program. Findings establish benchmarks for screening administration.

Study quality level 2 (limited-quality patient-oriented evidence)

Pignone, M. P., et al. (2002). "Screening for depression in adults: A summary of the evidence for the U.S. preventive services task force." Annals of Internal Medicine 136: 765-776.

This study aims to clarify whether screening adults for depression in primary care settings improves recognition, treatment, and clinical outcomes. It concludes that, compared with usual care, screening for depression can improve outcomes, particularly when screening is coupled with system changes that help ensure adequate treatment and follow-up.

Study quality level 2 (limited-quality patient-oriented evidence)

Sherman, S. E., et al. (2004). "Improving recognition of depression in primary care: A study of evidence-based quality improvement." Joint Commission Journal on Quality and Patient Safety 30(2).

Implemented at a VA ambulatory care center, this evidence-based QI intervention led to profound and lasting changes in primary care providers' recognition of depression or depressive symptoms.

Study quality level 2 (limited-quality patient-oriented evidence)

* The following notice applies to each of the measures that contain an asterisk (*) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA) in collaboration with the Physician Consortium for Performance Improvement (the Consortium) and the National Committee for Quality Assurance (NCQA) pursuant to government sponsorship under subcontract 6205-05-054 with Mathematica Policy Research, Inc. under contract 500-00-0033 with Centers for Medicare & Medicaid Services.

These performance Measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the AMA, (on behalf of the Consortium) or NCQA. Neither the AMA, NCQA, Consortium nor its members shall be responsible for any use of the Measures.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

© 2004-6 American Medical Association and National Committee for Quality Assurance. All Rights Reserved.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, NCQA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measures specifications is copyright 2005 American Medical Association G codes and associated descriptions included in these Measure specifications are in the public domain.

▲ The following notice applies to each of the measures that contain a triangle (▲) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

© 2007 American Medical Association. All Rights Reserved

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

CPT® contained in the Measures specifications is copyright 2006 American Medical Association.

♣ The following notice applies to each of the measures that contain a clover (♣) before the title:

These Physician Performance Measures (Measures) are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

The Measures, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and the American Medical Association (AMA), [on behalf of the Physician Consortium for Performance Improvement® (Consortium)] or the American Society of Hematology (ASH). Neither the AMA, ASH, Consortium nor its members shall be responsible for any use of the Measures.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

© 2006-7 American Medical Association and American Society of Hematology. All Rights Reserved. Applicable FARS/DFARS Restrictions Apply to Government Use.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, ASH, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

CPT® contained in the Measures specifications is copyright 2005 American Medical Association. LOINC® copyright 2004 Regenstrief Institute, Inc. SNOMED CLINICAL TERMS (SNOMED CT®) copyright 2004 College of American Pathologists (CAP). All Rights Reserved. Use of SNOMED CT® is only authorized within the United States.

◆ The following notice applies to each of the measures that contain a diamond (◆) before the title:

NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and the measure developers have agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care providers in connection with their own practices is not commercial use. Commercial use of a measure does require the prior written consent of the measure developer. As used herein, a "commercial use" refers to any sale, license, or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed, or distributed for commercial gain, (even if there is no actual charge for inclusion of the measure.)

These performance measure were developed and are owned by the National Committee for Quality Assurance ("NCQA"). These performance measures are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties, or endorsement about the quality of any organization or physician that uses or reports performance measures and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in this measure and can rescind or alter this measure at any time. Users of the measure shall not have the right to alter, enhance, or otherwise modify the measure and shall not disassemble, recompile, or reverse engineer the source code or object code relating to the measure. Anyone desiring to use or reproduce the measure without modification for a noncommercial purpose may do so without obtaining any approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. ©2004 National Committee for Quality Assurance, all rights reserved.

Performance measures developed by NCQA for CMS may look different from the measures solely created and owned by NCQA.

♥ The following notice applies to each of the measures that contain a heart (♥) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

© 2007 American Medical Association and American Society of Clinical Oncology. All Rights Reserved.
CPT® Copyright 2006 American Medical Association.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

CPT® contained in the Measures specifications is copyright 2006 American Medical Association.

¥ The following notice applies to each of the measures that contain a Yen sign (¥) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

© 2007 American Medical Association, American Society of Clinical Oncology, and National Comprehensive Cancer Network. All Rights Reserved.
CPT® Copyright 2006 American Medical Association

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

CPT® contained in the Measures specifications is copyright 2006 American Medical Association.

€ The following notice applies to each of the measures that contain a Euro (€) before the title:

Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance Improvement® (the Consortium), are intended to facilitate quality improvement activities by physicians.

These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures.

Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures.

THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND

© 2007 American Medical Association and College of American Pathologists. All Rights Reserved

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

CPT® contained in the Measures specifications is copyright 2006 American Medical Association

♪ The following notice applies to each of the measures that contain a musical note (♪) before the title:

These measures are owned by the American Podiatric Medical Association (APMA).

Ω The following notice applies to each of the measures that contain an Omega (Ω) before the title:

These measures are owned by The Society of Thoracic Surgeons (STS).

♠ The following notice applies to each of the measures that contain a spade (♠) before the title:

These measures were developed by Quality Insights of Pennsylvania as a special project under the Quality Insights' Medicare Quality Improvement Organization (QIO) contract HHSM-500-2005-PA001C with the Centers for Medicare & Medicaid Services.. These measures are in the public domain.

2007 PQRI Measure Specifications Retired Effective January 1, 2008

Measure #	Measure Title
13	Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended
15	Cataracts: Assessment of Visual Functional Status
16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation
17	Cataracts: Pre-Surgical Dilated Fundus Evaluation
25	Melanoma: Patient Medical History
26	Melanoma: Complete Physical Skin Examination
27	Melanoma: Counseling on Self-Examination
29	Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)
37	Dialysis Dose in End Stage Renal Disease (ESRD) Patients
38	Hematocrit Level in End Stage Renal Disease (ESRD) Patients
42	Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise
60	Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms
61	Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms
62	Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus
63	Gastroesophageal Reflux Disease (GERD): Barium Swallow- Inappropriate Use