Review the following worksheets, which were developed by the AMA in cooperation with the measure developers. All measurement information is copyrighted by the measure owner.
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Diabetic Foot and Ankle Care, Peripheral Neuropathy — Neurological Evaluation

This measure is to be reported for all patients aged 18 years and older with diabetes mellitus — a minimum of once per reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described based on the services provided and the measure-specific denominator coding.

Measure description

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

What will you need to report for each patient with diabetes mellitus for this measure?

If you select this measure for reporting, you will report:

- Whether or not you performed a lower extremity neurological exam.\(^1\)

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to perform a lower extremity neurological exam, due to:

- Documented reasons (eg. patient was not an eligible candidate for lower extremity neurological exam).

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exceptions).

\(^1\) A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities and may include: reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. The components listed are consistent with the neurological assessment recommended by the Task Force of the Foot Care Interest Group of the American Diabetes Association. They generally recommend at least two of the listed tests be performed when evaluating for loss of protective sensation; however, the clinician should perform all necessary tests to make the proper evaluation.

Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur. Risk categorization and follow up treatment plan should be done according to the following table:

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk Profile</th>
<th>Evaluation Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal</td>
<td>Annually</td>
</tr>
<tr>
<td>1</td>
<td>Peripheral Neuropathy (LOPS)</td>
<td>Semi-annually</td>
</tr>
<tr>
<td>2</td>
<td>Neuropathy, deformity, and/or PAD</td>
<td>Quarterly</td>
</tr>
<tr>
<td>3</td>
<td>Previous ulcer or amputation</td>
<td>Monthly to quarterly</td>
</tr>
</tbody>
</table>

\(^1\)A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities and may include: reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. The components listed are consistent with the neurological assessment recommended by the Task Force of the Foot Care Interest Group of the American Diabetes Association. They generally recommend at least two of the listed tests be performed when evaluating for loss of protective sensation; however, the clinician should perform all necessary tests to make the proper evaluation.
Coding Specifications

Codes required to document patient has diabetes mellitus and a visit occurred:

An ICD-9-CM diagnosis code for diabetes mellitus and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Diabetes mellitus ICD-9-CM diagnosis codes
- 250.00, 250.01, 250.02, 250.03 (diabetes mellitus without mention of complication)
- 250.10, 250.11, 250.12, 250.13 (diabetes with ketoacidosis)
- 250.20, 250.21, 250.22, 250.23 (diabetes with hyperosmolarity)
- 250.30, 250.31, 250.32, 250.33 (diabetes with other coma)
- 250.40, 250.41, 250.42, 250.43 (diabetes with renal manifestations)
- 250.50, 250.51, 250.52, 250.53 (diabetes with ophthalmic manifestations)
- 250.60, 250.61, 250.62, 250.63 (diabetes with neurological manifestations)
- 250.70, 250.71, 250.72, 250.73 (diabetes with peripheral circulatory disorders)
- 250.80, 250.81, 250.82, 250.83 (diabetes with other specified manifestations)
- 250.90, 250.91, 250.92, 250.93 (diabetes with unspecified complication)

AND

CPT codes
- 11042, 11043, 11044
- 11055, 11056, 11057
- 11719
- 11720, 11721
- 11730
- 11740
- 97001, 97002
- 97597, 97598
- 97802, 97803
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309, 99310
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Quality codes for this measure:

G-code descriptors
(Data collection sheet should be used to determine appropriate code.)
- **G8404**: Lower extremity neurological exam performed and documented
- **G8406**: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure
- **G8405**: Lower extremity neurological exam not performed

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.

These measures are owned by the American Podiatric Medical Association (APMA).
### Diabetic Foot and Ankle Care, Peripheral Neuropathy — Neurological Evaluation

**Physician Quality Reporting System Data Collection Sheet**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Provider Identifier (NPI)</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Clinical Information

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Patient is aged 18 years and older on date of encounter.
- Patient has a diagnosis of diabetes mellitus.
- There is a CPT code for this visit.

If No is checked for any of the above, STOP. Do not report a G-code.

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Lower Extremity Neurological Exam¹</th>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed</td>
<td></td>
<td></td>
<td>G8404</td>
</tr>
<tr>
<td>Not performed for the following reason:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Documented reasons (eg, patient was not an eligible candidate for lower extremity neurological exam)</td>
<td></td>
<td></td>
<td>G8406</td>
</tr>
<tr>
<td>Document reason here and in medical chart.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If No is checked for all of the above, report G8405 (Lower extremity neurological exam not performed)

---

¹A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities and may include: reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection. The components listed are consistent with the neurological assessment recommended by the Task Force of the Foot Care Interest Group of the American Diabetes Association. They generally recommend at least two of the listed tests be performed when evaluating for loss of protective sensation; however, the clinician should perform all necessary tests to make the proper evaluation.
Foot Exam

This measure is to be reported for all patients aged 18 through 75 years with diabetes mellitus — a minimum of once per reporting period.

Measure description
Percentage of patients aged 18 through 75 years with diabetes mellitus who had a foot examination

What will you need to report for each patient with diabetes mellitus for this measure?
If you select this measure for reporting, you will report:
- Whether or not you performed a foot examination (includes visual inspection, sensory exam with monofilament, or pulse exam)

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to perform a foot examination, due to:
- Medical reasons (ie, patient with bilateral foot/leg amputation)

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).
Coding Specifications

Codes required to document patient has diabetes mellitus and a visit occurred:

An ICD-9-CM diagnosis code for diabetes mellitus and a CPT or HCPCS code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Diabetes mellitus ICD-9-CM diagnosis codes

- 250.00, 250.01, 250.02, 250.03 (diabetes mellitus without mention of complication)
- 250.10, 250.11, 250.12, 250.13 (diabetes with ketoacidosis)
- 250.20, 250.21, 250.22, 250.23 (diabetes with hyperosmolarity)
- 250.30, 250.31, 250.32, 250.33 (diabetes with other coma)
- 250.40, 250.41, 250.42, 250.43 (diabetes with renal manifestations)
- 250.50, 250.51, 250.52, 250.53 (diabetes with ophthalmic manifestations)
- 250.60, 250.61, 250.62, 250.63 (diabetes with neurological manifestations)
- 250.70, 250.71, 250.72, 250.73 (diabetes with peripheral circulatory disorders)
- 250.80, 250.81, 250.82, 250.83 (diabetes with other specified manifestations)
- 250.90, 250.91, 250.92, 250.93 (diabetes with unspecified complication)
- 357.2 (polyneuropathy in diabetes)
- 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07 (diabetic retinopathy)
- 366.41 (diabetic cataract)
- 648.00, 648.01, 648.02, 648.03, 648.04 (diabetes mellitus in pregnancy, not gestational)

AND

CPT or HCPCS codes

- 97802, 97803, 97804
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309, 99310
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99346, 99348, 99349, 99350
- G0270, G0271
- G0402

Quality codes for this measure:

CPT II code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **CPT II 2028F**: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam — report when any of the three components are completed)
- **2028F–1P**: Documentation of medical reason for not performing foot exam (ie, patient with bilateral foot/leg amputation)
- **2028F–8P**: Foot exam was not performed, reason not otherwise specified

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.

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### Foot Exam

**Physician Quality Reporting System Data Collection Sheet**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>Date of Service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Clinical Information

**Step 1 Is patient eligible for this measure?**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is aged 18 through 75 years on date of encounter.</td>
<td>☐</td>
<td>☐</td>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td>Patient has a diagnosis of diabetes mellitus.</td>
<td>☐</td>
<td>☐</td>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
<tr>
<td>There is a CPT or HCPCS code for this visit.</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a CPT category II code.

**Step 2 Does patient meet or have an acceptable reason for not meeting the measure?**

<table>
<thead>
<tr>
<th>Foot Exam (includes visual inspection, sensory exam with monofilament or pulse exam)</th>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed</td>
<td>☐</td>
<td>☐</td>
<td>2028F</td>
</tr>
<tr>
<td>Not performed for the following reason: • Medical (ie, patient with bilateral foot/leg amputation)</td>
<td>☐</td>
<td>☐</td>
<td>2028F–1P</td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

If No is checked for all of the above, report 2028F–8P (Foot exam was not performed, reason not otherwise specified).
Seizure Type(s) and Current Seizure Frequency(ies)

This measure is to be reported for all patients with epilepsy — at all visits during the reporting period for patients with a diagnosis of epilepsy.

Measure description
Percentage of patient visits with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure frequency(ies) for each seizure type documented in the medical record.

What will you need to report for each patient with epilepsy for this measure?
If you select this measure for reporting, you will report:
- Whether or not you documented seizure type(s) and frequency(ies)

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to document seizure type and frequency, due to:
- Medical reasons (e.g., patient is unable to communicate and no informant is available) OR
- Patient reasons (e.g., patient and/or informant refuses to answer or comply)

In these cases, you will need to indicate which reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).
Coding Specifications

Codes required to document patient has epilepsy and a visit occurred:

An ICD-9-CM diagnosis code for epilepsy and a CPT code are required to identify patients to be included in this measure.

All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Epilepsy ICD-9-CM diagnosis codes

- 345.00, 345.01, 345.10, 345.11, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91

AND

CPT codes

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309

Quality codes for this measure:

CPT II code descriptors
(Data collection sheet should be used to determine appropriate code.)

- **CPT II 1200F**: Seizure type(s) and current seizure frequency(ies) documented
- **CPT II 1200F–1P**: Documentation of medical reason(s) for not documenting seizure type(s) and current seizure frequency(ies) (eg, patient is unable to communicate and no informant is available)
- **CPT II 1200F–2P**: Documentation of patient reason(s) for not documenting seizure type(s) and current seizure frequency(ies) (eg, patient and/or informant refuses to answer or comply)
- **CPT II 1200F–8P**: Seizure type(s) and current seizure frequency was not documented, reason not otherwise specified
### Seizure Type(s) and Current Seizure Frequency(ies)

**Physician Quality Reporting System Data Collection Sheet**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Provider Identifier (NPI)</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Clinical Information

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any patient regardless of age.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Patient has a diagnosis of epilepsy.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>There is a CPT code for this visit.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If **No** is checked for any of the above, STOP. Do not report a CPT category II code.

#### Billing Information

**Code Required on Claim Form**

- Verify date of birth on claim form.
- Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Seizure type(s) and current seizure frequency(ies)</th>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented</td>
<td>☐</td>
<td>☐</td>
<td>1200F</td>
</tr>
<tr>
<td>Not documented for one of the following reasons:</td>
<td>☐</td>
<td>☐</td>
<td>1200F–1P</td>
</tr>
<tr>
<td>• Medical (eg, patient is unable to communicate and no informant is available)</td>
<td>☐</td>
<td>☐</td>
<td>1200F–2P</td>
</tr>
<tr>
<td>• Patient (eg, patient and/or informant refuses to answer or comply)</td>
<td>☐</td>
<td>☐</td>
<td>1200F–2P</td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

- If **No** is checked for all of the above, report 1200F–8P (Seizure type(s) and current seizure frequency was not documented, reason not otherwise specified)
Documentation of Etiology of Epilepsy or Epilepsy Syndrome

This measure is to be reported for all patients with a diagnosis of epilepsy at all visits during the reporting period.

Measure description
All visits for patients with a diagnosis of epilepsy who had their etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic

What will you need to report for each patient with epilepsy for this measure?
If you select this measure for reporting, you will report:
- Whether or not you reviewed and documented the etiology of epilepsy or epilepsy syndrome

What if this process or outcome of care is not appropriate for your patient?
Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.
Coding Specifications

Codes required to document patient has epilepsy and a visit occurred:

An ICD-9-CM diagnosis code for epilepsy and a CPT code are required to identify patients to be included in this measure.

All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Epilepsy ICD-9-CM diagnosis codes
- 345.00, 345.01, 345.10, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91

AND

CPT codes
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.

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Epilepsy PQRS #267

Documentation of Etiology of Epilepsy or Epilepsy Syndrome

Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
</table>

National Provider Identifier (NPI) Date of Service

Clinical Information

Step 1  Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify date of birth on claim form.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 2  Does patient meet or have an acceptable reason for not meeting the measure?</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1205F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1205F–8P (Etiology of epilepsy or epilepsy syndrome(s) not reviewed and documented, reason not otherwise specified)</td>
</tr>
</tbody>
</table>

Etiology of epilepsy or epilepsy syndrome(s)¹

<table>
<thead>
<tr>
<th>Reviewed and documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes No</td>
</tr>
<tr>
<td>Yes No</td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

¹Report 1205F if documentation of etiology is known, unknown, or cryptogenic.

Physician Quality Reporting System 2013 Measure 267, Effective Date 01/01/2013

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(Disclaimers, Copyright and other Notices indicated on the Coding Specifications document are incorporated by reference)

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Counseling for Women of Childbearing Potential with Epilepsy

This measure is to be reported for all female patients aged 12 to 44 years with a diagnosis of epilepsy — at all visits during the reporting period.

Measure description
All female patients of childbearing potential (12–44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year

What will you need to report for each patient with epilepsy for this measure?
If you select this measure for reporting, you will report:
■ Whether or not you counseled women of childbearing potential with epilepsy

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to counsel women of childbearing potential with epilepsy, due to:
■ Medical reasons (eg, not indicated, contraindicated, other medical reason)

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).
### Coding Specifications

Codes required to document patient has epilepsy and a visit occurred:

An ICD-9-CM diagnosis code for epilepsy and a CPT code are required to identify patients to be included in this measure.

