CODING FOR QUALITY

A HANDBOOK FOR PQRI PARTICIPATION

June 18, 2007

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2007 Physician Quality Reporting Initiative (PQRI)
Coding for Quality – A Handbook for PQRI Implementation

Section I
Introduction

Handbook Purpose

This Handbook is provided to promote understanding about how to implement PQRI measures in clinical practice and to facilitate successful reporting of quality data by eligible professionals who wish to participate in PQRI.

The Handbook is organized into sections. Section I discusses basic factors and issues that eligible professionals may wish to consider when selecting measures and preparing to report. Section II reviews PQRI coding and reporting principles for the claims-based submission of quality-data codes. Section III provides a list of 2007 PQRI measures arranged in alphabetical order by clinical condition/topic with sample clinical scenarios for each measure to illustrate coding principles.

Handbook Content

The Handbook includes information to assist eligible professionals in:

- Identifying eligible cases by denominator codes, usually ICD-9-CM and CPT Category I codes
- Choosing quality-data codes to report in the form of numerator CPT Category II codes and temporary G codes, where CPT Category II codes have not yet been developed
- Using performance exclusion modifiers 1P, 2P, and 3P
- Using the reporting modifier 8P
- Walking through the implementation of a measure using sample clinical scenarios

2007 PQRI Measures and Specifications

There are 74 process and outcome measures that have been identified for 2007 PQRI. These measures address various aspects of care, such as prevention, chronic- and acute-care management, surgical care, resource utilization, and care coordination.

The CMS PQRI Quality Measures Specifications document, posted on the CMS website at www.cms.hhs.gov/PQRI, contains detailed descriptions for each PQRI quality measure. The list is arranged in numerical order and includes instructions for how to code each measure's numerator and denominator using diagnosis codes from the International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM) and CPT codes from the Healthcare Common Procedure Coding System (HCPCS).

PQRI Measure Selection

Measure selection begins with a review of PQRI 2007 measures. At a minimum, the following factors should be considered when selecting measures for reporting:

- Conditions usually treated
- Types of care typically provided – *e.g.,* preventive, chronic, acute
- Settings where care is usually delivered – *e.g.,* office, ED, surgical suite

- Quality improvement goals for 2007

Review the Specifications for each measure under consideration and select measures that apply to services most frequently provided to Medicare by the practice.

Section II
PQRI Measure Coding and Reporting Principles

PQRI Measure Denominators and Numerators

Each PQRI measure consists of two major components:

1) A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator)
2) A numerator that describes the clinical action required by the measure for reporting and performance

Measure denominators and numerators are further specified by specific codes, usually ICD-9-CM and CPT Category I codes for denominators and CPT Category II codes or G codes (where CPT Category II codes are not yet available) for numerators. Each measure is unique, so it is important to review and understand each measure's specifications, which provide definitions and specific instructions for coding and reporting measure components.

Reporting Frequency and Performance Timeframes

Each measure includes a *reporting frequency* requirement for each denominator-eligible patient seen during the reporting period. The reporting frequency is described in the instructions:

- Report one-time only
- Report once for each procedure performed
- Report once for each acute episode

A measure's *performance timeframe* is defined in the measure's description and is distinct from the reporting frequency requirement. The performance timeframe, unique to each measure, delineates the timeframe in which the clinical action described in the numerator may be accomplished.

Performance timeframes may be stated as "within 12 months," or "most recent." This means that:

1) The clinical action in the numerator need be performed only once during a 12-month period for each patient seen during the reporting period
2) The quality code need be reported only one time for each patient by each eligible professional caring for the patient who has chosen to report that measure during the reporting period

If the measure calls for a clinical test result, then the most recent test result only needs to be obtained, assessed, and reported one time per reporting period. A test does not need to have been performed within the reporting period, nor does it need to have been performed by the same eligible professional.

Performance timeframes may also be tied to a specific clinical event that requires reporting each time the event occurs within the reporting period. The following are examples of measures reported each time the clinical action described by the measure numerator is taken:

- Procedure-related measures require reporting each time the procedure is performed and have distinct performance timeframes tied to them. The date of service is the date that is used to report the measure. Examples are perioperative care or imaging measures.
- Chronic care measures, such as those that call for prescribing a medication, require the eligible professional to verify whether the medication is current and being taken by the

patient. A new prescription is not required to meet the measure requirement unless it is clinically indicated.

- Acute care measures are tied to specific episodes of acute care and require reporting each time an acute event occurs. Examples are measures related to hospitalizations, fractures and osteoporosis management, or stroke measures.

CPT Category II Codes

CPT Category II or CPT II codes, developed through the CPT Editorial Panel for use in performance measurement, serve to encode the clinical action(s) described in a measure's numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter "F." CPT II codes are published annually in the CPT code manual. Updates to CPT II codes are published every January and July and are available on the CPT II web pages at the American Medical Association's website:
http://www.ama-assn.org/ama/pub/category/10616.html

Use of CPT II Modifiers

CPT II modifiers are unique to CPT II codes and may be used to report PQRI measures by appending the appropriate modifier to a CPT II code if allowed for a given measure. The modifiers for a code are mutually exclusive and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the PQRI Measure Specifications. Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes. Descriptions of each modifier are provided below to help identify circumstances when the use of an exclusion modifier may be appropriate. Note that in a pay-for-reporting model, accurate reporting on all selected applicable measures counts the same, whether reporting that the clinical action was performed or not.

CPT II code modifiers fall into two categories, *exclusion modifiers* and the 8P *reporting modifier*.

1) Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not provide for performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:
   - **1P** exclusion modifier due to *medical reasons*
     - Examples include: not indicated (absence of organ/limb, already received/performed); contraindicated (patient allergic history, potential adverse drug interaction)
   - **2P** exclusion modifier due to *patient reasons*
     - Examples include: patient declined; economic, social, or religious reasons
   - **3P** exclusion modifier due to *system reasons*
     - Examples include: resources to perform the services not available; insurance or coverage/payer-related limitations; other reasons attributable to health care delivery system

2) Reporting modifier 8P is available for use only with CPT II codes to facilitate reporting an eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this modifier to CPT Category II codes are included in applicable measures. Use of the 8P reporting

modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.

- **8P** reporting modifier - action not performed, reason not otherwise specified

The 8P modifier facilitates reporting an eligible case on a given measure when the clinical action does not apply to a specific encounter. Eligible professionals can use the 8P modifier to receive credit for successful reporting but will not receive credit for performance.

For example, a patient with diabetes may present to a clinician for reasons that do not involve glycemic control, hypertension, or cholesterol management. However, the claim for services for that encounter will contain ICD-9-CM and CPT codes that will draw the patient into the diabetes measures' denominator during analysis. The 8P modifier serves to include the patient in the numerator when reporting rates are calculated for PQRI.

Claims-Based Reporting Principles

The following principles apply to the reporting of quality-data codes for PQRI measures:

- The CPT Category II code, which supplies the numerator, must be reported on the same claim form as the payment codes, usually ICD-9-CM and CPT Category I codes, which supply the denominator.
- Quality-data codes must be submitted with a line item charge of zero dollars ($0.00) at the time the associated covered service is performed.
  - The submitted charge field cannot be blank.
  - The line item charge should be $0.00.
  - If a system does not allow a $0.00 line item charge, use a small amount such as $0.01
  - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00)
  - Quality data code line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis.
- Multiple eligible professionals' quality-data codes can be reported on the same claim.
- Multiple CPT Category II codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.
- The individual NPI of the participating eligible professional(s) must be properly used on the claim.

Submission Through Carriers/Medicare Administrative Contractors (MACs)

Quality-data codes shall be submitted to carriers/MACs either through:

- **Electronic submission**, which is accomplished using the **ASC X 12N Health Care Claim Transaction (Version 4010A1)**.
  - CPT Category II or temporary G-codes should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the **2400 "Service Line" Loop**.
    - It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the **HC** in data element **SV101-1** within the **SV1** "Professional Service" Segment.

- Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI08** as needed.
- In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data elements **NM108 and NM109**.

OR

- **Paper-based submission**, which is accomplished by using the new **CMS 1500 claim form (version 08-05).** Relevant ICD-9-CM diagnosis codes are entered in **Field 21**. **Service codes** (including CPT, HCPCS, CPT Category II and temporary G- codes) with any associated modifiers are entered in **Field 24D** with the diagnosis pointer in **Field 24E**.
  - For group billing, the **National Provider Identifier (NPI)** of the **rendering provider** is entered in **Field 24J**.
  - The Tax **Identification Number (TIN**) of the employer is entered in **Field 25.**

Individual/Group NPI Submission

If the rendering physician provided all services on the claim there is no need to include the NPI on the line level as long as the individual NPI is provided at the claim level.

If a group NPI is used at the claim level, the individual rendering physician NPI must be placed on each line item.

Timeliness of Quality Data Submission

Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 29, 2008 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add quality-data codes will not be included in the analysis.

Section III
Successful Reporting of PQRI Measures

PQRI measures and their components are arranged alphabetically by clinical condition/topic in this section of the Handbook to facilitate review and selection of measures.

Informational items taken from the PQRI Measure Specifications are provided in the following sequence:

- Measure title and description with reporting frequency and performance timeframe requirements specific to the measure.
- Identification of eligible cases as described in the denominator and ICD-9 diagnosis and CPT I codes that describe the patient population associated with the numerator.
- Instructions for how to code and report the clinical action described in the measure's numerator using CPT II codes (or G-codes where CPT codes are not yet available) for each of the following circumstances:
    1) The measure requirement was met,
    2) The measure requirement was not met due to documented allowable performance exclusions (using performance exclusion modifiers), and
    3) The measure requirement was not met and the reason is not documented in the medical record (using the 8P reporting modifier).
- Clinical scenarios of successful reporting (and performance where applicable) with coding examples relevant to circumstances unique to each measure.

2007 PQRI Measures List

The following table groups PQRI measures alphabetically by clinical condition/topic and provides the page number on which the measure's Implementation Guide Sheet may be found in the Handbook.

Clinical Condition/Topic	Measure Number	Measure Title	Page
Advance Care	47	Advance Care Plan	12
Asthma	53	Asthma: Pharmacologic Therapy	14
	64	Asthma Assessment	16
Breast Cancer	71	Hormonal Therapy for Stage IC-III, ER/PR Positive Breast Cancer	18
CABG	43	Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery	20
	44	Pre-Operative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery	22
Cataracts	15	Cataracts: Assessment of Visual Functional Status	24
	16	Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation	26
	17	Cataracts: Pre-Surgical Dilated Fundus Evaluation	28
Chemotherapy	73	Plan for Chemotherapy Documented Before Chemotherapy Administered	30
Chest Pain	54	Electrocardiogram Performed for Non-Traumatic Chest Pain	33
Colon Cancer	72	Chemotherapy for Stage III Colon Cancer Patients	35
COPD	51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	37
	52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	39
Coronary Artery Disease	6	Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease	41
	7	Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)	43
Depression	9	Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression	45
Diabetes	1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus	47
	2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus	49
	3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus	51

Measure #47: Advance Care Plan

- **Reporting Description:** Percentage of patients aged 65 years and older seen by the clinician and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 65 years and older with documentation of a surrogate decision-maker or advance care plan in the medical record

Sample Clinical Scenario

A 70 year old male patient presents to the clinician for medical care. During the encounter, the clinician asks if the patient has a surrogate decision-maker and documents an advance care plan with the patient.

Eligible Cases:

Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period	**CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance: Surrogate decision maker or advance care plan documented in the medical record	**CPT II** 1080F

OR

Successful Reporting & Excluded from Performance: Documentation of patient reason(s) for no documentation of a surrogate decision maker or advance care plan in the medical record (e.g., patient does not wish to discuss advance care planning)	**CPT II** 1080F-2P

OR

Successful Reporting & Performance Not Met: Surrogate decision maker or advance directive not documented, reason not specified	**CPT II** 1080F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. The entire patient population aged 65 years and older must be reported a minimum of once per patient seen from July 1 through December 31, 2007.
- Review clinical data regarding the presence or absence of documentation of an advance care plan at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #53: Asthma: Pharmacologic Therapy

- **Reporting Description:** Percentage of patients aged 5 through 40 years with a diagnosis of asthma and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment

Sample Clinical Scenario

A 37 year old female patient with moderate persistent asthma presents to the clinician for continuing medical care. The clinician reviews her symptoms and medication list and prescribes inhaled corticosteroids.

Eligible Cases:

Patient aged ≥ 5 and ≤ 40 years on date of encounter

AND

Diagnosis of asthma

AND

Patient encounter during reporting period

ICD-9
493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.92

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance:

Persistent asthma, preferred long term control medication or acceptable alternative treatment prescribed
AND
Persistent asthma (mild, moderate or severe)

CPT II
4015F **AND** 1038F

OR

Successful Reporting & Excluded from Performance: Documentation of patient reasons for not prescribing either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta$_2$-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylaxanthines) **AND** Persistent asthma (mild, moderate or severe) **OR** Intermittent Asthma	**CPT II** 4015F-2P **AND** 1038F **OR** **CPT II** 1039F

OR

Successful Reporting & Performance Not Met: Preferred long-term control medication or acceptable alternative treatment not prescribed, reason not specified **AND** Persistent asthma (mild, moderate or severe)	**CPT II** 4015F-8P **AND** 1038F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- This measure must be reported a minimum of once per reporting period for ALL asthma patients.
- At an encounter occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether asthma is persistent or intermittent. For persistent cases, preferred long-term control medication or acceptable alternative treatment should be prescribed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- One method of identifying persistent asthma is at least daily use of short-acting bronchodilators.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #64: Asthma Assessment

- **Reporting Description:** Percentage of patients aged 5 through 40 years with asthma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 5 through 40 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Sample Clinical Scenario

A 38 year old patient with known asthma is seen by the clinician for follow-up care. The clinician documents in the medical record the numeric frequency of daytime and nocturnal asthma symptoms.

Eligible Cases:

Patient aged ≥ 5 and ≤ 40 years on date of encounter

AND

Diagnosis of asthma

AND

Patient encounter during reporting period

ICD-9
493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.92

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance:

Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)

CPT II
1005F

OR

Successful Reporting & Excluded from Performance:

There are no allowable performance exclusions for this measure

NONE

OR

Successful Reporting & Performance Not Met:

Asthma symptom frequency not evaluated, reason not specified

CPT II
1005F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of the most recent asthma assessment performed at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- To be counted in calculations of this measure, symptom frequency must be numerically quantified. Measure may also be met by clinician documentation or patient completion of an asthma assessment tool/survey/questionnaire. Assessment tool may include the Quality Metric Asthma Control Test™, National Asthma Education & Prevention Program (NAEPP) Asthma Symptoms and Peak Flow Diary.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #71: Hormonal Therapy for Stage IC-III, ER/PR Positive Breast Cancer

- **Reporting Description:** Percentage of female patients aged 18 years and older with breast cancer and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of Stage IC-III, estrogen receptor (ER) or progesterone receptor (PR) positive, female breast cancer patients aged 18 years and older who are receiving tamoxifen or aromatase inhibitor (AI) at the time of the visit

Sample Clinical Scenario

A 65 year old female patient with breast cancer presents to the clinician. The clinician confirmed the breast cancer is stage IC-III and ER positive. The clinician documents in the medical record that tamoxifen has been prescribed.

Eligible Cases:

Female patient aged ≥ 18 years on date of encounter **AND** Diagnosis of breast cancer **AND** Patient encounter during reporting period	**ICD-9** 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255

Reporting Options:

Successful Reporting & Performance: For patients with ER or PR positive, Stage IC-III breast cancer, clinician documented or prescribed that the patient is receiving tamoxifen or aromatase inhibitor	**G-CODE** G8381

OR

Successful Reporting & Excluded from Performance: Clinician documentation that breast cancer patient was not eligible for tamoxifen or aromatase inhibitor therapy measure	**G-CODE** G8376

OR

Successful Reporting & Performance Not Met: For patients with ER or PR positive, Stage IC-III breast cancer, clinician did not document that the patient received or was prescribed tamoxifen or aromatase inhibitor	**G-CODE** G8380

Implementation Guidelines:

- Review clinical data regarding the presence or absence of tamoxifen or aromatase inhibitor therapy at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate G-code corresponding to the measure.
- The reporting clinician is not required to have written the initial prescription.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #43: Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery

- **Reporting Description:** Percentage of patients undergoing coronary artery bypass surgery and an applicable CPT Category II code reported each time a CABG is performed during the reporting period
- **Performance Description:** Percentage of patients undergoing coronary artery bypass graft (CABG) surgery using an internal mammary artery (IMA)

Sample Clinical Scenario

A hospitalized 85 year old female patient undergoes primary CABG. The surgery includes an arterial graft, using an internal mammary artery (IMA) and the surgeon documents this in the operative report.

Eligible Cases:	
Patients of ALL ages **AND** CABG surgery performed during reporting period	**CPT** 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

Reporting Options:	
Successful Reporting & Performance: Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure	**CPT II** 4110F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not utilizing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure	**CPT II** 4110F-1P

OR

Successful Reporting & Performance Not Met: IMA graft not utilized, reason not specified	**CPT II** 4110F-8P

Implementation Guidelines:

- Review clinical data regarding the use of an IMA graft for each CABG surgery occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This measure does not include patients undergoing a repeat CABG.
- Each CABG surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II codes(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #44: Pre-Operative Beta-Blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery

- **Reporting Description:** Percentage of patients undergoing CABG surgery and an applicable CPT Category II code reported each time a CABG is performed during the reporting period
- **Performance Description:** Percentage of patients undergoing coronary artery bypass (CABG) surgery who received a beta-blocker pre-operatively

Sample Clinical Scenario

A 68 year old hospitalized male patient undergoes coronary artery bypass (CABG) surgery. The clinician orders a beta-blocker to be given within 24 hours prior to the incision. The hospital medical record reveals that a beta-blocker was given per the order.