All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

**Epilepsy ICD-9-CM diagnosis codes**

- 345.00, 345.01, 345.10, 345.40, 345.41, 345.50, 345.51, 345.60, 345.61, 345.70, 345.71, 345.90, 345.91

**AND**

**CPT codes**

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309

Quality codes for this measure:

**CPT II code descriptors**

(Data collection sheet should be used to determine appropriate code or combination of codes.)

- **CPT II 4340F**: Counseling for women of childbearing potential with epilepsy
- **CPT II 4340F–1P**: Documentation of medical reason(s) why counseling was not performed for women of childbearing potential with epilepsy
- **CPT II 4340F–8P**: Counseling about epilepsy specific safety issues provided to patient or caregiver was not performed, reason not otherwise specified

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.
# Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Clinical Information</th>
<th>Billing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong> Is patient eligible for this measure?</td>
<td>Code Required on Claim Form</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Patient is aged 12 to 44 years.</td>
<td>□</td>
</tr>
<tr>
<td>Patient is female.</td>
<td>□</td>
</tr>
<tr>
<td>Patient has a diagnosis of epilepsy.</td>
<td>□</td>
</tr>
<tr>
<td>There is a CPT code for this visit.</td>
<td>□</td>
</tr>
<tr>
<td>If No is checked for any of the above, STOP. Do not report a CPT category II code.</td>
<td></td>
</tr>
</tbody>
</table>

<p>| <strong>Step 2</strong> Does patient meet or have an acceptable reason for not meeting the measure? | Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form) |</p>
<table>
<thead>
<tr>
<th>Epilepsy and treatment</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>4340F</td>
<td></td>
</tr>
<tr>
<td>Not counseled for one of the following reasons:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medical (eg, not indicated, contraindicated, other medical reason)</td>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Document reason here and in medical chart.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If No is checked for all of the above, report 4340F–8P (Counseling about epilepsy specific safety issues provided to patient or caregiver was not performed, reason not otherwise specified)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medication Reconciliation

This measure is to be reported each time during the reporting period that a patient aged 65 and older is discharged from an inpatient facility and seen by the physician within 30 days following discharge. This measure is to be reported at an outpatient visit occurring within 30 days of each inpatient facility discharge date during the reporting period. This measure is appropriate for use in the ambulatory setting only. This measure is not to be reported unless a patient has been discharged from an inpatient facility within 30 days prior to the outpatient visit.

Measure description
Percentage of patients aged 65 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 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 outpatient medical record documented.

What will you need to report when a patient is discharged from an inpatient facility and seen within 30 days following discharge?
If you select this measure for reporting, you will:
- At each visit, ask your patient if he/she has been discharged from an inpatient facility within the last 30 days. If yes, you will report that the patient was discharged from any inpatient facility. If no, you will not need to report any information for this measure for this visit.

If the patient was discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) within the last 30 days, you will then need to report:
- Whether or not there was documentation that the discharge medications were reconciled with the current medication list in the outpatient medical record\(^1\)

What if this process or outcome of care is not appropriate for your patient?
Some measures provide an opportunity for the physician or non-physician provider to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

\(^1\)Medical Record — Must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.
Medication Reconciliation

Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes

- 90791, 90792
- 90832, 90834, 90837, 90839
- 90845
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
- G0402, G0438, G0439

Quality codes for this measure (at least one of the following for every eligible patient):

CPT II code descriptors

(Data collection sheet should be used to determine appropriate combination of codes.)

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

Note: Medication reconciliation should be completed and documented within 30 days of discharge. If the patient has an eligible discharge but medication reconciliation is not performed and documented within 30 days, report CPT category II code 1111F-8P.
## Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Clinical Information</th>
<th>Billing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1 Is patient eligible for this measure?</strong></td>
<td>Code Required on Claim Form</td>
</tr>
<tr>
<td>Patient is aged 65 years and older.</td>
<td>Yes</td>
</tr>
<tr>
<td>There is a CPT or HCPCS code for this visit.</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient was discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) within the last 30 days.</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Step 2 Does patient meet the measure?</strong></td>
<td>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</td>
</tr>
<tr>
<td>Discharge Medications and Current Medication List in the Outpatient Medical Record(^1)</td>
<td>Yes</td>
</tr>
<tr>
<td>Reconciled</td>
<td>Yes</td>
</tr>
</tbody>
</table>

\(^1\)Medical Record — Must indicate: The clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.

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1. **Geriatric Care**
2. **PQRS #46**

**Medication Reconciliation**

**Physician Quality Reporting System Data Collection Sheet**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>Date of Service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Advance Care Plan

This measure is to be reported for all patients aged 65 years and older seen by the clinician — a minimum of once during the reporting period.

Measure 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.

What if this process or outcome of care is not appropriate for your patient?
Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

What will you need to report for each patient aged 65 years and older for this measure?
If you select this measure for reporting, you will report:

- Whether or not you documented a surrogate decision maker or advance care plan in the medical record OR
- Whether or not you documented that you discussed an advance care plan in the medical record but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

1Provide an Advance Care Plan — May also include, as appropriate, the following: that the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship.
Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99218, 99219, 99220
- 99221, 99222, 99223
- 99231, 99232, 99233
- 99234, 99235, 99236
- 99291
- 99304, 99305, 99306, 99307, 99308, 99309, 99310
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
- G0402

Quality codes for this measure:

CPT II code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **CPT II 1123F**: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record
- **CPT II 1124F**: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan
- **CPT II 1123F–8P**: Advance care planning not documented, reason not otherwise specified

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1 Clinicians indicating the place of service as the emergency department (23) will not be included in this measure.

2 Provide an Advance Care Plan — May also include, as appropriate, the following: that the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship.

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.
## Advance Care Plan

### Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
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</thead>
<tbody>
<tr>
<td>Patient’s Name</td>
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</tr>
<tr>
<td>Practice Medical Record Number (MRN)</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Birth Date (mm/dd/yyyy)</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Gender</td>
<td>□ Male □ Female</td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>[Blank]</td>
</tr>
<tr>
<td>Date of Service</td>
<td>[Blank]</td>
</tr>
</tbody>
</table>

### Clinical Information

#### Step 1  Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Verify date of birth on claim form.</td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a CPT category II code.

#### Step 2  Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Advance Care Planning</th>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented — advance care plan or surrogate decision maker documented in medical record</td>
<td>☐</td>
<td>☐</td>
<td>1123F</td>
</tr>
<tr>
<td>Documented as discussed — patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan¹</td>
<td>☐</td>
<td>☐</td>
<td>1124F²</td>
</tr>
</tbody>
</table>

If No is checked for all of the above, report 1123F–8P (Advance care planning not documented, reason not otherwise specified)

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¹Provide an Advance Care Plan — May also include, as appropriate, the following; that the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship.

²If patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, report 1124F.
Falls — Risk Assessment (Measure 154) and Plan of Care (Measure 155)

Measure 154 (falls — risk assessment) is to be reported for all patients aged 65 years and older seen by the clinician — a minimum of once per reporting period. If patient is identified as at risk for future falls, then paired measure 155 (falls — plan of care) should also be reported.

Measure description

Measure 154 (falls — risk assessment)
Percentage of patients aged 65 years and older with a history of falls¹ who had a risk assessment² for falls completed within 12 months

Measure 155 (falls — plan of care)
Percentage of patients aged 65 years and older with a history of falls who had a plan of care³ for falls documented within 12 months

What will you need to report for each patient aged 65 years and older for these paired measures?
If you select measures 154 and 155 for reporting, you will report:
- Whether or not the patient is at risk for future falls (ie, there is documentation of two or more falls in the past year or any fall with injury in the past year)

If the patient is at risk for future falls, you will then need to report:
- Whether or not you completed a risk assessment² for falls AND
- Whether or not you documented a plan of care³ for falls

If a patient is not at risk for future falls, you do not need to report measure 155 for this patient.

What if these processes or outcomes of care are not appropriate for your patient?
There may be times when it is not appropriate to complete a risk assessment for falls or document a plan of care for falls, due to:
- Medical reasons (eg, reduced mobility, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair, not indicated, contraindicated, other medical reason)

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).

¹Fall — 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.

²Risk Assessment — Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months. NOTE: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

³Plan of Care — Must include: 1) consideration of appropriate assistance device AND 2) balance, strength, and gait training. Consideration of Appropriate Assistance Device — Medical record must include: documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device. Balance, Strength, and Gait Training — Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait. NOTE: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.
Falls — Risk Assessment (Measure 154) and Plan of Care (Measure 155)

Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS 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
- G0402
- G0438, G0439

Quality codes for this measure:

CPT II code descriptors

(Data collection sheet should be used to determine appropriate code or combination of codes.)

- 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
- 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
- CPT II 1101F–8P: No documentation of falls status
- CPT II 3288F: Falls risk assessment documented
- CPT II 3288F–1P: Documentation of medical reason(s) for not completing a risk assessment for falls (eg, reduced mobility, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair)
- CPT II 3288F–8P: Falls risk assessment not completed, reason not otherwise specified
- CPT II 0518F: Falls plan of care documented
- CPT II 0518F–1P: Documentation of medical reason(s) for no plan of care for falls (eg, not indicated, contraindicated, other medical reason)
- CPT II 0518F–8P: Plan of care not documented, reason not otherwise specified
### Physician Quality Reporting System Data Collection Sheet

**Patient’s Name**

**Practice Medical Record Number (MRN)**

**Birth Date (mm/dd/yyyy)**

**Gender**

**National Provider Identifier (NPI)**

**Date of Service**

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#### Clinical Information

**Step 1 Is patient eligible for this measure?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
</tbody>
</table>

**Step 2 Does patient also have the other requirements for this measure?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>If No (ie, there is documentation of no falls in the past year OR only one fall without injury in the past year), report only 1101F and STOP. You do not need to report measure 155 for this patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If Yes, report 1100F and proceed to Steps 3 and 4.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If there is no documentation of falls status, report 1101F–8P and STOP.</td>
</tr>
</tbody>
</table>

**Step 3 Does patient meet or have an acceptable reason for not meeting the measure [measure 154 (falls — risk assessment)]?**

**Falls Risk Assessment**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>3288F and proceed to Step 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3288F–1P and proceed to Step 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3288F and proceed to Step 4</td>
</tr>
</tbody>
</table>

**Document reason here and in medical chart.**

---

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

2. **Risk Assessment** — Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls within the past 12 months. **NOTE:** All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

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**continued on next page**
### Clinical Information

**Step 4** Does patient meet or have an acceptable reason for not meeting the measure [measure 155 (falls — plan of care)]?

<table>
<thead>
<tr>
<th>Plan of Care for Falls</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not documented for the following reason:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical (eg, not indicated, contraindicated, other medical reason)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0518F</td>
</tr>
<tr>
<td>0518F–1P</td>
</tr>
</tbody>
</table>

If **No** is checked for all of the above, report 0518F–8P (Plan of care not documented, reason not otherwise specified)

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3Plan of Care — Must include: 1) consideration of appropriate assistance device AND 2) balance, strength, and gait training. Consideration of Appropriate Assistance Device — Medical record must include: documentation that an assistive device was provided or considered OR referral for evaluation for an appropriate assistance device. Balance, Strength, and Gait Training — Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait. **NOTE**: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.
Elder Maltreatment Screen and Follow-Up Plan

This measure is to be reported once during the reporting period. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding at the time of the qualifying visit.

Measure description
Percentage of patients aged 65 years and older with a documented elder maltreatment screen on the date of encounter AND a documented follow-up plan on the date of positive screen

What will you need to report at each visit for each patient aged 65 years and older for this measure?
Whether or not you screened for elder maltreatment and documented a follow up plan, if necessary.

The screen includes a review of the following components:
1) physical abuse, 2) emotional or psychological abuse, 3) neglect (active or passive), 4) sexual abuse, 5) abandonment, 6) financial or material exploitation, 7) self-neglect, and 8) unwanted control.

A follow-up plan may include but is not limited to documentation of a referral or discussion with other providers, on-going monitoring or assessment, and/or a direct intervention.

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to screen for elder maltreatment, due to:

- Documented reasons (eg. patient refuses to participate, patient is in an urgent or emergent situation and to delay treatment would jeopardize the patient’s health status).

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exceptions).

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1Screen for Elder Maltreatment — An elder maltreatment screen includes assessment and documentation of all of the following components: (1) physical abuse, (2) emotional or psychological abuse, (3) neglect (active or passive), (4) sexual abuse, (5) abandonment, (6) financial or material exploitation, (7) self-neglect, and (8) unwanted control.

2Physical Abuse — Infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.

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

Neglect — Involves attitudes of others or actions caused by others—such as family members, friends, or institutional caregivers—that have an extremely detrimental effect upon well-being.
   - Active — Behavior that is willful or when the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts.
   - Passive — Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources.

Sexual Abuse — The forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.

Elder Abandonment — Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.

Financial or Material Exploitation — Taking advantage of a person for monetary gain or profit.

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

Unwanted Control — Controlling a person’s ability to make choices about living situations, household finances, and medical care.