Eligible Cases:	
Patients of ALL ages **AND** CABG surgery performed during reporting period	**CPT** 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

Reporting Options:	
Successful Reporting & Performance: Beta blocker administered within 24 hours prior to surgical incision	**CPT II** 4115F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not administering beta blocker within 24 hours prior to surgical incision	**CPT II** 4115F-1P

OR

Successful Reporting & Performance Not Met: Pre-operative beta-blocker not received, reason not specified	**CPT II** 4115F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of pre-operative beta-blocker at each CABG surgery occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each CABG surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II codes(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #15: Cataracts: Assessment of Visual Functional Status

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of cataracts and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of cataracts who were assessed for visual functional status during one or more office visits within 12 months

Sample Clinical Scenario

A 70 year old male with previously diagnosed bilateral cataracts presents to the clinician for evaluation of decreased vision. The clinician performs and documents an assessment of the patient's visual functional status.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of cataracts

AND

Patient encounter during reporting period

ICD-9
366.00, 366.01, 366.02, 366.03, 366.04, 366.09, 366.10, 366.11, 366.12, 366.13, 366.14, 366.15, 366.16, 366.17, 366.19, 366.20, 366.22, 366.34, 366.41, 366.42, 366.43, 366.45, 366.46

AND

CPT
92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance:

Visual functional status assessed

CPT II
1055F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical reason(s) for not assessing patient's visual functional status

CPT II
1055F-1P

OR

Successful Reporting & Performance Not Met:

Visual functional status not assessed, reason not specified

CPT II
1055F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of visual functional status assessment at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Documentation in medical record of visual functional status must include: documentation that patient is operating well with vision or not operating well with vision based on discussion with the patient OR documentation of use of a standardized scale or completion of an assessment questionnaire (e.g., VF-14, ADVS [Activities of Daily Vision Scale], VFQ [Visual Function Questionnaire]).
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #16: Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation

- **Reporting Description:** Percentage of patients aged 18 years and older who undergo cataract surgery and applicable CPT Category II code reported each time a cataract surgery with intraocular lens placement is performed during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older who had cataract surgery who had the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation performed and documented within 6 months prior to the procedure

Sample Clinical Scenario

A 69 year old male patient, with a known diagnosis of left cataract, presents to the clinician for pre-surgical evaluation. He is scheduled for cataract extraction with intraocular lens implant. Results of pre-surgical measurements and intraocular lens power calculations are documented in the medical record.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Each cataract surgery with intraocular lens placement performed during reporting period	**CPT** 66982, 66983, 66984 *The above codes submitted with Modifier 55 will not be counted as eligible cases.*

Reporting Options:

Successful Reporting & Performance: Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation documented (must be performed within six months prior to surgery	**CPT II** 3073F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not performing pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation	**CPT II** 3073F-1P

OR

Successful Reporting & Performance Not Met: Pre-surgical measurements and intraocular lens power calculation method not performed and documented, reason not specified	**CPT II** 3073F-8P

Implementation Guidelines:

- Review clinical data (within six months prior to each cataract surgery) regarding the presence or absence of documentation of pre-surgical axial length, corneal power measurement and method of intraocular lens (IOL) calculation at the time a cataract surgery is performed during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each cataract surgery with IOL placement in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #17: Cataracts: Pre-Surgical Dilated Fundus Evaluation

- **Reporting Description:** Percentage of patients aged 18 years and older who undergo cataract surgery and an applicable CPT Category II code reported each time a cataract surgery is performed during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older who had cataract surgery who had a dilated fundus evaluation performed within six months prior to the procedure

Sample Clinical Scenario

A 71 year old male patient with a known diagnosis of left cataract presents to the clinician for a pre-operative evaluation. The patient had the same surgery on his right eye four weeks earlier and at that time a pre-surgical dilated fundus evaluation of both eyes was performed by another clinician.

Eligible Cases:	
Patient aged ≥ 18 years on date of encounter **AND** Each cataract surgery performed during reporting period	CPT: 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984 *The above codes submitted with Modifier 55 will not be counted as eligible cases.*

Reporting Options:	
Successful Reporting & Performance: Dilated fundus evaluation performed within six months prior to cataract surgery	CPT II: 2020F

OR

Successful Reporting & Excluded from Performance: Documentation of patient reason(s) for not performing a dilated fundus evaluation	CPT II: 2020F-2P

OR

Successful Reporting & Performance Not Met: Pre-surgical dilated fundus evaluation not performed, reason not specified	CPT II: 2020F-8P

Implementation Guidelines:

- Review clinical data (within six months prior to each cataract surgery) regarding the presence or absence of pre-surgical dilated fundus evaluation at the time a cataract surgery is performed during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each cataract surgery occurring during the reporting period will be counted when calculating the reporting and performance rates
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #73: Plan for Chemotherapy Documented Before Chemotherapy Administered

- **Reporting Description:** Percentage of patients with a diagnosis of cancer and an applicable G-code reported once per chemotherapy regimen during the reporting period
- **Performance Description:** Percentage of cancer patients for whom a plan for the amount of chemotherapy to be given was documented before the chemotherapy was administered

Sample Clinical Scenario

A 70 year old male patient with lung cancer presents to the clinician for evaluation of chemotherapy administration. A plan for chemotherapy is documented in the medical record that includes chemotherapeutic agent, dose and administration time intervals.

Eligible Cases:

Patients of ALL ages

AND

Diagnosis of cancer

ICD-9
140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18

Eligible Cases:

ICD-9
202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.10, 203.11, 203.80, 203.81, 204.00, 204.01, 204.10, 204.11, 204.20, 204.21, 204.80, 204.81, 204.90, 204.91, 205.00, 205.01, 205.10, 205.11, 205.20, 205.21, 205.30, 205.31, 205.80, 205.81, 205.90, 205.91, 206.00, 206.01, 206.10, 206.11, 206.20, 206.21, 206.80, 206.81, 206.90, 206.91, 207.00, 207.01, 207.10, 207.11, 207.20, 207.21, 207.80, 207.81, 208.00, 208.01, 208.10, 208.11, 208.20, 208.21, 208.80, 208.81, 208.90, 208.91, 210.0, 210.1, 210.2, 210.3, 210.4, 210.5, 210.6, 210.7, 210.8, 210.9, 211.0, 211.1, 211.2, 211.3, 211.4, 211.5, 211.6, 211.7, 211.8, 211.9, 212.0, 212.1, 212.2, 212.3, 212.4, 212.5, 212.6, 212.7, 212.8, 212.9, 213.0, 213.1, 213.2, 213.3, 213.4, 213.5, 213.6, 213.7, 213.8, 213.9, 214.0, 214.1, 214.2, 214.3, 214.4, 214.8, 214.9, 215.0, 215.2, 215.3, 215.4, 215.5, 215.6, 215.7, 215.8, 215.9, 216.0, 216.1, 216.2, 216.3, 216.4, 216.5, 216.6, 216.7, 216.8, 216.9, 217, 218.0, 218.1, 218.2, 218.9, 219.0, 219.1, 219.8, 219.9, 220, 221.0, 221.1, 221.2, 221.8, 221.9, 222.0, 222.1, 222.2, 222.3, 222.4, 222.8, 222.9, 223.0, 223.1, 223.2, 223.3, 223.81, 223.89, 223.9, 224.0, 224.1, 224.2, 224.3, 224.4, 224.5, 224.6, 224.7, 224.8, 224.9, 225.0, 225.1, 225.2, 225.3, 225.4, 225.8, 225.9, 226, 227.0, 227.1, 227.3, 227.4, 227.5, 227.6, 227.8, 227.9, 228.00, 228.01, 228.02, 228.03, 228.04, 228.09, 228.1, 229.0, 229.8, 229.9, 230.0, 230.1, 230.2, 230.3, 230.4, 230.5, 230.6, 230.7, 230.8, 230.9, 231.0, 231.1, 231.2, 231.8, 231.9, 232.0, 232.1, 232.2, 232.3, 232.4, 232.5, 232.6, 232.7, 232.8, 232.9, 233.0, 233.1, 233.2, 233.3, 233.4, 233.5, 233.6, 233.7, 233.9, 234.0, 234.8, 234.9, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.8, 239.9

AND

Chemotherapy administration during reporting period

CPT
96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549

AND

Patient encounter during reporting period

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255

Reporting Options:	
Successful Reporting & Performance: Chemotherapy plan documented prior to chemotherapy administration	G-CODE: G8373

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure.	NONE

OR

Successful Reporting & Performance Not Met: Chemotherapy plan not documented prior to chemotherapy administration	G-CODE: G8374

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a chemotherapy plan at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate G-code corresponding to the measure.
- A plan for the amount of chemotherapy to be given must include doses and time intervals.
- Each administration of chemotherapy occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #54: Electrocardiogram Performed for Non-Traumatic Chest Pain

- **Reporting Description:** Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain and an applicable CPT Category II code for each episode of non-traumatic chest pain occurring during the reporting period
- **Performance Description:** Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had an electrocardiogram (ECG) performed

Sample Clinical Scenario

A 68 year old male patient presents to the emergency department with symptoms of non-traumatic chest pain. The clinician performs a diagnostic work-up that includes a 12-lead ECG. The patient is discharged from the ED.