3Follow-Up Plan — May include but is not limited to documentation of a referral or discussion with other providers, on-going monitoring or assessment, and/or a direct intervention.
Elder Maltreatment Screen and Follow-Up Plan

Coding Specifications
Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes
- 90791, 90792
- 96116*
- 96150
- 97003
- 97802, 97803*
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
- G0101
- G0270*
- G0402
- G0438, G0439

Quality codes for this measure:

G-code descriptors
(Data collection sheet should be used to determine appropriate code.)
- **G8733:** Documentation of a positive elder maltreatment screen and follow-up plan at the time of positive screen
- **G8734:** Elder maltreatment screen documented as negative, no follow-up required
- **G8941:** Elder maltreatment screen documented, patient not eligible for follow-up
- **G8735:** Elder maltreatment screen documented as positive, follow-up plan not documented, reason not given
- **G8535:** No documentation of an elder maltreatment screen, patient not eligible (eg, patient refuses to participate, patient is in an urgent or emergent situation and to delay treatment would jeopardize the patient’s health status)
- **G8536:** No documentation of an elder maltreatment screen, reason not given

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# Elder Maltreatment Screen and Follow-Up Plan

**Physician Quality Reporting System Data Collection Sheet**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

**Clinical Information**

### Step 1 Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- **Patient is aged 65 years or older on date of encounter.**
- **There is a CPT or HCPCS code for this visit.**
- **If No is checked for any of the above, STOP. Do not report a G-code.**

### Step 2 Does patient meet or have an acceptable reason for not meeting the measure?

**Elder Maltreatment Screen**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

- **Positive screen AND follow-up plan documented**
- **Screened, but no follow-up plan documented for the following reason:**
  - Elder maltreatment screen was negative, no follow-up required
  - Elder maltreatment screen documented, patient not eligible
- **Not screened, patient not eligible**

**Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)**

<table>
<thead>
<tr>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
<tr>
<td>G8733</td>
</tr>
<tr>
<td>G8734</td>
</tr>
<tr>
<td>G9841</td>
</tr>
<tr>
<td>G8535</td>
</tr>
</tbody>
</table>

**Billing Information**

**Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)**

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8536 (No documentation of an elder maltreatment screen, reason not given)</td>
</tr>
</tbody>
</table>

---

1. Elder Maltreatment screen includes assessment and documentation of all of the following components: 1) physical abuse, 2) emotional or psychological abuse, 3) neglect (active or passive), 4) sexual abuse, 5) abandonment, 6) financial or material exploitation, 7) self-neglect, and 8) unwanted control.

2. Follow-Up Plan — May include but is not limited to documentation of a referral or discussion with other providers, on-going monitoring or assessment, and/or a direct intervention.
Antidepressant Medication During Acute Phase for Patients with MDD

This measure is to be reported for each occurrence of MDD during the reporting period for all patients aged 18 years and older.

Measure description
Percentage of patients aged 18 years and older diagnosed with new episode1 of MDD and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase

What will you need to report for each occurrence of MDD for this measure?
If you select this measure for reporting, you will need to determine:
- Whether or not the patient is being seen for a new episode1 of MDD

If the patient is being seen for a new episode of MDD, you will then need to report:
- Whether or not you prescribed (or the patient completed) an 84-day (12-week) acute treatment of antidepressant medication

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to complete an 84-day (12-week) acute treatment of antidepressant medication, due to:
- Documented reasons (eg, patient with a new episode of MDD was not an eligible candidate for antidepressant medication treatment)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exceptions).

---

1New Episode — Patient with major depression who has not been seen or treated for major depression by any practitioner in the prior 4 months. A new episode can either be a recurrence for a patient with prior major depression or a patient with a new onset of major depression.
Coding Specifications

Codes required to document patient has MDD and a visit occurred:

An ICD-9-CM diagnosis code for MDD and a CPT or HCPCS code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

MDD ICD-9-CM diagnosis codes
- 296.20, 296.21, 296.22, 296.23, 296.24, 296.25 (major depressive disorder, single episode)
- 296.30, 296.31, 296.32, 296.33, 296.34, 296.35 (major depressive disorder, recurrent episode)
- 298.0 (other nonorganic psychoses)
- 300.4 (dysthymic disorder)
- 309.0 (adjustment disorder with depressed mood)
- 309.1 (prolonged depressive reaction)
- 311 (major depression)

AND

CPT or HCPCS codes
- 90791, 90792
- 90832, 90834, 90837, 90839
- 90845
- 90849, 90853, 90857
- 99078
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
- G0402

Quality codes for this measure:

G-code descriptors
(Data collection sheet should be used to determine appropriate code.)
- G8126: Patient with new episode of MDD documented as being treated with antidepressant medication during the entire 12 week acute treatment phase
- 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
- G8127: Patient with new episode of MDD not documented as being treated with antidepressant medication during the entire 12 week acute treatment phase
### Clinical Information

**Step 1  Is patient eligible for this measure?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
</tbody>
</table>

**Step 2  Does patient also have the other requirements for this measure?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>If No, report G8128 and STOP. If Yes, proceed to Step 3.</td>
</tr>
</tbody>
</table>

**Step 3  Does patient meet or have an acceptable reason for not meeting the measure?**

84-Day (12-Week) Acute Treatment with Antidepressant Medication

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>G8126</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G8128</td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

---

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

Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with evidence that they met the DSM-IV-TR criteria for MDD AND for whom there is an assessment of depression severity during the visit in which a new diagnosis or recurrent episode was identified.

What will you need to report for each patient with MDD for this measure?

If you select this measure for reporting, you will report:

- Whether or not you documented DSM-IV-TR criteria for major depressive disorder and assessed the severity of MDD during the visit in which the new diagnosis or recurrent episode was identified.

What if this process or outcome of care is not appropriate for your patient?

Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

This measure is to be reported for all patients aged 18 years and older with an active diagnosis of MDD, including episodes of MDD that began prior to the reporting period — a minimum of once per reporting period.

---

1MDD diagnosis (DSM-IV-TR) — For a diagnosis of MDD a patient must endorse five of nine symptoms, with one of those five being either 1) depressed mood or 2) loss of interest or pleasure. The other symptoms include significant weight loss or gain; decrease or increase in appetite nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; feelings of worthlessness or guilt nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day; and recurrent thoughts of death or suicidal ideation.

These symptoms must be present for a duration of 2 weeks or longer and cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

These symptoms must: not meet criteria for a mixed episode; not be due to the direct physiological effects of a substance (eg, a drug of abuse, a medication) or a general medical condition (eg, hypothyroidism); OR not be better accounted for by bereavement, ie, 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.

2Severity — According to DSM-IV-TR, severity is judged to be mild, moderate, or severe based on the number of criteria symptoms, the severity of the symptoms, and the degree of functional disability and distress.

3This measure is intended to capture either an initial or recurrent episode. For patients whose episode of MDD began prior to the current reporting period, the clinician will need to report, once during the current reporting period, whether or not DSM-IV-TR criteria and severity was assessed during the visit in which the new diagnosis or recurrent episode was identified.
Coding Specifications

Codes required to document patient has MDD and a visit occurred:

An ICD-9-CM diagnosis code for MDD and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

MDD ICD-9-CM diagnosis codes

- 296.20, 296.21, 296.22, 296.23, 296.24
- 296.30, 296.31, 296.32, 296.33, 296.34

AND

CPT codes

- 90791, 90792
- 90832, 90834, 90837, 90839
- 90845
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215

Quality codes for this measure:

CPT II code G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **CPT II 1040F**: DSM-IV-TR criteria for major depressive disorder documented at the initial evaluation
- **CPT II 1040F–8P**: DSM-IV-TR criteria for major depressive disorder not documented at the initial evaluation, reason not otherwise specified
- **G8930**: Assessment of depression severity at the initial evaluation
- **G8931**: Assessment of depression severity not documented, reason not given

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.

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### Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Clinical Information</th>
<th>Billing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong> Is patient eligible for this measure?</td>
<td><strong>Code Required on Claim Form</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Verify date of birth on claim form.</td>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
<tr>
<td><strong>Step 2</strong> Does patient meet the measure?</td>
<td><strong>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</strong></td>
</tr>
<tr>
<td><strong>DSM-IV-TR Criteria for Major Depressive Disorder</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>During the visit in which the new diagnosis or recurrent episode was identified, at least 5 of the following symptoms have been documented as present nearly every day during the same two week period (must include symptom 1 or 2):</td>
<td></td>
</tr>
<tr>
<td>1) depressed mood</td>
<td></td>
</tr>
<tr>
<td>2) loss of interest or pleasure</td>
<td></td>
</tr>
<tr>
<td>3) significant weight loss or gain</td>
<td></td>
</tr>
<tr>
<td>4) decrease or increase in appetite</td>
<td></td>
</tr>
<tr>
<td>5) insomnia or hypersomnia</td>
<td></td>
</tr>
<tr>
<td>6) psychomotor agitation or retardation</td>
<td></td>
</tr>
<tr>
<td>7) feelings of worthlessness or guilt</td>
<td></td>
</tr>
<tr>
<td>8) diminished ability to think or concentrate, or indecisiveness</td>
<td></td>
</tr>
<tr>
<td>9) recurrent thoughts of death or suicidal ideation</td>
<td></td>
</tr>
<tr>
<td><strong>Level of Severity Assessed</strong></td>
<td>Yes</td>
</tr>
<tr>
<td>If Yes, report G8930</td>
<td>If Yes, report G8930</td>
</tr>
<tr>
<td>If No, report G8931 (Assessment of depression severity not documented, reason not given)</td>
<td>If No, report G8931 (Assessment of depression severity not documented, reason not given)</td>
</tr>
</tbody>
</table>

---

1This measure is intended to capture either an initial or recurrent episode of MDD. For patients whose episode of MDD began prior to the current reporting period, the clinician will need to report, once during the current reporting period, whether or not DSM-IV-TR criteria and severity was assessed during the visit in which the new diagnosis or recurrent episode was identified.
Suicide Risk Assessment

This measure is to be reported at each visit during the reporting period for all patients aged 18 years and older with an active diagnosis of MDD, including episodes of MDD that began prior to the reporting period.

Measure description

Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.

What if this process or outcome of care is not appropriate for your patient?

Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

What will you need to report for each visit for patients with MDD for this measure?

If you select this measure for reporting, you will report:

- Whether or not you completed a suicide risk assessment during the visit in which a new diagnosis or recurrent episode was identified.

1Suicide Risk Assessment — Must include questions about the following: suicidal ideation, patient’s intent of initiating suicide attempt AND, if either is present, patient plans for suicide attempt and whether the patient has means for completing suicide.
Suicide Risk Assessment

Coding Specifications

Codes required to document patient has major depressive disorder and a visit occurred:

An ICD-9-CM diagnosis code for MDD and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

MDD ICD-9-CM diagnosis codes

- 296.20, 296.21, 296.22, 296.23, 296.24
- 296.30, 296.31, 296.32, 296.33, 296.34

AND

CPT codes

- 90791, 90792
- 90832, 90834, 90837, 90839
- 90845
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215

Quality codes for this measure:

CPT II code and G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- CPT II 3092F: Major depressive disorder, in remission
- G8932: Suicide risk assessed at the initial evaluation
- G8933: Suicide risk not assessed at the initial evaluation, reason not given

1If the patient has been assigned an ICD-9-CM diagnosis code of either 296.20 or 296.30 (unspecified MDD) AND is in remission, code 3092F should be reported. Suicide risk does not need to be assessed for patients in remission, however all instances of 296.20 or 296.30 require that a CPT II code be reported. If the patient is in remission, report 3092F; if the patient is not in remission, suicide risk should be assessed.

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.

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## Suicide Risk Assessment

### Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Clinical Information</th>
<th>Billing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong> Is patient eligible for this measure?</td>
<td>Code Required on Claim Form</td>
</tr>
<tr>
<td>Patient is aged 18 years and older on date of encounter.</td>
<td>Yes</td>
</tr>
<tr>
<td>Patient has a diagnosis of new or recurrent episode of MDD.</td>
<td></td>
</tr>
<tr>
<td>There is a CPT code for this visit.</td>
<td></td>
</tr>
<tr>
<td>If No is checked for any of the above, STOP. Do not report a CPT category II code or G-code.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Step 2</strong> Does patient also have the other requirements for this measure?</th>
<th>Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient meet the full criteria for MDD (ie, patient is not in remission(^1))?</td>
<td>Yes</td>
</tr>
<tr>
<td>If No (ie, patient is in remission(^1)), report only 3092F(^2) and STOP. If Yes, proceed to Step 3.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Step 3</strong> Does patient meet the measure?</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide Risk Assessed at initial evaluation(^3)</td>
<td>Yes</td>
</tr>
<tr>
<td>G8932</td>
<td></td>
</tr>
<tr>
<td>If No is checked for the above, report G8933 (Suicide risk not assessed at initial evaluation, reason not given)</td>
<td></td>
</tr>
</tbody>
</table>

---

\(^1\)According to DSM-IV-TR criteria, full remission requires no symptoms of depression over at least 2 months, and partial remission is the presence of depressive symptoms without meeting full MDD criteria, or no significant symptoms for a period of less than 2 months.

\(^2\)If the patient has been assigned an ICD-9-CM diagnosis code of either 296.20 or 296.30 (unspecified MDD) AND is in remission, code 3092F should be reported. This measure does not require suicide risk assessment to be reported for patients in remission, however all instances of 296.20 or 296.30 require that a CPT II code be reported. If the patient is in remission, report 3092F; if the patient is not in remission, then report a code to identify whether or not you assessed for suicide risk.

\(^3\)Suicide Risk Assessment — Must include questions about the following: suicidal ideation, patient’s intent of initiating suicide attempt AND, if either is present, patient plans for suicide attempt and whether the patient has means for completing suicide.
Documentation of Current Medications in the Medical Record

This measure is to be reported at each visit occurring during the reporting period for all patients aged 18 years and older.

Measure description
Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.

What will you need to report for each patient for this measure?
If you select this measure for reporting, you will report:

- Whether you documented a list of the patient’s current medications including drug name, dosage, frequency, and route of administration.

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to document current medications, due to:

- Documented reasons (eg, 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)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exceptions).

1Current Medications — Medications the patient is presently taking including all prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements with each medication’s name, dosage, frequency, and route of administration.
Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT codes

- 90791, 90792
- 90832, 90834, 90837, 90839
- 90957, 90958, 90959
- 90960, 90962, 90965, 90966
- 92002, 92004
- 92012, 92014
- 92507, 92508
- 92526
- 92541, 92542, 92543, 92544, 92545, 92547, 92548
- 92557
- 92567
- 92568, 92570
- 92585
- 92588
- 92626
- 96116
- 96150, 96152
- 97001, 97002
- 97003, 97004
- 97532
- 97802, 97803, 97804
- 98960, 98961, 98962
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99324, 99325, 99326, 99327, 99328
- 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

OR

HCPCS codes

- G0101
- G0108
- G0270
- G0402
- G0438
- G0439

Quality codes for this measure:

G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **G8427**: Eligible professional attests to documenting the patient’s current medications to the best of his/her knowledge and ability
- **G8430**: Eligible professional attests the patient is not eligible for medication documentation
- **G8428**: Current medications not documented by the eligible professional, reason not given
## Documentation of Current Medications in the Medical Record

### Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender □ Male □ Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>Date of Service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Information

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

- Patient is aged 18 years and older on date of encounter.
- There is a CPT or HCPCS code for this visit.

If No is checked for any of the above, STOP. Do not report a G-code.

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

### Current Medications

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

- Documented
- Not documented for the following reason:
  - Documented reasons (e.g., 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)

Document reason here and in medical chart.

<table>
<thead>
<tr>
<th>Code Required on Claim Form</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes or Service Line 24 of Electronic Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8427</td>
<td>G8430</td>
</tr>
</tbody>
</table>

If No is checked for all of the above, report G8428 (Current medications not documented by the eligible professional, reason not given)

---

1Current Medications — Medications the patient is presently taking including all prescriptions, over-the-counters, herbals, vitamin/mineral/dietary (nutritional) supplements with each medication’s name, dosage, frequency, and route of administration.
Pain Management

Pain Assessment and Follow-Up

This measure is to be reported for each visit occurring during the reporting period for all patients aged 18 years and older seen during the reporting period.

Measure description

Percentage of visits for patients aged 18 years and older with documentation of a pain assessment\(^1\) through discussion with the patient including the use of a standardized tool(s)\(^2\) on each visit AND documentation of a follow-up plan\(^3\) when pain is present.

What will you need to report for each visit for patients aged 18 years and older for this measure?

If you select this measure for reporting, you will report:

- Whether or not you assessed for pain using a standardized tool(s)\(^2\) AND documented a follow-up plan when pain is present.

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to assess for pain prior to initiation of therapy or document a follow-up plan, due to:

- Documented reasons (e.g., severe mental and/or physical incapacity; patient is in urgent or emergent situation and to delay treatment would jeopardize the patient’s health status)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exceptions).

\(^1\) Pain assessment — A clinical assessment of pain using a standardized tool for the presence and characteristics of pain; characteristics may include location, intensity, quality, and onset/duration.

\(^2\) Standardized tool — An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNR), Visual Analog Scale (VAS).

\(^3\) Follow-Up Plan — Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up must include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other providers as applicable.
Pain Management

Pain Assessment and Follow-Up

Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes

- 90791, 90792
- 92507, 92508
- 92526
- 96116
- 96150
- 97001
- 97003
- 97532
- 98940, 98941, 98942
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- G0101
- G0402
- G0438, G0439

Quality codes for this measure:

G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **G8730**: Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented
- **G8731**: Pain assessment documented as negative, no follow-up plan required
- **G8939**: Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate¹
- **G8442**: Documentation that patient is not eligible¹ for a pain assessment
- **G8732**: No documentation of pain assessment, reason not given
- **G8509**: Documentation of positive pain assessment; no documentation of a follow-up plan, reason not given

¹Not eligible — A patient is not eligible if one or more of the following reasons exist: severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others (for example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools); patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status.
# Pain Assessment and Follow-Up

## Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Provider Identifier (NPI)</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Information

#### Step 1  Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Code Required on Claim Form**

- Verify date of birth on claim form.
- Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.

#### Step 2  Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Pain Assessment</th>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessed AND Follow-up plan documented</td>
<td>☐</td>
<td>☐</td>
<td>G8730</td>
</tr>
<tr>
<td>Not assessed for the following reason:</td>
<td></td>
<td></td>
<td>G8442</td>
</tr>
<tr>
<td>• Documented reasons (eg, severe mental and/or physical incapacity; patient is in urgent or emergent situation and to delay treatment would jeopardize the patient’s health status)</td>
<td>☐</td>
<td>☐</td>
<td>G8731</td>
</tr>
<tr>
<td>Assessed, but no follow-up plan documented for the following reason:</td>
<td></td>
<td></td>
<td>G8939</td>
</tr>
<tr>
<td>• Documented reasons (eg, absence of pain on assessment, diagnosis/condition/illness if not situationally related to pain)</td>
<td>☐</td>
<td>☐</td>
<td>G8732</td>
</tr>
<tr>
<td>• Patient not eligible/not appropriate</td>
<td>☐</td>
<td>☐</td>
<td>G8509</td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

If **No** is checked for all of the above, report:
- G8732 (No documentation of pain assessment, reason not given)
- OR
- G8509 (Documentation of positive pain assessment, no documentation of a follow-up plan, reason not given)

---

1**Follow-Up Plan** — Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up must include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other providers as applicable.
Influenza Immunization

This measure is to be reported for all patients aged 6 months and older seen by the clinician — a minimum of once for visits between January and March of the 2012–2013 influenza season AND a minimum of once for the visits between October and December for the 2013–2014 influenza season.

Measure description
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt\(^1\) of an influenza immunization

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to order or administer an influenza immunization during the flu season, due to:
- Documented reasons (e.g., patient allergy or other medical reasons, patient declined or other patient reasons, or other system reasons)

In these cases, you will need to indicate that the documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exceptions).

What will you need to report for each patient aged 6 months and older for this measure?
If you select this measure for reporting, you will report:
- Whether or not you administered an influenza immunization OR that the patient reported previous receipt of influenza immunization between October 1 and March 31 of the current flu season

\(^1\)Previous Receipt — Receipt of the current season’s influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).
Influenza Immunization

**Coding Specifications**

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

**CPT or HCPCS codes**

- 90653, 90655, 90657, 90660, 90661, 90664, 90666, 90667, 90668, 90672
- 90945, 90947
- 90951, 90952, 90953, 90954, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970
- 90989, 90993, 90997, 90999
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99304, 99305, 99306, 99307, 99308, 99309, 99310
- 99315, 99316
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
- G0438, G0439
- Q2035, Q2036, Q2037, Q2038, Q2039

**Quality codes for this measure:**

**G-code descriptors**

(Data collection sheet should be used to determine appropriate code.)

- **G8482:** Influenza immunization administered or previously received
- **G0919:** Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit
- **G8483:** Influenza immunization was not ordered or administered for reasons documented by clinician (eg, patient allergy or other medical reasons, patient declined or other patient reasons, or other system reasons)
- **G8484:** Influenza immunization was not ordered or administered, reason not given
## Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**National Provider Identifier (NPI)**

<table>
<thead>
<tr>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Clinical Information

#### Step 1 Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Patient is aged 6 months and older on date of encounter.
- There is a CPT or HCPCS code for this visit.

If **No** is checked for any of the above, STOP. Do not report a G-code.

#### Billing Information

### Step 2 Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8482</td>
</tr>
<tr>
<td>G0919</td>
</tr>
<tr>
<td>G8483</td>
</tr>
</tbody>
</table>

**Influenza Immunization**

1. **Administered or Previously Received**
2. **Ordered or recommended, but not administered**
   - **Vaccine not available at time of visit**
3. **Not administered for the following reason:**
   - **Documented reasons (eg, patient allergy or other medical reasons, patient declined or other patient reasons, or other system reasons)**

Document reason here and in medical chart.

If **No** is checked for all of the above, report G8484 (Influenza immunization was not ordered or administered, reason not given).

---

1. If reporting this measure between January 1, 2013 and March 31, 2013, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of September, October, November, and December of 2012 or January, February, or March of 2013 for the flu season ending March 31, 2013.

2. If reporting this measure between October 1, 2013 and December 31, 2013, G-code G8482 should be reported when the influenza immunization is ordered or administered to the patient during the months of September, October, November, and December of 2013 for the flu season ending March 31, 2014.

2. Previous Receipt — Receipt of the current season’s influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).
Pneumococcal Vaccination for Patients 65 Years and Older

This measure is to be reported for all patients aged 65 years and older seen by the clinician — a minimum of once per reporting period.

Measure description
Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine

What will you need to report for each patient aged 65 years and older for this measure?
If you select this measure for reporting, you will report:
- Whether or not you administered or the patient previously received a pneumococcal vaccine

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to administer a pneumococcal vaccine, due to:
- Medical reasons (e.g., not indicated, contraindicated, other medical reason)

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).
Pneumococcal Vaccination for Patients 65 Years and Older

Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes

- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99218, 99219, 99220
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
- 99356, 99357
- G0402

Quality codes for this measure:

CPT II code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **CPT II 4040F**: Pneumococcal vaccine administered or previously received
- **CPT II 4040F–1P**: Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccination (eg, not indicated, contraindicated, other medical reason)
- **CPT II 4040F–8P**: Pneumococcal vaccine was not administered or previously received, reason not otherwise specified
# Physician Quality Reporting System Data Collection Sheet

Patient’s Name | Practice Medical Record Number (MRN) | Birth Date (mm/dd/yyyy) | Gender
---|---|---|---

National Provider Identifier (NPI) | Date of Service

### Clinical Information

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Clinical Information</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is aged 65 years and older on date of encounter.</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>There is a CPT or HCPCS code for this visit.</td>
<td>□ Yes □ No</td>
</tr>
</tbody>
</table>

If **No** is checked for any of the above, STOP. Do not report a CPT category II code.

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Pneumococcal Vaccine</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administered or previously received</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>Not administered or previously received for the following reason:</td>
<td>□ Yes □ No</td>
</tr>
<tr>
<td>• Medical (eg, not indicated, contraindicated, other medical reason)</td>
<td></td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

If **No** is checked for **all** of the above, report 4040F–8P (Pneumococcal vaccine was not administered or previously received, reason not otherwise specified).
**Measure description**

Percentage of patients aged 18 years and older with a calculated BMI\(^1\) in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan\(^2\) is documented within the past six months or during the current visit.

**Normal Parameters:**
- Age 65 and older BMI ≥23 and <30
- Age 18–64 BMI ≥18.5 and <25

**What if this process or outcome of care is not appropriate for your patient?**

There may be times when it is not appropriate to calculate BMI, due to:
- Documented reasons that a patient is not eligible/not appropriate for BMI measurement, patients can be considered not eligible in the following situations:
  - If the patient is receiving palliative care
  - If the patient is pregnant
  - 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
  - If the 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

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exceptions).

---

\(^1\)BMI — Body Mass Index (BMI) is expressed as weight/height (kg/m\(^2\)) and is commonly used to classify weight categories.

Calculated BMI — Requires an eligible professional or their staff to measure both the height and weight. Self-reported values cannot be used. BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared.

\(^2\)Follow-Up Plan — Proposed outline of treatment to be conducted as a result of BMI out of normal parameters. Such follow-up may include but is not limited to: documentation of a future appointment, education, referral, (such as, a registered dietician, nutritionist, occupational therapist, primary care provider, exercise physician, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.
Body Mass Index (BMI) Screening and Follow-Up

Coding Specifications

Codes required to document a visit occurred:

A CPT code, HCPCS D-code or HCPCS G-code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT codes
- 90791, 90792
- 90832, 90834, 90837, 90839
- 97001
- 97003
- 97802, 97803
- 98960
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215

OR

HCPCS D-codes
- D7140 (extraction, erupted tooth or exposed root)
- D7210 (surgical removal of erupted tooth)

OR

HCPCS G-codes
- G0101
- G0108
- G0270
- G0271
- G0402
- G0438, G0439
- G0447, G0449

Quality codes for this measure:

G-code descriptors
(Data collection sheet should be used to determine appropriate code.)
- **G8420**: Calculated BMI within normal parameters and documented
- **G8417**: Calculated BMI above normal parameters and a follow-up plan was documented
- **G8418**: Calculated BMI below normal parameters and a follow-up plan was documented
- **G8422**: Patient not eligible for BMI calculation
- **G8938**: BMI is calculated, but patient not eligible for follow-up plan
- **G8421**: BMI not calculated
- **G8419**: Calculated BMI outside normal parameters, no follow-up plan documented

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. Quality Insights of Pennsylvania disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. CPT contained in the Measure specifications is copyright 2004–2012 American Medical Association. All Rights Reserved. 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.

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Physician Quality Reporting System 2013 Measure 128, Effective Date 01/01/2013
CPT® copyright 2012 American Medical Association
### Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>Date of Service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Information

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Verify date of birth on claim form.</td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a G-code.

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Body Mass Index (BMI) Screening</th>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calculated BMI within normal parameters(^1) and documented; no follow-up plan needed</td>
<td></td>
<td></td>
<td>G8420</td>
</tr>
<tr>
<td>Calculated BMI above normal parameters; follow-up plan documented</td>
<td></td>
<td></td>
<td>G8417</td>
</tr>
<tr>
<td>Calculated BMI below normal parameters; follow-up plan documented</td>
<td></td>
<td></td>
<td>G8418</td>
</tr>
<tr>
<td>Calculated BMI, but patient not eligible for follow-up plan</td>
<td></td>
<td></td>
<td>G8938</td>
</tr>
<tr>
<td>Not documented for the following reason: (\cdot) Documented reasons (eg, patient not eligible for BMI calculation(^2))</td>
<td></td>
<td></td>
<td>G8422</td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

If No is checked for all of the above, report G8421 (BMI not calculated)

OR

G8419 (Calculated BMI outside normal parameters, no follow-up plan documented)

---

**Normal Parameters:**

\(^1\) Age 65 and older BMI ≥ 23 and < 30

Age 18–64 BMI ≥ 18.5 and < 25

\(^2\) Not Eligible / Not Appropriate for BMI Measurement or Follow-Up Plan — A patient is not eligible if one or more of the following reasons exists:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI Measurement
- 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
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement or follow-up plan was not appropriate

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Physician Quality Reporting System 2013 Measure 128, Effective Date 01/01/2013

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Screening for Clinical Depression and Follow-Up Plan

This measure is to be reported a minimum of once per reporting period for all patients aged 12 years and older seen by the clinician during the reporting period.