Eligible Cases:

Patient aged ≥ 40 years on date of encounter **AND** Discharge diagnosis of non-traumatic chest pain **AND** Patient encounter during reporting period	**ICD-9** 413.0, 413.1, 413.9, 786.50, 786.51, 786.52, 786.59 **AND** **CPT** 99281, 99282, 99283, 99284, 99285, 99291

Reporting Options:

Successful Reporting & Performance: 12-Lead ECG performed	**CPT II** 3120F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reasons for not performing an ECG	**CPT II** 3120F-1P **OR** 3120F-2P

OR

Successful Reporting & Performance Not Met: 12-Lead ECG not performed, reason not specified	**CPT II** 3120F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of an ECG for each episode of non-traumatic chest pain at each emergency department discharge occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of an emergency department discharge diagnosis of non-traumatic chest pain in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #72: Chemotherapy for Stage III Colon Cancer Patients

- **Reporting Description:** Percentage of patients aged 18 through 80 years with colon cancer and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of stage III colon cancer patients aged 18 through 80 years who were prescribed chemotherapy

Sample Clinical Scenario

A 70 year old male patient with a recent diagnosis of colon cancer presents to the clinician for care. The clinician confirmed the colon cancer was stage III. During the encounter, the clinician documents that chemotherapy has been prescribed.

Eligible Cases:

Patient aged ≥ 18 and ≤ 80 years on date of encounter

AND

Diagnosis of colon cancer

AND

Patient encounter during reporting period

ICD-9
153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99241, 99242, 99243, 99244, 99245, 99251, 99252, 99253, 99254, 99255

Reporting Options:

Successful Reporting & Performance:

Chemotherapy documented as received or prescribed for Stage III colon cancer patients

G-CODE
G8372

OR

Successful Reporting & Excluded from Performance:

Clinician documentation that colon cancer patient is not eligible for the chemotherapy measure

G-CODE
G8377

OR

Successful Reporting & Performance Not Met:

Chemotherapy documented as not received or prescribed for Stage III colon cancer patients

G-CODE
G8371

Implementation Guidelines:

- Review clinical data regarding the presence or absence of chemotherapy at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate G-code corresponding to the measure.
- Neoadjuvant and adjuvant chemotherapy should be reported.
- The reporting clinician is not required to have written the initial prescription; 'prescribed' can include managing treatment started by another clinician.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #51: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of COPD and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented

Sample Clinical Scenario

A 72 year old male patient with COPD presents to his clinician for evaluation and management of his condition. His clinician reviews the most recent spirometry test results obtained during the patient's last office visit 2 months ago.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of COPD **AND** Patient encounter during reporting period	**ICD-9** 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance: Spirometry results documented and reviewed	**CPT II** 3023F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reasons for not documenting and reviewing spirometry results	**CPT II** 3023F-1P **OR** 3023F-2P **OR** 3023F-3P

OR

Successful Reporting & Performance Not Met:	CPT II
Spirometry results not documented and reviewed, reason not specified	3023F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of spirometry evaluation results at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Look for most recent documentation of spirometry evaluation results in the medical record; do not limit the search for spirometry evaluation results to the reporting period.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #52: Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of COPD and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator

Sample Clinical Scenario

A 72 year old male patient with COPD presents to his clinician on July 18, 2007 for evaluation and management of COPD. The clinician reviews documented spirometry test results obtained during the last office visit on June 23, 2007, which demonstrated $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing). Clinician prescribes appropriate bronchodilator therapy.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of COPD

AND

Patient encounter during reporting period

ICD-9
491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance:

Inhaled bronchodilator prescribed
AND
Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)

CPT II
4025F **AND** 3025F

OR

Successful Reporting & Excluded from Performance:	
Documentation of medical, patient, or system reasons for not prescribing an inhaled bronchodilator **AND** Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing) **OR** Spirometry test results demonstrate $FEV_1/FVC \geq 70\%$ or patient does not have COPD symptoms **OR** Spirometry test results not performed or documented, reason not specified	**CPT II** 4025F-1P **OR** 4025F-2P **OR** 4025F-3P **AND** 3025F **OR** **CPT II** 3027F **OR** 3025F-8P

OR

Successful Reporting & Performance Not Met:	
Inhaled bronchodilator not prescribed, reason not specified **AND** Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing)	**CPT II** 4025F-8P **AND** 3025F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- This measure must be reported a minimum of once per reporting period for ALL COPD patients.
- At an encounter occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine which of these three options applies to the patient: 1) Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing), 2) Spirometry test results demonstrate $FEV_1/FVC \geq 70\%$ or patient does not have COPD symptoms, or 3) Spirometry test results not performed or documented, reason not specified. For patients where spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (e.g., dyspnea, cough/sputum, wheezing), inhaled bronchodilator should be prescribed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #6: Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease (CAD)

- **Reporting Description:** Percentage of patients aged 18 years and older with CAD and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease who were prescribed oral antiplatelet therapy

Sample Clinical Scenario

A 75 year old male patient presents to the clinician for medical care. He had a myocardial infarction two years ago and was placed on 325 mg of aspirin daily at that time. The clinician documents continuation of antiplatelet therapy in the medical record.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of CAD

AND

Patient encounter during reporting period

ICD-9
410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Reporting Options:

Successful Reporting & Performance:

Oral antiplatelet therapy prescribed (e.g., aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)

CPT II
4011F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical, patient, or system reason(s) for not prescribing oral antiplatelet therapy (e.g., aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox)

CPT II
4011F-1P **OR** 4011F-2P **OR** 4011F-3P

OR

Successful Reporting & Performance Not Met:	CPT II
Oral antiplatelet therapy not prescribed, reason not specified	4011F-8P

Implementation Guidelines:

- Review clinical data to determine the presence or absence of a current oral antiplatelet prescription on the date of an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Oral antiplatelet therapy consists of aspirin, clopidogrel/Plavix, or combination of aspirin and dipyridamole/Aggrenox.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #7: Beta-blocker Therapy for Coronary Artery Disease (CAD) Patients with Prior Myocardial Infarction (MI)

- **Reporting Description:** Percentage of patients aged 18 years and older with CAD and a prior MI and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease and prior myocardial infarction (MI) who were prescribed beta-blocker therapy

Sample Clinical Scenario

A 69 year old female patient with a prior history of myocardial infarction 2 years ago presents to the clinician for continuing medical care. The clinician documents continuation of beta-blocker therapy in the medical record.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of CAD*
(**Eligible cases for this measure require the presence of a prior MI diagnosis AND at least one E/M code during the measurement period. Diagnosis codes for Coronary Artery Disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.)*

AND

Diagnosis of prior MI at any time

AND

Patient encounter during reporting period

ICD-9
411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.8, 414.9, V45.81, V45.82, 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412

AND

ICD-9
410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Reporting Options:

Successful Reporting & Performance:

Beta-blocker therapy prescribed

CPT II
4006F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not prescribing beta-blocker therapy	**CPT II** 4006F-1P **OR** 4006F-2P **OR** 4006F-3P

OR

Successful Reporting & Performance Not Met: Beta-blocker therapy not prescribed, reason not specified	**CPT II** 4006F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a current beta-blocker prescription on the date of an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Denominator inclusion for this measure requires the presence of a prior MI diagnosis and at least one E/M code during the measurement period. Diagnosis codes for coronary artery disease (which include MI diagnosis codes) may also accompany the MI diagnosis code, but are not required for inclusion in the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with major depressive disorder (MDD) and an applicable G-code reported with each new occurrence of MDD during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older diagnosed with new episode of major depressive disorder and documented as treated with antidepressant medication during the entire 84-day (12 week) acute treatment phase

Sample Clinical Scenario

A 66 year old female patient with increased symptoms of depression presents to the clinician for medical care. The clinician diagnoses a new episode of major depressive disorder and prescribes antidepressant medication for a 12 week course of therapy.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of major depression **AND** Patient encounter during reporting period	**ICD-9** 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34, 298.0, 300.4, 309.1, 311 **AND** **CPT** 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

Reporting Options:

Successful Reporting & Performance: Patient with new episode of MDD documented as being treated with antidepressant medication during the entire 12 week acute treatment phase	**G-CODE** G8126

OR

Successful Reporting & Excluded from Performance: 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	**G-CODE** G8128

OR

Successful Reporting & Performance Not Met:	G-CODE
Patient with new episode of MDD not documented as being treated with antidepressant medication during the entire 12 week acute treatment phase	G8127

Implementation Guidelines:

- Review clinical data regarding the patient's antidepressant medication status on the date of an encounter during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate G-code corresponding to the antidepressant medication status.
- Report G8126: 1) For all patients with a diagnosis of Major Depression, New Episode who were prescribed a full 12 week course of antidepressant medication OR 2) At the completion of a 12 week course of antidepressant medication.
- A "new episode" is defined as a patient with major depression who has not been seen or treated for major depression by any practitioner in the prior 4 months. A new episode can either be a recurrence for a patient with prior major depression or a patient with a new onset of major depression.
- Each eligible patient seen during the reporting period will be counted once when calculating the reporting and performance rates.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

- **Reporting Description:** Percentage of patients aged 18 through 75 years with diabetes and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) who had most recent hemoglobin A1c greater than 9.0%

Sample Clinical Scenario

A 75 year old male patient with diabetes presents to the clinician who documents inadequate glycemic control based on the patient's most recent hemoglobin A1c value of 9.2% per lab work obtained 3 months prior to the visit.