**Measure description**
Percentage of patients aged 12 years and older screened\(^1\) for clinical depression on the date of encounter using an age appropriate standardized depression screening tool\(^2\) AND, if positive, a follow-up plan\(^3\) is documented on the date of the positive screen

**What will you need to report for each patient aged 12 and older?**
If you select this measure for reporting, you will report:

- Whether or not the patient was screened for depression using a standardized depression screening tool\(^2\) AND documentation of a follow-up plan\(^3\), if appropriate

**What if this process or outcome of care is not appropriate for your patient?**
There may be times when it is not appropriate to screen for depression, due to:

- Documented reasons (eg, patient refuses to participate, patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status, situations where the patient’s functional capacity or motivation to improve may impact the accuracy of results of standardized depression screening tools (i.e. certain court appointed cases or cases of delirium), patient has an active diagnosis of Depression or Bipolar Disorder)

In these cases, you will need to indicate that a documented reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report the G-code that represents these valid reasons (also called exceptions).

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\(^1\)Screening — Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

\(^2\)Standardized Depression Screening Tool — A normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years):** Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2

- **Adult Screening Tools (18 years and older):** Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

\(^3\)Follow-Up Plan — Proposed outline of treatment to be conducted as a result of positive clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following: additional evaluation, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, other interventions or follow-up for the diagnosis or treatment of depression.
Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes

- 90791, 90792
- 90832, 90834, 90837, 90839
- 92557
- 92567
- 92568
- 92625, 92626
- 96150, 96151
- 97003
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- G0101
- G0402
- G0438, G0439
- G0444

Quality codes for this measure:

G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- G8431: Positive screen for clinical depression with a documented follow-up plan
- G8510: Negative screen for clinical depression, follow-up not required
- G8433: Screening for clinical depression not documented, patient not eligible/appropriate
- G8940: Screening for clinical depression documented, follow-up plan not documented, patient not eligible/appropriate
- G8432: Clinical depression screening not documented, reason not given
- G8511: Positive screen for clinical depression documented, follow-up plan not documented, reason not given
### Physician Quality Reporting Code Data Collection Sheet

<table>
<thead>
<tr>
<th>Clinical Information</th>
<th>Billing Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Step 1</strong> Is patient eligible for this measure?</td>
<td><strong>Step 2</strong> Does patient meet or have an acceptable reason for not meeting the measure?</td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Patient is aged 12 years and older on date of encounter.</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>There is a CPT or HCPCS code for this visit.</td>
<td>□</td>
</tr>
<tr>
<td>If No is checked for any of the above, STOP. Do not report a G-code.</td>
<td></td>
</tr>
<tr>
<td><strong>Clinical Depression Screening</strong> Using a Standardized Depression Screening Tool AND Follow-Up Plan</td>
<td><strong>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>□</td>
<td>□</td>
</tr>
<tr>
<td>Perform — Positive screen, follow-up plan documented</td>
<td></td>
</tr>
<tr>
<td>Perform — Negative screen, follow-up plan not required</td>
<td></td>
</tr>
<tr>
<td>Perform — Screen documented, follow-up plan not documented, patient not eligible/appropriate⁴</td>
<td></td>
</tr>
<tr>
<td>Not performed for the following reason:</td>
<td></td>
</tr>
<tr>
<td>• Documented reasons (eg, patient not eligible/appropriate for clinical depression screening)</td>
<td></td>
</tr>
<tr>
<td>Document reason here and in medical chart.</td>
<td></td>
</tr>
<tr>
<td>If No is checked for all of the above, report G8432</td>
<td></td>
</tr>
<tr>
<td>(Clinical depression screening not documented, reason not given)</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>G8511</td>
<td></td>
</tr>
<tr>
<td>(Positive screen for clinical depression documented, follow-up plan not documented, reason not given)</td>
<td></td>
</tr>
<tr>
<td>continued on next page</td>
<td></td>
</tr>
</tbody>
</table>
Screening — Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.

Standardized Depression Screening Tool — A normalized and validated depression screening tool developed for the patient population in which it is being utilized. Examples of depression screening tools include but are not limited to:

- Adolescent Screening Tools (12-17 years): Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2

- Adult Screening Tools (18 years and older): Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

Follow-Up Plan — Proposed outline of treatment to be conducted as a result of positive clinical depression screening. Follow-up for a positive depression screening must include one (1) or more of the following: additional evaluation, suicide risk assessment, referral to a practitioner who is qualified to diagnose and treat depression, pharmacological interventions, other interventions or follow-up for the diagnosis or treatment of depression.

Not Eligible/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 functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools (i.e. certain court appointed cases or cases of delirium), patient has an active diagnosis of Depression or Bipolar Disorder.
Unhealthy Alcohol Use — Screening

This measure is to be reported for all patients aged 18 years and older seen by the clinician — a minimum of once per reporting period.

Measure description
Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use1 using a systematic screening method within 24 months

What will you need to report for each patient aged 18 years and older for this measure?
If you select this measure for reporting, you will report:
- Whether or not you screened for unhealthy alcohol use using a systematic screening method within 24 months

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to screen for unhealthy alcohol use, due to:
- Medical reasons (eg, limited life expectancy, other medical reasons)

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).

1Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as > 7 standard drinks per week or > 3 drinks per occasion for women and persons > 65 years of age; > 14 standard drinks per week or > 4 drinks per occasion for men ≤ 65 years of age.
Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes
- 90791, 90792
- 90832, 90834, 90837, 90839
- 90845
- 96150, 96152
- 97003, 97004
- 97802, 97803, 97804
- 98960, 98961, 98962
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- G0270, G0271
- G0438, G0439

Quality codes for this measure:

CPT II code descriptors
(Data collection sheet should be used to determine appropriate code.)
- CPT II 3016F: Patient screened for unhealthy alcohol use using a systematic screening method
- CPT II 3016F–1P: Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy, other medical reasons)
- CPT II 3016F–8P: Unhealthy alcohol use screening not performed, reason not otherwise specified
Unhealthy Alcohol Use — Screening

Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td></td>
<td>Date of Service</td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Information**

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is aged 18 years and older on date of encounter.</td>
<td>☐</td>
</tr>
<tr>
<td>There is a CPT or HCPCS code for this visit.</td>
<td>☐</td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a CPT category II code.

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Unhealthy Alcohol Use Screening (using a systematic screening method)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Not performed for the following reason:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>• Medical (eg, limited life expectancy, other medical reasons)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3016F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24F of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3016F–1P</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24F of Paper Claim Form, if No (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3016F–8P (Unhealthy alcohol use screening not performed, reason not otherwise specified)</td>
</tr>
</tbody>
</table>

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1Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as > 7 standard drinks per week or > 3 drinks per occasion for women and persons > 65 years of age; > 14 standard drinks per week or > 4 drinks per occasion for men ≤ 65 years of age.
Tobacco Use: Screening and Cessation Intervention

This measure is to be reported for all patients aged 18 years and older seen by the clinician — a minimum of once per reporting period.

Measure description
Percentage of patients aged 18 years and older who were screened for tobacco use\(^1\) one or more times within 24 months AND who received cessation counseling intervention\(^2\) if identified as a tobacco user

What will you need to report for each patient aged 18 years and older for this measure?
If you select this measure for reporting, you will report:
- Whether or not you screened the patient for tobacco use AND provided cessation counseling intervention\(^2\) if the patient was identified as a tobacco user

If you screened the patient for tobacco use, you will also report:
- That you provided cessation counseling intervention\(^2\) if the patient was identified as a tobacco user
  OR
- That the patient does not use any type of tobacco

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to screen for tobacco use and provide cessation counseling intervention, due to:
- Medical reasons (e.g., limited life expectancy, other medical reason)

In these cases, you will need to indicate the medical reason that applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).

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\(^1\)Tobacco Use — Includes use of any type of tobacco.
\(^2\)Cessation Counseling Intervention — Includes brief counseling (3 minutes or less), and/or pharmacotherapy.
Coding Specifications

Codes required to document a visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes

- 90791, 90792
- 90832, 90834, 90837, 90839, 90845
- 92002, 92004, 92012, 92014
- 96150, 96151, 96152
- 97003, 97004
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- 99406, 99407
- G0438, G0439

Quality codes for this measure:

CPT II code descriptors

(Data collection sheet should be used to determine appropriate code or combination of codes.)

- **CPT II 1036F**: Current tobacco non-user
- **CPT II 4004F**: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user
- **CPT II 4004F–1P**: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, or other medical reason)
- **CPT II 4004F–8P**: Tobacco screening or tobacco cessation intervention not performed, reason not otherwise specified
  
  *In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling, report **CPT II 4004F–8P**.*
## Tobacco Use: Screening and Cessation Intervention

### Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Information

#### Step 1  Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Verify date of birth on claim form.</td>
</tr>
</tbody>
</table>

- Patient is aged 18 years and older on date of encounter.
- There is a CPT or HCPCS code for this visit.

If No is checked for any of the above, STOP. Do not report a CPT category II code.

#### Step 2  Does patient also have the other requirements for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>If No, report only code 1036F and STOP. If Yes, proceed to Step 3.</td>
</tr>
</tbody>
</table>

- Does patient use any type of tobacco (smoke, smokeless, chew, snuff)?

#### Step 3  Does patient meet the measure?

<table>
<thead>
<tr>
<th>Tobacco Use¹ Screening and Cessation Intervention²</th>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed</td>
<td></td>
<td></td>
<td>4004F</td>
</tr>
<tr>
<td>Not Performed for the following reason:</td>
<td></td>
<td></td>
<td>4004F–1P</td>
</tr>
<tr>
<td>• Medical (eg, limited life expectancy, other medical reasons )</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If No is checked for all of the above, report 4004F–8P (Tobacco screening or tobacco cessation intervention not performed, reason not otherwise specified OR Patient is screened for tobacco use and identified as a tobacco user but did not receive tobacco cessation counseling).

¹Tobacco Use — Includes use of any type of tobacco.

²Cessation Counseling Intervention — Includes brief counseling (3 minutes or less), and/or pharmacotherapy.
Stenosis Measurement in Carotid Imaging Reports

This measure is to be reported each time a carotid imaging study is performed for all patients, regardless of age, during the reporting period.

Measure description
Percentage of final reports for carotid imaging studies (neck magnetic resonance angiography [MRA], neck computed tomography angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement1,2

What will you need to report for each patient undergoing a carotid imaging study for this measure?
If you select this measure for reporting, you will report:
- Whether or not the final report for carotid imaging study includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

What if this process or outcome of care is not appropriate for your patient?
Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are not allowable performance exclusions.

1“Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement” includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (eg, for duplex ultrasound studies, velocity parameters that correlate with anatomic measurements that use the distal internal carotid lumen as the denominator for stenosis measurement).

2This measure requires that the estimate of stenosis included in the report of the imaging study employ a method such as the North American Symptomatic Carotid Endarterectomy Trial (NASCET) method for calculating the degree of stenosis. The NASCET method calculates the degree of stenosis with reference to the lumen of the carotid artery distal to the stenosis.

For duplex imaging studies the reference is indirect, since the degree of stenosis is inferred from velocity parameters and cross referenced to published or self-generated correlations among velocity parameters and results of angiography or other imaging studies which serve as the gold standard. In Doppler ultrasound, the degree of stenosis can be estimated using Doppler parameter of the peak systolic velocity (PSV) of the internal carotid artery (ICA), with concordance of the degree of narrowing of the ICA lumen. Additional Doppler parameters of ICA-to-common carotid artery (CCA) PSV ratio and ICA end-diastolic velocity (EDV) can be used when degree of stenosis is uncertain from ICA PSV. Reference (Grant et al, Society of Radiologists in Ultrasound, 2003).

A short note can be made in the final report, such as:
- “Severe left ICA stenosis of 70-80% by NASCET criteria” or
- “Severe left ICA stenosis of 70-80% by criteria similar to NASCET” or
- “70% stenosis derived by comparing the narrowest segment with the distal luminal diameter as related to the reported measure of arterial narrowing” or
- “Severe stenosis of 70-80% — validated velocity measurements with angiographic measurements; velocity criteria are extrapolated from diameter data as defined by the Society of Radiologists in Ultrasound Consensus Conference Radiology 2003; 229:340-346.”
Stenosis Measurement in Carotid Imaging Reports

Coding Specifications

Codes required to document final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed:

CPT code is required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

CPT codes
- 36222, 36223, 36224
- 70498, 70547, 70548, 70549
- 93880, 93882

Quality codes for this measure:

CPT II code descriptors
(Data collection sheet should be used to determine appropriate code.)