Eligible Cases:

Patient aged ≥ 18 and ≤ 75 years on date of encounter

AND

Diagnosis of diabetes

ICD-9
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04

AND

AND

Patient encounter during reporting period

CPT	HCPCS
97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	G0270, G0271

Reporting Options:

Successful Reporting & Increases Performance Rate:

Most recent hemoglobin A1c level > 9.0%

(This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care))

CPT II
3046F

OR

Successful Reporting & Excluded from Performance:

There are no allowable performance exclusions for this measure

NONE

OR

Successful Reporting & Lowers Performance Rate:	**CPT II**
Most recent hemoglobin A1c level < 7.0% **OR** Most recent hemoglobin A1c level 7.0% to 9.0% **OR** Hemoglobin A1c not performed, reason not specified	3044F **OR** 3045F **OR** 3046F-8P

Implementation Guidelines:

- **This is a poor control measure. A lower performance rate indicates better performance** (e.g., low rates of poor control indicate better care).
- Review clinical data (within the last 12 months of this encounter) regarding the most recent hemoglobin A1c at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the most recent A1c level.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The most recent quality data code submitted will be used for performance calculations.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #2: Low-Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus

- **Reporting Description:** Percentage of patients aged 18 through 75 years with diabetes and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) who had most recent LDL-C level in control (less than 100 mg/dl)

Sample Clinical Scenario

A 75 year old male patient with diabetes presents to the clinician for continued medical care. The clinician documents an LDL-C value within normal range based on a lipid panel obtained during the prior encounter that showed an LDL-C value of 90 mg/dl.

Eligible Cases:

Patient aged ≥ 18 and ≤ 75 years on date of encounter

AND

Diagnosis of diabetes

AND

Patient encounter during reporting period

ICD-9
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04

AND

CPT	HCPCS
97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99211, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337	G0270, G0271

Reporting Options:

Successful Reporting & Performance:

Most recent LDL-C <100 mg/dL

CPT II
3048F

OR

Successful Reporting & Excluded from Performance:

There are no allowable performance exclusions for this measure.

NONE

OR

Successful Reporting & Performance Not Met: Most recent LDL-C 100-129 mg/dL **OR** Most recent LDL-C ≥ 130 mg/dL **OR** LDL-C level not performed, reason not specified	**CPT II** 3049F **OR** 3050F **OR** 3048F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the latest LDL-C level at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the most recent LDL-C level.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The most recent quality data code submitted will be used for performance calculations.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #3: High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus

- **Reporting Description:** Percentage of patients aged 18 through 75 years with diabetes and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 through 75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (less than 140/80 mm Hg)

Sample Clinical Scenario

A 65 year old female patient with diabetes returns for a follow-up visit to the clinician for continued medical care. The clinician documents a current blood pressure of 130/72.

Eligible Cases:

Patient aged ≥ 18 and ≤ 75 years on date of encounter

AND

Diagnosis of diabetes

AND

Patient encounter during reporting period

ICD-9
250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04

AND

CPT	HCPCS
97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	G0270, G0271

Reporting Options:

Successful Reporting & Performance:

Most recent systolic blood pressure < 130 mm Hg
OR
Most recent systolic blood pressure 130 to 139 mm Hg

AND

Most recent diastolic blood pressure < 80 mm Hg

CPT II
3074F **OR** 3075F **AND** 3078F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure	NONE

OR

Successful Reporting & Performance Not Met: Most recent systolic blood pressure ≥ 140 mm Hg (in addition, a diastolic CPT II code is required) **OR** Most recent diastolic blood pressure 80-89 mm Hg (in addition, a systolic CPT II code is required) **OR** Most recent diastolic blood pressure ≥ 90 mm Hg (in addition, a systolic CPT II code is required) **OR** No documentation of blood pressure measurement, reason not specified	**CPT II** 3077F **OR** 3079F **OR** 3080F **OR** 2000F-8P

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- Review clinical data (within the last 12 months of this encounter) regarding the latest blood pressure measurement at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code(s) corresponding to the most recent blood pressure measurement.
- A CPT Category II code must be reported for both a systolic and a diastolic blood pressure measurement for this measure, unless reporting 2000F-8P to identify that there was no documentation of blood pressure measurement. For the systolic blood pressure value, report one of the systolic codes; for the diastolic blood pressure value, report one of the diastolic codes. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates. The most recent quality data code submitted will be used for performance calculations.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #37: Dialysis Dose in End Stage Renal Disease (ESRD) Patients

- **Reporting Description:** Percentage of patients aged 18 years and older with end-stage renal disease undergoing hemodialysis and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis with a documented urea reduction ratio (URR) value greater than or equal to 65% (or a single-pool Kt/V greater than or equal to 1.2)

Sample Clinical Scenario

A 69 year old female patient with end-stage renal disease presents to the clinician for continued hemodialysis. The clinician documents in the medical record that her URR value is 68%.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of end-stage renal disease

AND

Hemodialysis performed during reporting period

ICD-9
585.6

AND

CPT	HCPCS
90935, 90937	G0314, G0315, G0316, G0317, G0318, G0319, G0322, G0323, G0326, G0327

Reporting Options:

Successful Reporting & Performance:

End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)

G-CODE
G8075

OR

Successful Reporting & Excluded from Performance:

Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure

G-CODE
G8077

OR

Successful Reporting & Performance Not Met: End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2) **OR** End-stage renal disease patient with URR OR Kt/V value not documented, but otherwise eligible for measure	**G-CODE** G8076 **OR** **G-CODE** G8388

Implementation Guidelines:

- Review clinical data regarding the URR value at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate G-code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the reporting and performance rates. The most recent quality data code submitted will be used for performance calculations.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #38: Hematocrit Level in End Stage Renal Disease (ESRD) Patients

- **Reporting Description:** Percentage of patients aged 18 years and older with end-stage renal disease undergoing hemodialysis and an applicable G-code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis with a documented hematocrit value greater than or equal to 33 (or a hemoglobin value greater than or equal to 11)

Sample Clinical Scenario

A 69 year old female patient with end-stage renal disease presents to the clinician for hemodialysis. The clinician documents in the medical record that the patient's hematocrit is 35.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of end-stage renal disease

AND

Hemodialysis performed during reporting period

ICD-9
585.6

AND

CPT	HCPCS
90935, 90937	G0314, G0315, G0316, G0317, G0318, G0319, G0322, G0323, G0326, G0327

Reporting Options:

Successful Reporting & Performance:

End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)

G-CODE
G8078

OR

Successful Reporting & Excluded from Performance:

Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure

G-CODE
G8080

OR

Successful Reporting & Performance Not Met:

End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)
OR
End-stage renal disease patient with a hematocrit OR hemoglobin not documented

G-CODE
G8079 **OR** G8387

Implementation Guidelines:

- Review clinical data regarding the hematocrit value at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate G-code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the reporting and performance rates. The most recent quality data code submitted will be used for performance calculations.
- Failure to report an applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #4: Screening for Future Fall Risk

- **Reporting Description:** Percentage of patients aged 65 years and older seen by the clinician and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 65 years and older who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months

Sample Clinical Scenario

A 72 year old female patient presents to the clinician for continued medical care. The clinician documents that the patient had fallen twice in the past four months.