- CPT II 3100F: Carotid imaging study report (includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement)
- CPT II 3100F–8P: Carotid imaging study report did not include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement, reason not otherwise specified
Stenosis Measurement in Carotid Imaging Reports

Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Male</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Female</td>
</tr>
</tbody>
</table>

National Provider Identifier (NPI) Date of Service

**Step 1 Is patient eligible for this measure?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
</tbody>
</table>

**Step 2 Does patient meet or have an acceptable reason for not meeting the measure?**

**Direct or Indirect Reference to Measurements of Distal Internal Carotid Diameter as Denominator for Stenosis Measurement**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>3100F</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>If No is checked for the above, report 3100F–8P (Carotid imaging study report did not include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement, reason not otherwise specified)</td>
</tr>
</tbody>
</table>

*1*“Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement” includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (eg, for duplex ultrasound studies, velocity parameters that correlate with anatomic measurements that use the distal internal carotid lumen as the denominator for stenosis measurement).

*2*This measure requires that the estimate of stenosis included in the report of the imaging study employ a method such as the North American Symptomatic Carotid Endarterectomy Trial (NASCET) method for calculating the degree of stenosis. The NASCET method calculates the degree of stenosis with reference to the lumen of the carotid artery distal to the stenosis.

For duplex imaging studies the reference is indirect, since the degree of stenosis is inferred from velocity parameters and cross referenced to published or self-generated correlations among velocity parameters and results of angiography or other imaging studies which serve as the gold standard. In Doppler ultrasound, the degree of stenosis can be estimated using Doppler parameter of the peak systolic velocity (PSV) of the internal carotid artery (ICA), with concordance of the degree of narrowing of the ICA lumen. Additional Doppler parameters of ICA-to-common carotid artery (CCA) PSV ratio and ICA end-diastolic velocity (EDV) can be used when degree of stenosis is uncertain from ICA PSV. Reference (Grant et al, Society of Radiologists in Ultrasound, 2003).

A short note can be made in the final report, such as:

• “Severe left ICA stenosis of 70-80% by NASCET criteria” or
• “Severe left ICA stenosis of 70-80% by criteria similar to NASCET” or
• “70% stenosis derived by comparing the narrowest segment with the distal luminal diameter as related to the reported measure of arterial narrowing” or
• “Severe stenosis of 70-80% — validated velocity measurements with angiographic measurements, velocity criteria are extrapolated from diameter data as defined by the Society of Radiologists in Ultrasound Consensus Conference Radiology 2003; 229:340-346.”
Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage

This measure is to be reported for all patients aged 18 years and older undergoing active treatment for ischemic stroke or intracranial hemorrhage for each hospital stay during the reporting period.

Measure description
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who were administered DVT prophylaxis\(^1\) by end of hospital day two\(^2\)

What will you need to report for each hospital stay for patients under active treatment for ischemic stroke or intracranial hemorrhage for this measure?
If you select this measure for reporting, you will report:
- Whether or not your patient received deep vein thrombosis (DVT) prophylaxis by the end of hospital day two

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate for a patient to receive DVT prophylaxis by the end of hospital day two, due to:
- Medical reasons (e.g., patient is ambulatory, patient expired during inpatient stay, patient already on warfarin or another anticoagulant, other medical reason(s)) OR
- Patient reasons (e.g., patient left against medical advice, other patient reason(s))

In these cases, you will need to indicate which reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).

---

\(^1\)DVT prophylaxis — can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), low-dose subcutaneous heparin, or intermittent pneumatic compression devices.

\(^2\)Ends at 11:59 p.m. on the second day of hospitalization; day one is day patient was admitted.
Coding Specifications

Codes required to document patient has ischemic stroke or intracranial hemorrhage and a visit occurred:

An ICD-9-CM diagnosis code for ischemic stroke or intracranial hemorrhage and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Ischemic stroke or intracranial hemorrhage
ICD-9-CM diagnosis codes

- 430 (subarachnoid hemorrhage)
- 431 (intracerebral hemorrhage)
- 432.0, 432.1, 432.9 (unspecified intracranial hemorrhage)
- 433.01, 433.11, 433.21, 433.31, 433.81, 433.91 (occlusion and stenosis of precerebral arteries)
- 434.01, 434.11, 434.91 (occlusion of cerebral arteries)

AND

CPT codes

- 99221, 99222, 99223
- 99231, 99232, 99233
- 99291

Quality codes for this measure:

CPT II code descriptors
(Data collection sheet should be used to determine appropriate code.)

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

- **CPT II 4070F–1P**: Documentation of medical reason(s) for not receiving DVT prophylaxis by end of hospital day 2 (eg, patient is ambulatory, patient expired during inpatient stay, patient already on warfarin or another anticoagulant, other medical reason(s))

- **CPT II 4070F–2P**: Documentation of patient reason(s) for not receiving DVT prophylaxis by end of hospital day 2 (eg, patient left against medical advice, other patient reason(s))

- **CPT II 4070F–8P**: Deep vein thrombosis (DVT) prophylaxis was not received by end of hospital day 2, reason not otherwise specified
# Deep Vein Thrombosis (DVT) Prophylaxis for Ischemic Stroke or Intracranial Hemorrhage

## Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
<th>National Provider Identifier (NPI)</th>
<th>Date of Service</th>
</tr>
</thead>
</table>

### Clinical Information

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td>☐</td>
<td>☐</td>
<td>Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>4070F</td>
</tr>
</tbody>
</table>

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>DVT Prophylaxis ¹</th>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received by end of hospital day two²</td>
<td>☐</td>
<td>☐</td>
<td>4070F</td>
</tr>
<tr>
<td>Not received for one of the following reasons:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medical (eg, patient is ambulatory, patient expired during inpatient stay, patient already on warfarin or another anticoagulant, other medical reason(s))</td>
<td>☐</td>
<td>☐</td>
<td>4070F–1P</td>
</tr>
<tr>
<td>• Patient (eg, patient left against medical advice, other patient reason(s))</td>
<td>☐</td>
<td>☐</td>
<td>4070F–2P</td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

If No is checked for all of the above, report 4070F–8P (DVT prophylaxis not received by end of hospital day 2, reason not otherwise specified)

---

¹DVT prophylaxis — can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), low-dose subcutaneous heparin, or intermittent pneumatic compression devices.

²Ends at 11:59 p.m. on the second day of hospitalization; day one is day patient was admitted.
Discharged on Antithrombotic Therapy

This measure is to be reported each time a patient aged 18 years and older undergoing active treatment for ischemic stroke or transient ischemic attack (TIA) is discharged from the hospital during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting will submit this measure.

Measure description

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

What will you need to report each time a patient under active treatment for ischemic stroke or TIA is discharged from the hospital for this measure?

If you select this measure for reporting, you will report:

■ Whether or not you prescribed antithrombotic therapy at discharge.

What if this process or outcome of care is not appropriate for your patient?

There may be times when it is not appropriate to prescribe antithrombotic therapy at discharge, due to:

■ Documented reasons (e.g., patient admitted for performance of elective carotid intervention, patient had stroke during hospital stay, patient expired during inpatient stay, other medical reason(s)); (e.g., patient left against medical advice, other patient reason(s)).

In these cases, you will need to indicate which reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).

1Prescribed may include prescription given to the patient for antithrombotic therapy at discharge or therapy to be continued after discharge as documented in the discharge medication list.

2Antithrombotic therapy: aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine, warfarin, low molecular weight heparin, dabigatran, rivaroxaban.
Coding Specifications

Codes required to document patient has ischemic stroke or transient ischemic attack (TIA) and a visit occurred:

An ICD-9-CM diagnosis code for ischemic stroke or TIA and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Ischemic stroke or TIA ICD-9-CM diagnosis codes

- 433.01, 433.11, 433.21, 433.31, 433.81, 433.91 (occlusion and stenosis of cerebral arteries)
- 434.01, 434.11, 434.91 (occlusion of cerebral arteries)
- 435.0, 435.1, 435.2, 435.3, 435.8, 435.9 (transient cerebral ischemia)

AND

CPT codes

- 99221, 99222, 99223
- 99231, 99232, 99233
- 99234, 99235, 99236
- 99238, 99239

Quality codes for this measure:

G-code descriptors

(Data collection sheet should be used to determine appropriate code.)

- **G8696**: Antithrombotic therapy prescribed at discharge
- **G8697**: Antithrombotic therapy was not prescribed for documented reasons (eg, patient admitted for performance of elective carotid intervention, patient had stroke during hospital stay, patient expired during inpatient stay, other medical reason(s)); (eg, patient left against medical advice, other patient reason(s))
- **G8698**: Antithrombotic therapy was not prescribed at discharge, reason not given
**Discharged on Antithrombotic Therapy**

Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Step 1 Is patient eligible for this measure?</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is aged 18 years and older on date of encounter.</td>
<td>Yes: Verify date of birth on claim form.</td>
</tr>
<tr>
<td>Patient has a diagnosis of ischemic stroke or transient ischemic attack.</td>
<td>No: Refer to coding specifications document for list of applicable codes. Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified below.</td>
</tr>
<tr>
<td>There is a CPT code for this visit.</td>
<td>No:</td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a CPT category II code.

**Step 2 Does patient meet or have an acceptable reason for not meeting the measure?**

<table>
<thead>
<tr>
<th>Antithrombotic Therapy</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed at discharge</td>
<td>G8696</td>
</tr>
</tbody>
</table>

Not prescribed for the following reason:

- Documented reasons (eg, patient admitted for performance of elective carotid intervention, patient had stroke during hospital stay, patient expired during inpatient stay, other medical reason(s)); (eg, patient left against medical advice, other patient reason(s))

Document reason here and in medical chart.

If No is checked for all of the above, report G8698

(Antithrombotic therapy was not prescribed at discharge, reason not given)

---

1 Antithrombotic therapy: aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine, warfarin, low molecular weight heparin, dabigatran, rivaroxaban.

2 Prescribed may include prescription given to the patient for antithrombotic therapy at discharge or therapy to be continued after discharge as documented in the discharge medication list.
Screening for Dysphagia

This measure is to be reported for all patients aged 18 years and older undergoing active treatment for ischemic stroke or intracranial hemorrhage for each hospital stay during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

Measure description
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who receive any foods, fluids, or medication by mouth (PO) for whom a dysphagia screening1 was performed prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care.

What will you need to report for each hospital stay for patients under active treatment for ischemic stroke or intracranial hemorrhage for this measure?
If you select this measure for reporting, you will report:

- Whether or not the patient is receiving or is eligible to receive food, fluids, or medication by mouth (PO)2

If the patient is receiving or eligible to receive food, fluids, or medication by mouth (PO), you will then need to report:

- Whether or not you performed a dysphagia screening prior to order or receipt of any foods, fluids or medications by mouth

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to conduct dysphagia screening prior to the order for or the patient’s receipt of any foods, fluids or medication by mouth, due to:

- Medical reasons (eg, not indicated, contraindicated, other medical reason[s]) OR
- Patient reasons (eg, patient left against medical advice, other patient reason[s])

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exceptions).

1Dysphagia screening may include, but is not limited to videofluoroscopic swallow evaluation (VSE), fiberoptic endoscopic evaluation of swallowing (FEES), modified barium swallow, structured bedside swallowing assessment.

2For 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.
Coding Specifications

Codes required to document patient has ischemic stroke or intracranial hemorrhage and a visit occurred:

An ICD-9-CM diagnosis code for ischemic stroke or intracranial hemorrhage and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Ischemic stroke or intracranial hemorrhage

ICD-9-CM diagnosis codes

- 430 (subarachnoid hemorrhage)
- 431 (intracerebral hemorrhage)
- 432.0, 432.1, 432.9 (unspecified intracranial hemorrhage)
- 433.01, 433.11, 433.21, 433.31, 433.81, 433.91 (occlusion and stenosis of cerebral arteries)
- 434.01, 434.11, 434.91 (occlusion of cerebral arteries)

AND

CPT codes

- 99218, 99219, 99220
- 99221, 99222, 99223
- 99234, 99235, 99236
- 99281, 99282, 99283, 99284, 2985
- 99291

Quality codes for this measure:

CPT II code descriptors

(Data collection sheet should be used to determine appropriate code or combination of codes.)

- CPT II 6015F: Patient receiving or eligible to receive food, fluids or medication by mouth
- CPT II 6020F: NPO (nothing by mouth) ordered
- CPT II 6010F: Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth

- CPT II 6010F–1P: Documentation of medical reason(s) for not conducting a dysphagia screening prior to taking any foods, fluids or medication by mouth (eg, patient expired during inpatient stay, patient without any focal findings and not thought to be having a stroke when initially evaluated, other medical reason(s))

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

- CPT II 6010F–8P: Dysphagia screening was not conducted prior to order or receipt of any foods, fluids or medication by mouth, reason not otherwise specified

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.
### Screening for Dysphagia

**Physician Quality Reporting System Data Collection Sheet**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Provider Identifier (NPI)</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Information**

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Verify date of birth on claim form.</td>
</tr>
</tbody>
</table>

**Step 2** Does patient also have the other requirements for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Step 3** Does patient meet or have an acceptable reason for not meeting the measure?

**Dysphagia Screening** prior to PO intake in accordance with a dysphagia screening tool approved by the institution in which the patient is receiving care:

<table>
<thead>
<tr>
<th>Conducted</th>
<th>Not conducted for the following reason:</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Medical (eg, patient expired during inpatient stay, patient without any focal findings and not thought to be having a stroke when initially evaluated, other medical reason(s))</td>
<td>6010F–1P</td>
</tr>
<tr>
<td></td>
<td>• Patient (eg, patient left against medical advice, other patient reason(s))</td>
<td>6010F–2P</td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

| If No is checked for all of the above, report 6010F–8P (Dysphagia screening was not conducted prior to order for or receipt of any foods, fluids or medication by mouth (PO), reason not otherwise specified) |

---

1. 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.

2. Dysphagia screening may include, but is not limited to videofluoroscopic swallow evaluation (VSE), fiberoptic endoscopic evaluation of swallowing (FEES), modified barium swallow, structured bedside swallowing assessment.

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**Physician Quality Reporting System 2013 Measure 35, Effective Date 01/01/2013**

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Rehabilitation Services Ordered

This measure is to be reported for all patients aged 18 years and older undergoing active treatment for ischemic stroke or intracranial hemorrhage a minimum of once for each hospital stay during the reporting period. It is anticipated that clinicians who care for patients with a diagnosis of ischemic stroke or intracranial hemorrhage in the hospital setting will submit this measure.

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

What will you need to report for each hospital stay for patients under active treatment for ischemic stroke or intracranial hemorrhage for this measure?
If you select this measure for reporting, you will report:
- Whether or not you ordered rehabilitation services at or prior to inpatient discharge
  OR
- Whether or not you documented that no rehabilitation services were indicated at or prior to inpatient discharge

What if this process or outcome of care is not appropriate for your patient?
Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

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

1Rehabilitation services includes services required in order to improve physical, cognitive (including neuropsychological), behavioral, and speech functions. Rehabilitation order can include one or more of the services listed.

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Rehabilitation Services Ordered

Coding Specifications
Codes required to document patient has ischemic stroke or intracranial hemorrhage and a visit occurred:

An ICD-9-CM diagnosis code for ischemic stroke or intracranial hemorrhage and a CPT code are required to identify patients to be included in this measure.

All measure specific coding should be reported on the claim(s) representing the eligible encounter.

Ischemic stroke or intracranial hemorrhage
ICD-9-CM diagnosis codes

- 430 (subarachnoid hemorrhage)
- 431 (intracerebral hemorrhage)
- 432.0, 432.1, 432.9 (unspecified intracranial hemorrhage)
- 433.01, 433.11, 433.21, 433.31, 433.81, 433.91 (occlusion and stenosis of cerebral arteries)
- 434.01, 434.11, 434.91 (occlusion of cerebral arteries)

AND

CPT codes

- 99221, 99222, 99223
- 99231, 99232, 99233
- 99234, 99235, 99236
- 99238, 99239

Quality codes for this measure:

G-code descriptors
(Data collection sheet should be used to determine appropriate code.)

- G8699: Rehabilitation services (occupational, physical, or speech) ordered at or prior to discharge
- G8700: Rehabilitation services (occupational, physical, or speech) not indicated at or prior to discharge
- G8701: Rehabilitation services were not ordered, reason not given

Rehabilitation Services Ordered

ICD-10-CM diagnosis codes can be found in the 2013 Physician Quality Reporting System Specifications Manual, which is located on the CMS website at http://www.cms.hhs.gov/pqrs. Because these codes are not reportable until 2014, they have not been included in the participation tools for PQRS 2013.

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# Rehabilitation Services Ordered

## Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>Date of Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Clinical Information

### Step 1 Is patient eligible for this measure?

<table>
<thead>
<tr>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
<th><strong>Code Required on Claim Form</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is aged 18 years and older on date of encounter.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Patient has a diagnosis of ischemic stroke or intracranial hemorrhage.</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>There is a CPT code for this visit.</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a G-code.

### Step 2 Does patient meet the measure?

<table>
<thead>
<tr>
<th><strong>Rehabilitation Services</strong>¹</th>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
<th><strong>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ordered at or prior to inpatient discharge</td>
<td>☐</td>
<td>☐</td>
<td>G8699</td>
</tr>
</tbody>
</table>
| Not ordered for the following reason:  
  - Documentation of rehabilitation services not indicated at or prior to discharge | ☐ |  ☐ | G8700 |

If No is checked for the above, report G8701 (Rehabilitation services were not ordered, reason not given).

---

¹Rehabilitation services includes services required in order to improve physical, cognitive (including neuropsychological), behavioral, and speech functions. Rehabilitation order can include one or more of the services listed.
Participation in a systematic qualified clinical database registry involves:

- Physician or other clinician submits standardized data elements to registry
- Data elements are applicable to consensus endorsed quality measures
- Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry’s clinical topic(s) and report on all patients eligible for the selected measures
- Registry provides calculated measure results, benchmarking, and quality improvement information to individual physicians and clinicians
- Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group’s practice. Participation in a national or state-wide registry is encouraged for this measure
- Registry may provide feedback directly to the provider’s local registry if one exists

What will you need to report for this measure?

If you select this measure for reporting, you will report:

- Whether or not you participate in a systematic qualified clinical database registry capable of the following:
  - Physician or other clinician submits standardized data elements to registry
  - Data elements are applicable to consensus endorsed quality measures
  - Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry’s clinical topic(s) and report on all patients eligible for the selected measures
  - Registry provides calculated measure results, benchmarking, and quality improvement information to individual physicians and clinicians
  - Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group’s practice. Participation in a national or state-wide registry is encouraged for this measure
  - Registry may provide feedback directly to the provider’s local registry if one exists

What if this process or outcome of care is not appropriate for you?

Some measures provide an opportunity for the physician or eligible health professional to document when a process or outcome of care is not appropriate for a given patient (also called performance exclusions). Because this measure is applicable to most if not all patients, there are no allowable performance exclusions.

---

1Qualified Registry — Qualified is defined as receiving data from more than five hospitals and providing calculated measures, results, benchmarks, and quality improvement information to the participant (and to designated third parties).
Coding Specifications

Codes required to document a patient visit occurred:

A CPT or HCPCS code is required to identify patients to be included in this measure.

All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

CPT or HCPCS codes

- 90791, 90792
- 90832, 90834, 90837, 90839
- 92002, 92004
- 92012, 92014
- 92506, 92507, 92508
- 92526
- 92541, 92542, 92543, 92544, 92548
- 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586, 92587, 92588
- 92601, 92602, 92603, 92604
- 92610, 92611, 92612
- 92620, 92621, 92625, 92626, 92627
- 92640
- 95920
- 96150, 96151, 96152
- 97001, 97002, 97003, 97004
- 97532
- 97750
- 97802, 97803, 97804
- 98940, 98941, 98942
- 99201, 99202, 99203, 99204, 99205
- 99212, 99213, 99214, 99215
- D7140
- D7210
- G0101, G0108, G0109
- G0270, G0271
- G0402
- G0438, G0439
- G0442, G0443, G0445, G0446, G0447, G0448, G0449, G0450

Quality codes for this measure:

G-code descriptor
(Data collection sheet should be used to determine appropriate code or combination of codes.)

- **G8954**: Complete and appropriate patient data were reported to a qualified clinical database registry
## Physician Quality Reporting System Data Collection Sheet

<table>
<thead>
<tr>
<th></th>
<th>/ /</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice Medical Record Number (MRN)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birth Date (mm/dd/yyyy)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Provider Identifier (NPI)</th>
<th>Date of Service</th>
</tr>
</thead>
</table>

### Clinical Information

#### Step 1 Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Verify date of birth on claim form.</td>
</tr>
</tbody>
</table>

- Any patient regardless of age.
- There is a CPT or HCPCS code for this visit.

If No is checked for any of the above, STOP. Do not report a G-code.

### Billing Information

#### Step 2 Does patient meet the measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>G8954</td>
</tr>
</tbody>
</table>

**Qualified Registry** — Qualified is defined as receiving data from more than five hospitals and providing calculated measures, results, benchmarks, and quality improvement information to the participant (and to designated third parties).

Registry must be capable of the following:
- Physician or other clinician submits standardized data elements to registry
- Data elements are applicable to consensus endorsed quality measures
- Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures
- Registry provides calculated measure results, benchmarking, and quality improvement information to individual physicians and clinicians
- Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice. Participation in a national or state-wide registry is encouraged for this measure
- Registry may provide feedback directly to the provider's local registry if one exists

*Disclaimer:* Copyright and other Notices indicated on the Coding Specifications document are incorporated by reference.
This measures group is to be reported for patients aged 18 through 79 years with back pain receiving office or other outpatient services.

OR

This measures group is to be reported each time a back surgical procedure is performed for patients aged 18 through 79 years.

You will need to report G-code G8493 once to indicate your intent to report on the Back Pain Measures Group. Once you have reported the G-code, you should begin reporting using one of the patient sample methods listed below.

The intent of this measures group is to assess whether the clinician caring for a patient with back pain performs the assessment or advice described by each of the individual measures at the first visit with that clinician for that episode of back pain. A new episode of back pain has been defined as the patient having a four month period without having been seen or treated in the prior four months for back pain. The first visit after the four months without being seen or treated for back pain is considered the beginning of the new episode.

The following 2013 Physician Quality Reporting System measures are included in the Back Pain Measures Group:

### #148. Initial Visit
Measure Description
Percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who had back pain and function assessed during the initial visit to the clinician for the episode of back pain

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

### #150. Advice for Normal Activities
Measure Description
Percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice for normal activities at the initial visit to the clinician for the episode of back pain

### #151. Advice Against Bed Rest
Measure Description
Percentage of patients aged 18 through 79 years with a diagnosis of back pain or undergoing back surgery who received advice against bed rest lasting four days or longer at the initial visit to the clinician for the episode of back pain

This measures group can be reported by one of the following patient sample methods:

- **20 Patient Sample Method via Claims:** 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
- **20 Patient Sample Method via Registries:** 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 or July 1 through December 31, 2013).
Step 1 Preliminary reporting requirements

You must identify your intent to report the Back Pain Measures Group by submitting the G-code specified for this measures group on the first patient claim (G8493: I intend to report the Back Pain Measures Group). You do not need to resubmit the measures group-specific G-code on more than one claim.

Step 2 Determine patient eligibility

(Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified in Step 3 below.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Refer to date of birth listed above or on claim form.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient is aged 18 through 79 on date of encounter.</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

If No is checked for the above, STOP. This patient is not eligible for reporting on this measures group. Do not report a CPT category II code or G-code.

- Patient has a diagnosis indicating back pain
  AND a CPT code for an office visit or physical therapy evaluation.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

AND
97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

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

If No is checked for both of the above, STOP. This patient is not eligible for reporting on this measures group. Do not report a CPT category II code or G-code.

continued on next page

*For additional information on the Physician Quality Reporting System program and reporting on measures groups, please visit the CMS Web site at http://www.cms.hhs.gov/pqri.
Back Pain Measures Group

**Determine if patient meets additional eligibility criteria**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is this the first visit(^1) to the clinician for a new episode(^2) of back pain (ie, a new or recurrent episode of back pain that has not been seen or treated by this practitioner during the four preceding months)?</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If No, report 0526F once for this patient AND STOP.
If Yes, proceed to Step 3.

### Step 3 Complete individual measures

**Initial Visit: Comprehensive Initial Assessment**

(INCLUDING PAIN ASSESSMENT, FUNCTIONAL STATUS, PATIENT HISTORY, ASSESSMENT OF PRIORITY TREATMENT AND RESPONSE, AND EMPLOYMENT STATUS)

<table>
<thead>
<tr>
<th>Report one code for comprehensive assessment OR one code for NOT completed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain assessment completed using one of the preferred standardized tools or an acceptable alternative</td>
</tr>
<tr>
<td>Functional assessment completed using one of the preferred standardized tool or assessment of activities of daily living</td>
</tr>
<tr>
<td>Patient history completed including notation of presence or absence of warning signs</td>
</tr>
<tr>
<td>Assessment of prior back pain episodes completed and if applicable, associated treatment and response</td>
</tr>
<tr>
<td>Employment status assessment completed using one of the preferred standardized tools or an assessment of specified variables</td>
</tr>
<tr>
<td>Comprehensive assessment NOT completed, patient not eligible, subsequent visit for episode</td>
</tr>
<tr>
<td><strong>OR</strong></td>
</tr>
<tr>
<td>Comprehensive assessment NOT completed</td>
</tr>
</tbody>
</table>

### Physical Exam

<table>
<thead>
<tr>
<th>Report the following code for physical exam OR one code for NOT performed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performed</td>
</tr>
<tr>
<td>Comprehensive assessment NOT completed, patient not eligible, subsequent visit for episode</td>
</tr>
<tr>
<td><strong>OR</strong></td>
</tr>
<tr>
<td>Physical exam NOT performed</td>
</tr>
</tbody>
</table>

\(^1\)Initial Visit — First visit to the clinician during an episode of back pain. There can only be one initial visit with each clinician, but there can be more than one initial visit for a patient, if multiple clinicians evaluate or treat the patient for the back pain episode. Report the appropriate Quality Data Codes on the claim for each initial visit. For each subsequent encounter after the initial visit with that clinician, or if the initial visit with that clinician occurred prior to the start of the reporting period, then report 0526F.

\(^2\)Episode — Patient with back pain who has not been seen or treated for back pain by any practitioner during the four months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.
This measure can be reported for each eligible patient in one of two ways:

1. Report the corresponding CPT category II code(s) as selected above for each of the four measures in the Back Pain Measures Group.
   
   OR

2. If all quality actions for the patient have been performed for each of the four measures in the Back Pain Measures Group, **G8502** may be reported. Note: **G8502** is not appropriate for this patient if any CPT category II codes with the BP modifier have been selected from Step 3.
This measures group is to be reported for patients regardless of age receiving office or other outpatient services, nursing facility care, or domiciliary/rest home/custodial care services with dementia.

You will need to report G-code G8902 once to indicate your intent to report on the Dementia Measures Group. Once you have reported the G-code, you should begin reporting using one of the patient sample methods listed below.

The following 2013 Physician Quality Reporting System measures are included in the Dementia Measures Group:

#280. Staging of Dementia
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period

#281. Cognitive Assessment
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

#282. Functional Status Assessment
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period

#283. Neuropsychiatric Symptom Assessment
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period

#284. Management of Neuropsychiatric Symptoms
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

#285. Screening for Depressive Symptoms
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia who were screened for depressive symptoms within a 12 month period

#286. Counseling Regarding Safety Concerns
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period

#287. Counseling Regarding Risks of Driving
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

#288. Caregiver Education and Support
Measure Description
Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

This measures group can be reported by one of the following patient sample methods:

- **20 Patient Sample Method via claims**: 20 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
- **20 Patient Sample Method via registries**: 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2013 OR July 1 through December 31, 2013).

*continued on next page*
Physician Performance Measures (Measures) and related data specifications, developed by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement® (PCPI®), 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 PCPI has not tested its Measures for all potential applications. The PCPI encourages the testing and evaluation of its Measures.

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

Physician Quality Reporting System Data Collection Sheet*

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Provider Identifier (NPI)</td>
<td>Date of Encounter</td>
<td></td>
</tr>
</tbody>
</table>

**Step 1 Preliminary reporting requirements**

You must identify your intent to report the Dementia Measures Group by submitting the measures group-specific G-code on the first patient claim (G8902: I intend to report the Dementia Measures Group). You do not need to resubmit the measures group-specific G-code on more than one claim.

**Step 2 Determine patient eligibility**

(Codes determining a patient’s eligibility must be reported on the same claim as the quality code(s) identified in Step 2 below.)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any patient regardless of age.</td>
<td>☐</td>
</tr>
<tr>
<td>Patient has a diagnosis of dementia.</td>
<td>☐</td>
</tr>
<tr>
<td>There is a CPT code for an office visit (including new and established patients).</td>
<td>☐</td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. This patient is not eligible for reporting on this measures group. Do not report a CPT category II code or a G-code.

**Step 3 Complete individual measures**

<table>
<thead>
<tr>
<th>Staging of Dementia</th>
<th>Report one code for classification of severity of dementia OR one code for NOT classified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Quality Reporting System Measure #280¹</td>
<td>Dementia severity classified, mild ☐ 1490F</td>
</tr>
<tr>
<td>• reporting frequency: dementia severity must be assessed and classified² once during the calendar year</td>
<td>Dementia severity classified, moderate ☐ 1491F</td>
</tr>
<tr>
<td>• dementia severity can be assessed using a number of valid and reliable instruments including, but not limited to: Global Deterioration Scale (GDS), Functional Assessment Staging Tool (FAST), Clinical Dementia Rating (CDR), Dementia Severity Rating Scale, Mini-Mental State Examination (MMSE), Formal Neuropsychological Evaluation</td>
<td>Dementia severity classified, severe ☐ 1493F</td>
</tr>
<tr>
<td>OR</td>
<td>Dementia severity NOT classified, reason not otherwise specified ☐ 1490F–8P</td>
</tr>
</tbody>
</table>

¹The performance period for this measure is 12 months.

²Mild dementia — Can be classified quantitatively as MMSE score of > 18, GDS or FAST stage 4, CDR of 1; qualitatively as being likely to have difficulty with balancing a checkbook, preparing a complex meal, or managing a complicated medication schedule.

Moderate dementia — Can be classified quantitatively as MMSE score of 10–18, GDS or FAST stages 5 and 6, CDR of 2; qualitatively as experiencing difficulties with simpler food preparation, household cleanup, and yard work and requiring assistance with some aspects of self-care (e.g., picking out the proper clothing to wear).

Severe dementia — Can be classified quantitatively as MMSE score of < 10, GDS or FAST stages 6 and 7, CDR of 3; qualitatively as requiring considerable or total assistance with personal care, such as dressing, bathing, and toileting.

*For additional information on the Physician Quality Reporting System program and reporting on measures groups, please visit the CMS Web site at http://www.cms.hhs.gov/pqri.

continued on next page
Cognitive Assessment

<table>
<thead>
<tr>
<th>Physician Quality Reporting System Measure #281</th>
<th>Report one code for assessment of cognition performed and results reviewed OR one code for NOT performed and reviewed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• reporting frequency: at least once within a 12 month period</td>
<td>Cognition assessed and reviewed □ 1494F</td>
</tr>
<tr>
<td>• Cognition can be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to: Blessed Orientation-Memory-Concentration Test (BOMC), Mini-Cog, Montreal Cognitive Assessment (MoCA), Cognitive Assessment Screening Instrument (CASI), St. Louis University Mental Status Examination (SLUMS), Mini-Mental State Examination (MMSE), Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE), Ascertaining Dementia 8 (AD8) Questionnaire, Minimum Data Set (MDS) Brief Interview of Mental Status (BIMS) [Note: Validated for use with nursing home patients only], Formal neuropsychological evaluation.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not assessed and reviewed for medical reasons (eg, patient with very advanced stage dementia, other medical reason) □ 1494F–1P</td>
</tr>
<tr>
<td></td>
<td>Not assessed and reviewed for patient reasons □ 1494F–2P</td>
</tr>
<tr>
<td></td>
<td>OR Cognition NOT assessed and reviewed, reason not otherwise specified □ 1494F–8P</td>
</tr>
</tbody>
</table>

Functional Status Assessment

<table>
<thead>
<tr>
<th>Physician Quality Reporting System Measure #282</th>
<th>Report one code for assessment of functional status performed OR one code for NOT performed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• reporting frequency: at least once within a 12 month period</td>
<td>Functional status assessed and reviewed □ 1175F</td>
</tr>
<tr>
<td>• Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient’s ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL). Functional status can also be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to: Lawton IADL Scale, Barthel ADL Index, Katz Index of Independence in ADL.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Not assessed and reviewed for medical reasons (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason) □ 1175F–1P</td>
</tr>
<tr>
<td></td>
<td>OR Functional status for dementia NOT assessed and results NOT reviewed, reason not otherwise specified □ 1175F–8P</td>
</tr>
</tbody>
</table>

continued on next page
Neuropsychiatric Symptom Assessment

**Physician Quality Reporting System Measure #283**
- reporting frequency: at least once within a 12 month period
- Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant. Examples of reliable and valid instruments that are commonly used in research settings and that can be used to assess behavior include, but are not limited to: Dementia Signs and Symptoms (DSS) Scale, Neuropsychiatric Inventory (NPI). The assessment of behavioral status may include the assessment of Behavioral and Psychological Symptoms of Dementia (BPSD). For patients residing in nursing homes, it may include an assessment of the behavioral symptom items from the Minimum Data Set (MDS).
- The following is a non-exhaustive list of dimensions (based on items included in available validated instruments) that may be evaluated during an assessment of neuropsychiatric symptoms: **Activity disturbances:** agitation, wandering, purposeless hyperactivity, verbal or physical aggressiveness, resistiveness with care, apathy, impulsiveness, socially inappropriate behaviors, appetite, eating disturbances, sleep problems, diurnal/sleep-wake cycle disturbances, repetitive behavior; **OR mood disturbances:** anxiety, dysphoria, euphoria, irritability, mood lability/fluctuations; **OR thought and perceptual disturbances:** having fixed false beliefs (delusions), hearing or seeing non-present entities (hallucinations), paranoia.

Management of Neuropsychiatric Symptoms

**Physician Quality Reporting System Measure #284**
- reporting frequency:

- Neuropsychiatric symptoms assessed and results reviewed
  - 1181F

- Neuropsychiatric symptoms NOT assessed and results NOT reviewed, reason not otherwise specified
  - 1181F–8P

- Neuropsychiatric intervention NOT ordered for 1 or more neuropsychiatric symptoms, reason not otherwise specified
  - G8947 AND 4525F

- Neuropsychiatric intervention NOT received for 1 or more neuropsychiatric symptoms, reason not otherwise specified
  - G8947 AND 4526F

- Neuropsychiatric intervention ordered for 1 or more neuropsychiatric symptoms.
  - G8947 AND 4525F

- Neuropsychiatric intervention received for 1 or more neuropsychiatric symptoms.
  - G8947 AND 4526F

- Neuropsychiatric intervention NOT ordered for 1 or more neuropsychiatric symptoms, reason not otherwise specified
  - G8947 AND 4525F–8P

- Neuropsychiatric intervention NOT received for 1 or more neuropsychiatric symptoms, reason not otherwise specified
  - G8947 AND 4526F–8P

- No neuropsychiatric symptoms
  - G8948

*continued on next page*
Screening for Depressive Symptoms

<table>
<thead>
<tr>
<th>Physicians Quality Reporting Measure #285</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>reporting frequency:</strong> once within a 12 month period</td>
</tr>
<tr>
<td>In addition to clinical qualitative approaches, dementia patients can be screened for depressive symptoms using one of a number of valid, reliable instruments available from the medical literature. Examples include, but are not limited to: Cornell Scale for Depression in Dementia, Geriatric Depression Scale, PHQ-9.</td>
</tr>
<tr>
<td>• Depressive Symptoms — Depressive symptoms in a patient with dementia can include: anxiety, sadness, lack of reactivity to pleasant events, irritability, agitation, retardation, multiple physical complaints, acute loss of interest, appetite loss, lack of energy, diurnal variation of mood, difficulty falling asleep, multiple awakenings during sleep, early morning awakenings, suicide, self-deprecation, pessimism, and mood congruent delusions. Since patients may be unable to describe their symptoms, caregiver report of depressive symptoms should be reviewed and included in the screen for depressive symptoms.</td>
</tr>
</tbody>
</table>

Counseling Regarding Safety Concerns

<table>
<thead>
<tr>
<th>Physicians Quality Reporting System Measure #286</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>reporting frequency:</strong> once within a 12 month period</td>
</tr>
<tr>
<td>Counseling should include a discussion with the patient and their caregiver(s) regarding one or more of the following common safety concerns and potential risks to the patient. When appropriate, it should also include a recommendation or referral for a home safety evaluation. Note: for nursing home patients, different safety concerns might apply. A number of organizations have developed educational materials that are recommended to aid implementation of the measure. These materials/tools include: Alzheimer’s Association Safety Topics, Alzheimer’s Disease Education and Referral Center’s Home Safety for the Alzheimer’s Patient.</td>
</tr>
<tr>
<td>• Safety Concerns — Safety concerns include, but are not limited to: fall risk; gait/balance; medication management; financial management; home safety risks that could arise from cooking or smoking; physical aggression posing threat to self, family caregiver, or others; wandering; access to firearms or other weapons; access to potentially dangerous materials; being left alone in home or locked in room; inability to respond rapidly to crisis/household emergencies; driving; operation of hazardous equipment; suicidality; abuse or neglect.</td>
</tr>
</tbody>
</table>

### Table of Coding Options

<table>
<thead>
<tr>
<th>Coding Options</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening for depression performed</strong></td>
<td>3725F</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Screening for depression NOT performed, reason not otherwise specified</strong></td>
<td>3725F–8P</td>
</tr>
<tr>
<td><strong>Safety counseling provided</strong></td>
<td>6101F</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Safety counseling ordered</strong></td>
<td>6102F</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Documentation of medical reason(s) for NOT providing counseling regarding safety concerns (eg, patient in palliative care, other medical reason)</strong></td>
<td>6101F–1P</td>
</tr>
<tr>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Documentation of medical reason(s) for NOT ordering counseling regarding safety concerns (eg, patient in palliative care, other medical reason)</strong></td>
<td>6102F–1P</td>
</tr>
<tr>
<td><strong>Safety counseling for dementia NOT provided, reason not otherwise specified</strong></td>
<td>6101F–8P</td>
</tr>
<tr>
<td><strong>Safety counseling for dementia NOT ordered, reason not otherwise specified</strong></td>
<td>6102F–8P</td>
</tr>
</tbody>
</table>
Counseling Regarding Risks of Driving

Physician Quality Reporting System Measure #287
- reporting frequency: once within a 12 month period
- a resource that can be used as education materials for patient and caregiver is the Physician's Guide to Assessing and Counseling Older Drivers.

| Counseling provided regarding risks of driving and the alternatives to driving | □ 6110F |
| --- |
| Documentation of medical reason(s) for not counseling regarding the risks of driving (eg, patient is no longer driving, other medical reason) | □ 6110F–1P |

OR

Counseling regarding risks of driving and alternatives to driving NOT performed, reason not otherwise specified

□ 6110F–8P

Caregiver Education and Support

Physician Quality Reporting System Measure #288
- reporting frequency: once within a 12 month period
- There are a number of assessment tools available for the caregiver. These should be considered as an integral component of comprehensive caregiver education and support. The American Medical Association has developed a Caregiver Health Self-assessment Questionnaire to help caregivers analyze their own behavior and health risks and, with their physician's help, make decisions that will benefit both the caregiver and the patient.
- Education should also include advising the caregiver that he or she is at "increased risk of serious illness (including circulatory and heart conditions and respiratory disease and hypertension), increased physician visits and use of prescription medications, emotional strain, anxiety, and depression."

| Caregiver provided with education and referred to additional resources for support | □ 4322F |
| --- |
| Documentation of medical reason(s) for not providing the caregiver with education on disease management and health behaviors or referring to additional sources for support (eg, patient does not have a caregiver, other medical reason) | □ 4322F–1P |

OR

Caregiver NOT provided with education and NOT referred to additional resources for support, reason not otherwise specified

□ 4322F–8P

Step 4 Reporting Instructions

This measure can be reported for each eligible patient in one of two ways:

1. Report the corresponding CPT category II or G-code(s) as selected above for each of the nine measures in the Dementia Measures Group

OR

2. If all quality actions for the patient have been performed for each of the nine measures in the Dementia Measures Group, G8761 may be reported. Note: If any CPT category II code with the BP modifier has been selected from Step 3, G8761 is not appropriate for this patient.