Eligible Cases:

Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period	**CPT** 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99387, 99397, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year **OR** 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** 1100F **OR** 1101F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not screening for future fall risk (e.g., patient is not ambulatory)	**CPT II** 1100F-1P **OR** 1101F-1P

OR

Successful Reporting & Performance Not Met: Screening for future fall risk not performed, reason not specified	**CPT II** 1100F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. The entire patient population aged 65 years and older must be reported a minimum of once per patient seen from July 1 through December 31, 2007.
- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of documentation of a falls risk assessment at an encounter during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Patients are considered at risk for future falls if they have had two or more falls in the past year or any fall with injury in the past year.
- A fall is defined as a sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force (Tinetti).
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #60: Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms

- **Reporting Description:** Percentage of patients aged 18 years and older with GERD and an applicable CPT Category II code reported once for all GERD patients seen during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, who were assessed for the presence or absence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding

Sample Clinical Scenario

A 67 year old male patient presents to the clinician for an initial evaluation of GERD. The clinician documents the presence of dysphagia as the only alarm symptom present.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of GERD **AND** Patient encounter during reporting period	**ICD-9** 530.10, 530.11, 530.12, 530.19, 530.81 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance: Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; none present **OR** Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present	**CPT II** 1070F **OR** 1071F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reasons for not documenting presence or absence of alarm symptoms **OR** Not the initial evaluation of GERD, alarm symptoms not assessed	**CPT II** 1070F-1P **OR** 1071F-1P **OR** **CPT II** 1070F-8P

OR

Successful Reporting & Performance Not Met: Alarm symptoms not assessed, reason not specified	**CPT II** 1071F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of alarm symptoms at the initial evaluation of GERD occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- If the current encounter is not the initial evaluation of GERD during this reporting period, then quality-data code 1070F-8P should be reported for this measure.
- Alarm symptoms for GERD include involuntary weight loss, dysphagia, or gastrointestinal bleeding.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the since instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #61: Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms

- **Reporting Description:** Percentage of patients aged 18 years and older with GERD and applicable CPT Category II code(s) reported once for all GERD patients seen during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with at least one alarm symptom who were either referred for upper endoscopy or had an upper endoscopy performed

Sample Clinical Scenario

A 67 year old male patient presents to the clinician for an initial evaluation of GERD. The clinician documents the presence of dysphagia as the only alarm symptom present and refers the patient for an upper endoscopy.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of GERD

AND

Patient encounter during reporting period

ICD-9
530.10, 530.11, 530.12, 530.19, 530.81

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance:

Upper gastrointestinal endoscopy performed
OR
Documentation of referral for upper gastrointestinal endoscopy

AND

Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present

CPT II
3130F **OR** 3132F **AND** 1071F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not referring for or not performing an upper gastrointestinal endoscopy **AND** Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present **OR** Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; none present **OR** Not the initial evaluation of GERD, alarm symptoms not assessed	**CPT II** 3130F-1P **OR** 3132F-1P **OR** 3130F-2P **OR** 3132F-2P **OR** 3130F-3P **OR** 3132F-3P **AND** 1071F **OR** **CPT II** 1070F **OR** **CPT II** 1071F-8P

OR

Successful Reporting & Performance Not Met: Upper endoscopy not performed or patient not referred for upper endoscopy, reason not specified **AND** Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present	**CPT II** 3130F-8P **OR** 3132F-8P **AND** 1071F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- At the initial evaluation of GERD occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether alarm symptoms were assessed with one or more present or with none present. For patients where alarm symptoms were assessed with one or more present, upper gastrointestinal endoscopy should be performed or a referral for upper gastrointestinal endoscopy should be documented. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- If the current encounter is not the initial evaluation of GERD during this reporting period, then quality-data code 1071F-8P should be reported for this measure.
- Alarm symptoms for GERD include involuntary weight loss, dysphagia, or GI bleeding.

- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the since instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #62: Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus

- **Reporting Description:** Percentage of GERD or heartburn patients aged 18 years and older and applicable CPT Category II code(s) reported for each upper endoscopy performed during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of GERD or heartburn whose upper endoscopy report indicates a suspicion of Barrett's esophagus who had a forceps esophageal biopsy performed

Sample Clinical Scenario

A 67 year old male patient presents to the clinician for an initial evaluation of GERD. The clinician performs an upper endoscopy that indicates suspicion of Barrett's esophagus. Therefore, the clinician performs a forceps esophageal biopsy.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of GERD

AND

Upper endoscopy performed during reporting period

ICD-9
530.10, 530.11, 530.12, 530.19, 530.81, 787.1

AND

CPT
43200, 43201, 43202, 43216, 43217, 43228, 43234, 43235, 43236, 43239, 43250, 43251, 43258

Reporting Options:

Successful Reporting & Performance:

Forceps esophageal biopsy performed
AND
Upper gastrointestinal endoscopy report indicates suspicion of Barrett's esophagus

CPT II
3150F **AND** 3140F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical reason(s) for not performing an esophageal biopsy
AND
Upper gastrointestinal endoscopy report indicates suspicion of Barrett's esophagus

OR

Upper gastrointestinal endoscopy report indicates no suspicion of Barrett's esophagus

CPT II
3150F-1P **AND** 3140F

OR

CPT II
3141F

OR

Successful Reporting & Performance Not Met: Esophageal biopsy not performed, reason not specified **AND** Upper gastrointestinal endoscopy report indicates suspicion of Barrett's esophagus	**CPT II** 3150F-8P **AND** 3140F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- At an upper endoscopy procedure occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether an upper gastrointestinal endoscopy report indicates suspicion of Barrett's esophagus or indicates no suspicion of Barrett's esophagus. For patients where the upper gastrointestinal endoscopy report indicates suspicion of Barrett's esophagus, esophageal biopsy should be performed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Each upper gastrointestinal endoscopy procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #63: Gastroesophageal Reflux Disease (GERD): Barium Swallow-Inappropriate Use

- **Reporting Description:** Percentage of patients aged 18 years and older with GERD and an applicable CPT Category II code reported once for all GERD patients seen during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, who did not have a barium swallow test ordered

Sample Clinical Scenario

A 67 year old male patient with GERD presents to the clinician for an initial evaluation of GERD. During the evaluation, the clinician documents that a barium swallow test is not indicated.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of GERD

AND

Patient encounter during reporting period

ICD-9
530.10, 530.11, 530.12, 530.19, 530.81

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Lowers Performance Rate:

Barium swallow test ordered

CPT II
3142F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical reason(s) for ordering a barium swallow test

CPT II
3142F-1P

OR

OR

Not the initial evaluation of GERD, barium swallow test not ordered

CPT II
3200F-8P

OR

Successful Reporting & Increases Performance Rate:

Barium swallow test not ordered

CPT II
3200F

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a barium swallow test performed for the initial evaluation of GERD occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- If the current encounter is not the initial evaluation of GERD during this reporting period, then quality-data code 3200F-8P should be reported for this measure.
- **This is an overuse measure**. For performance, the numerator will be calculated as the difference between patients in the denominator and patients for whom a CPT Category II code was reported for barium swallow test *ordered.* **A higher score indicates appropriate treatment of patients with GERD** (i.e., the proportion for whom a barium swallow test *was not* ordered).
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the since instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #12: Primary Open Angle Glaucoma: Optic Nerve Evaluation

- **Reporting Description:** Percentage of patients aged 18 years with primary open-angle glaucoma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

Sample Clinical Scenario

An 81 year old female patient with known primary open angle glaucoma presents to the clinician for medical care. The clinician reviews her medical history and determines that further testing is appropriate. An optic nerve head evaluation is performed.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of primary open-angle glaucoma

AND

Patient encounter during reporting period

ICD-9
365.01, 365.10, 365.11, 365.12, 365.15

AND

CPT
92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance:

Optic nerve head evaluation performed

CPT II
2027F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical reason(s) for not performing an optic nerve head evaluation

CPT II
2027F-1P

OR

Successful Reporting & Performance Not Met:

Optic nerve head evaluation not performed, reason not specified

CPT II
2027F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of documentation of an optic nerve head evaluation at an encounter during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with heart failure and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure and left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB therapy

Sample Clinical Scenario

An 82 year old female patient with heart failure presents to the clinician for continued medical care. The clinician documents the patient's LVEF is 36% based on a recently obtained echocardiogram and continues her ACE inhibitor or ARB therapy.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of heart failure

AND

Patient encounter during reporting period

ICD-9
402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Reporting Options:

Successful Reporting & Performance:

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function

CPT II
4009F **AND** 3021F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy **AND** Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function **OR** Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function **OR** Left ventricular ejection fraction (LVEF) was not performed or documented, reason not specified	**CPT II** 4009F-1P **OR** 4009F-2P **OR** 4009F-3P **AND** 3021F **OR** **CPT II** 3022F **OR** **CPT II** 3021F-8P

OR

Successful Reporting & Performance Not Met: ACE inhibitor or ARB therapy not prescribed, reason not specified **AND** Left ventricular ejection fraction < 40% or documentation of moderately or severely depressed left ventricular systolic dysfunction	**CPT II** 4009F-8P **AND** 3021F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- This measure must be reported a minimum of once per reporting period for ALL heart failure patients.
- At an encounter during the reporting period (between July 1 and December 31, 2007), review clinical data to determine which of the following three options applies to the patient: 1) LVEF is < 40% indicating LVSD, 2) LVEF is ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function, or 3) LVEF was not performed or documented, reason not otherwise specified. For patients with LVSD, ACE inhibitor or ARB therapy should be prescribed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular dysfunction.

- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professionals reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #8: Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction

- **Reporting Description:** Percentage of patients aged 18 years and older with heart failure and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have left ventricular systolic dysfunction (LVSD) and who were prescribed beta blocker therapy

Sample Clinical Scenario

An 88 year old male patient with heart failure presents to the clinician who documents the patient's LVEF is 38% based on a recently obtained echocardiogram. The clinician continues the patient's current beta-blocker therapy.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of heart failure

AND

Patient encounter during reporting period

ICD-9
402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

Reporting Options:

Successful Reporting & Performance:

Beta blocker therapy prescribed
AND
Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function

CPT II
4006F **AND** 3021F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient or system reason(s) for not prescribing beta-blocker therapy **AND** Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function **OR** Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function **OR** Left ventricular ejection fraction (LVEF) was not performed or documented, reason not specified	**CPT II** 4006F-1P **OR** 4006F-2P **OR** 4006F-3P **AND** 3021F **OR** **CPT II** 3022F **OR** **CPT II** 3021F-8P

OR

Successful Reporting & Performance Not Met: Beta-blocker therapy not prescribed, reason not specified **AND** Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function	**CPT II** 4006F-8P **AND** 3021F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- This measure must be reported a minimum of once per reporting period for ALL heart failure patients.
- At an encounter during the reporting period (between July 1 and December 31, 2007), review clinical data to determine which of the following three options applies to the patient: 1) LVEF is < 40% indicating LVSD, 2) LVEF is ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function, or 3) LVEF was not performed or documented, reason not otherwise specified. For patients with LVSD, beta-blocker therapy should be prescribed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular dysfunction.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period,

the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.

- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or TIA or intracranial hemorrhage undergoing CT or MRI and applicable CPT Category II code(s) reported for each CT or MRI study performed during the reporting period
- **Performance Description:** Percentage of final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with the diagnosis of ischemic stroke or TIA or intracranial hemorrhage that include documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction

Sample Clinical Scenario

A 68 year old male patient arrives via ambulance to the ED with stroke symptoms. He receives an MRI of the brain within 24 hours of admission to the ED. The MRI report confirms the presence of acute cerebral infarction with hemorrhage and mass lesion.

Eligible Cases:

Patient aged ≥ 18 years on date of CT or MRI study

AND

Diagnosis of stroke, TIA or hemorrhage

AND

CT or MRI performed during the reporting period

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

AND

CPT
0042T, 70450, 70460, 70470, 70551, 70552, 70553

Reporting Options:

Successful Reporting & Performance:

Presence or absence of hemorrhage and mass lesion and acute infarction documented in final CT or MRI report
AND
CT or MRI of the brain performed within 24 hours of arrival to the hospital

CPT II
3110F **AND** 3111F

OR

Successful Reporting & Excluded from Performance:

CT or MRI of the brain performed greater than 24 hours after arrival to the hospital

CPT II
3112F

OR

Successful Reporting & Performance Not Met:	**CPT II**
Presence/absence of hemorrhage, mass lesion, and acute infarction not documented, reason not specified **AND** CT or MRI of the brain within 24 hours of arrival to the hospital	3110F-8P **AND** 3111F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- Clinicians may submit this measure from either the hospital or outpatient setting.
- At each encounter where a CT or MRI is performed during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether the CT or MRI of the brain was performed within 24 hours of arrival to the hospital or the CT or MRI of the brain was performed greater than 24 hours after arrival to the hospital. For patients where a CT or MRI of the brain was performed within 24 hours of arrival to the hospital, the presence or absence of hemorrhage and mass lesion and acute infarction should be documented in the final CT or MRI report. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Equivalent terms or synonyms for hemorrhage, mass lesion, or infarction, if documented in the CT or MRI report, would meet the measure.
- Each CT or MRI performed during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or TIA undergoing carotid imaging and an applicable CPT Category II code reported for each carotid imaging study performed during the reporting period
- **Performance Description:** Percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed for patients aged 18 years and older with the diagnosis of ischemic stroke or TIA that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

Sample Clinical Scenario

A 70 year old female patient is hospitalized for TIA. The final carotid imaging study report includes direct reference to measurements of distal internal carotid diameter as the denominator for determining stenosis measurement.

Eligible Cases:

Patient aged ≥ 18 years on date of carotid imaging study **AND** Diagnosis of ischemic stroke or TIA **AND** Carotid imaging study performed during reporting period	**ICD-9** 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9 **AND** **CPT** 70498, 70547, 70548, 70549, 75660, 75662, 75665, 75671, 75676, 75680, 93880, 93882

Reporting Options:

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

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not including direct or indirect reference to measurements of distal internal carotid diameter	**CPT II** 3100F-1P

OR

Successful Reporting & Performance Not Met:	CPT II
Measurements of distal internal carotid diameter not referenced, reason not specified	3100F-8P

Implementation Guidelines:

- Review clinical data regarding the patient's carotid imaging study's report performed during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the contents of the final report.
- Clinicians may submit this measure from either the hospital or outpatient setting.
- "Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" includes direct angiographic stenosis calculations based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (eg, for duplex ultrasound studies, velocity parameters that correlate the residual internal carotid lumen with methods based on the distal internal carotid lumen)
- Each carotid imaging study performed during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #70: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry

- **Reporting Description:** Percentage of patients aged 18 years and older with CLL and an applicable CPT II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

Sample Clinical Scenario

A 70 year old male patient with chronic lymphocytic leukemia presents to the clinician. Flow cytometry studies were performed with results documented in the medical record.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of CLL **AND** Patient encounter during reporting period	**ICD-9**: 204.10 **AND** **CPT**: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance: Flow cytometry studies performed at time of diagnosis or prior to initiating treatment	**CPT II**: 3170F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not performing baseline flow cytometry studies	**CPT II**: 3170F-1P **OR** 3170F-2P **OR** 3170F-3P

OR

Successful Reporting & Performance Not Met: Baseline flow cytometry studies not performed, reason not specified	**CPT II**: 3170F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of baseline flow cytometry test at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Baseline flow cytometry studies refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis; do not limit the search for baseline flow cytometry studies to the reporting period to qualify for this measure.
- Treatment may include anti-neoplastic therapy.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #13: Age-Related Macular Degeneration: Age-Related Eye Disease Study (AREDS) Prescribed/Recommended

- **Reporting Description:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration and applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had AREDS prescribed/recommended within 12 months

Sample Clinical Scenario

A 76 year old female patient with known age-related macular degeneration presents to the clinician. The clinician reviews her medical history and documents an AREDS prescription.

Eligible Cases:

Patient aged ≥ 50 years on date of encounter **AND** Diagnosis of age-related macular degeneration **AND** Patient encounter during reporting period	**ICD-9** 362.50, 362.51, 362.52 **AND** **CPT** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance: Age-related eye disease study (AREDS) formulation prescribed or recommended	**CPT II** 4007F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not prescribing or recommending AREDS formulation	**CPT II** 4007F-1P

OR

Successful Reporting & Performance Not Met: AREDS not prescribed/recommended, reason not specified	**CPT II** 4007F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of AREDS formulation prescribed/ recommended at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record must include documentation of the term “AREDS” if it is recommended. If it is prescribed, it must specify the AREDS formulation.
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #14: Age-Related Macular Degeneration: Dilated Macular Examination

- **Reporting Description:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration and applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

Sample Clinical Scenario

An 80 year old male patient with known age-related macular degeneration presents to the clinician for eye exam complaining of deteriorating vision. The clinician performs a dilated macular examination that documents the presence of increased macular thickening and degeneration.

Eligible Cases:

Patient aged ≥ 50 years on date of encounter **AND** Diagnosis of age-related macular degeneration **AND** Patient encounter during reporting period	**ICD-9** 362.50, 362.51, 362.52 **AND** **CPT** 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance: Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity	**CPT II** 2019F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not performing a dilated macular examination	**CPT II** 2019F-1P **OR** 2019F-2P

OR

Successful Reporting & Performance Not Met: Dilated macular examination not performed, reason not specified	**CPT II** 2019F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of a dilated macular examination at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #67: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow

- **Reporting Description:** Percentage of patients aged 18 years and older with MDS or acute leukemia and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow

Sample Clinical Scenario

A 66 year old male patient with myelodysplastic syndrome presents to the clinician for further medical care. The clinician documented an order for baseline cytogenetic testing prior to initiating treatment.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of MDS or acute leukemia

AND

Patient encounter during reporting period

ICD-9
204.00, 205.00, 206.00, 207.00, 207.20, 208.00, 238.72, 238.73, 238.74, 238.75

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance:

Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment

CPT II
3155F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical, patient, or system reason(s) for not performing baseline cytogenetic testing on bone marrow

CPT II
3155F-1P **OR** 3155F-2P **OR** 3155F-3P

OR

Successful Reporting & Performance Not Met:

Baseline cytogenetic testing not performed, reason not specified

CPT II
3155F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of a baseline cytogenetic test for eligible patients at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Baseline cytogenetic testing refers to testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis; do not limit the search for baseline cytogenetic testing to the reporting period to qualify for this measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #68: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

- **Reporting Description:** Percentage of patients aged 18 years and older with MDS and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy

Sample Clinical Scenario

A 66 year old male patient with myelodysplastic syndrome presents to the clinician for continued medical care. The clinician documents iron stores prior to initiating erythropoietin therapy. Erythropoietin therapy was subsequently administered.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of MDS

AND

Patient encounter during reporting period

ICD-9
238.72, 238.73, 238.74, 238.75

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance:

Documentation of iron stores prior to initiating erythropoietin therapy
AND
Patient receiving erythropoietin therapy

CPT II
3160F **AND** 4090F

OR

Successful Reporting & Excluded from Performance:

Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy
AND
Patient receiving erythropoietin therapy

OR

Patient not receiving erythropoietin therapy

CPT II
3160F-3P **AND** 4090F

OR

CPT II
4095F

OR

Successful Reporting & Performance Not Met:	**CPT II**
Documentation of iron stores prior to initiating erythropoietin therapy not performed, reason not specified **AND** Patient receiving erythropoietin therapy	3160F-8P **AND** 4090F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- This measure must be reported a minimum of once per reporting period for ALL MDS patients.
- At an encounter occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether the patient was or was not receiving erythropoietin therapy. For patients receiving erythropoietin therapy, documentation of iron stores prior to initiating erythropoietin therapy should be performed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- For the purpose of this measure erythropoietin therapy includes the following medications: epoetin and darbepoetin.
- Documentation of iron stores includes either: Bone marrow examination including iron stain OR Serum iron measurement by ferritin or serum iron and TIBC.
- Documentation of iron stores refers to findings that are recognized prior to initiating erythropoietin treatment; do not limit the search for iron stores to the reporting period to qualify for this measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #46: Medication Reconciliation

- **Reporting Description:** Percentage of patients aged 65 years and older seen by the clinician during the reporting period AND within 60 days of an inpatient discharge and applicable CPT Category II code(s) reported once for each inpatient discharge.
- **Performance Description:** Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented

Sample Clinical Scenario

A 70 year old male presents to the clinician for continued medical care following recent discharge from the hospital. The clinician documents review of the hospital discharge medications and reconciles them with the patient's current active medication list.

Eligible Cases:	
Patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period	**CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99387, 99397, 99401, 99402, 99403, 99404

Reporting Options:	
Successful Reporting & Performance: Discharge medications reconciled with the current medication list in outpatient medical record **AND** Patient discharged from an inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days	**CPT II** 1111F **AND** 1110F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure	NONE

OR

Successful Reporting & Performance Not Met: Discharge medication not reconciled with current medication list in the medical record, reason not specified **AND** Patient discharged from an inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days	**CPT II** 1111F-8P **AND** 1110F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- There is no diagnosis associated with this measure.
- At an encounter occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether the patient was discharged from an inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days or the patient was not discharged from an inpatient facility within the last 60 days. For patients who were discharged from an inpatient facility within the last 60 days, discharge medications should be reconciled with the current medication list in outpatient medical record. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- If a patient has not been discharged within the 60-day timeframe from an inpatient facility, there are no reporting requirements for this measure.
- The medical record must indicate that the clinician is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.
- Each eligible patient seen during the reporting period and within 60 days of an inpatient discharge will be counted when calculating the reporting and performance rates. Report this measure once following each inpatient discharge.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #25: Melanoma: Patient Medical History

- **Reporting Description:** Percentage of patients with a current diagnosis or history of cutaneous melanoma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months

Sample Clinical Scenario

A 67 year old male patient with diagnosed melanoma presents to the clinician for continued medical care. The clinician obtains a medical history which reveals that patient has developed a new mole since his last office visit.

Eligible Cases:	
Patients of ALL ages **AND** Current diagnosis or history of cutaneous melanoma **AND** Patient encounter during reporting period	**ICD-9** 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:	
Successful Reporting & Performance: History obtained regarding new or changing moles	**CPT II** 1050F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not asking about presence of new or changing moles	**CPT II** 1050F-1P **OR** 1050F-2P **OR** 1050F-3P

OR

Successful Reporting & Performance Not Met:	CPT II
Medical history of new or changing moles not completed, reason not specified	1050F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of melanoma patient medical history at an encounter occurring during the reporting period (occurring between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #26: Melanoma: Complete Physical Skin Examination

- **Reporting Description:** Percentage of patients with a current diagnosis or history of cutaneous melanoma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a complete physical skin exam performed at least once within 12 months

Sample Clinical Scenario

An 80 year old female patient with diagnosed melanoma presents to the clinician for continued medical care. The clinician performs and documents a complete physical skin exam.

Eligible Cases:

Patients of ALL ages **AND** Current diagnosis or history of cutaneous melanoma **AND** Patient encounter during reporting period	**ICD-9** 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance: Complete physical skin exam performed	**CPT II** 2029F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not performing a complete physical skin exam	**CPT II** 2029F-1P **OR** 2029F-2P **OR** 2029F-3P

OR

Successful Reporting & Performance Not Met: Complete physical skin exam was not performed, reason not specified	**CPT II** 2029F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of a complete skin examination at an encounter during the reporting period (occurring between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #27: Melanoma: Counseling on Self-Examination

- **Reporting Description:** Percentage of patients with a current diagnosis or history of cutaneous melanoma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who were counseled at least once within 12 months to perform a self-examination for new or changing moles

Sample Clinical Scenario

A 65 year old female patient with diagnosed melanoma presents to the clinician for continued care the clinician documents that he counseled her on the importance of performing self-examination for new or changing moles.

Eligible Cases:

Patients of ALL ages

AND

Current diagnosis or history of cutaneous melanoma

AND

Patient encounter during reporting period

ICD-9
172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance:

Patient counseled on self-examination for new or changing moles

CPT II
5005F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical, patient, or system reason(s) for not counseling patient to perform self-examination for new or changing moles

CPT II
5005F-1P **OR** 5005F-2P **OR** 5005F-3P

OR

Successful Reporting & Performance Not Met:	CPT II
Patient not counseled on performing a self-examination, reason not specified	5005F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of self-examination counseling at an encounter occurring during the reporting period (occurring between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #69: Multiple Myeloma: Treatment with Bisphosphonates

- **Reporting Description:** Percentage of patients aged 18 years and older with multiple myeloma and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within 12 months

Sample Clinical Scenario

A 68 year old female patient diagnosed with multiple myeloma presents to the clinician for continuing medical care. The clinician ordered bisphosphonate therapy.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of multiple myeloma **AND** Patient encounter during reporting period	**ICD-9** 203.00 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance: Bisphosphonate therapy, intravenous, ordered or received	**CPT II** 4100F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not prescribing bisphosphonates	**CPT II** 4100F-1P **OR** 4100F-2P

OR

Successful Reporting & Performance Not Met: Intravenous bisphosphonate therapy not prescribed, reason not specified	**CPT II** 4100F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of an order for or receipt of bisphosphonate therapy at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For the purpose of this measure bisphosphonate therapy includes the following medications: pamidronate and zoledronate.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients with an emergency department discharge diagnosis of AMI and an applicable CPT Category II code reported at each discharge during the reporting period
- **Performance Description:** Percentage of patients with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay

Sample Clinical Scenario

A 65 year old male presents to the emergency department with chest pain. The clinician confirms a diagnosis of acute myocardial infarction and aspirin is administered within 24 hours of arrival during the encounter.

Eligible Cases:

Patients of ALL ages

AND

Emergency department discharge diagnosis of AMI

AND

Patient encounter during reporting period

ICD-9
410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

AND

CPT
99281, 99282, 99283, 99284, 99285, 99291

Reporting Options:

Successful Reporting & Performance:

Aspirin received within 24 hours before emergency department arrival or during emergency department stay

CPT II
4084F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical or patient reason(s) for not receiving or taking aspirin within 24 hours before emergency department arrival or during emergency department stay

CPT II
4084F-1P **OR** 4084F-2P

OR

Successful Reporting & Performance Not Met:

Aspirin not received or taken 24 hours before emergency department arrival or during emergency department stay, reason not specified

CPT II
4084F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of an AMI as the emergency department discharge diagnosis and aspirin administration occurring during the reporting period (occurring between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of AMI occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #29: Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)

- **Reporting Description:** Percentage of patients with a diagnosis of AMI and an applicable G-code reported once during hospital stay(s) for each episode of AMI within the reporting period
- **Performance Description:** Percentage of patients with a diagnosis of AMI who had documentation of receiving beta-blocker within 24 hours before or after hospital arrival

Sample Clinical Scenario

A 65 year old male is admitted to the hospital with a diagnosis of acute myocardial infarction and beta-blocker therapy is ordered and administered to the patient within 24 hours of hospital arrival.

Eligible Cases:

Patients of ALL ages

AND

Diagnosis of AMI

AND

Patient encounter during reporting period

ICD-9
410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

AND

CPT
99218, 99219, 99220, 99221, 99222, 99223, 99234, 99235, 99236, 99291, 99292

Reporting Options:

Successful Reporting & Performance:

Acute myocardial infarction: patient documented to have received beta-blocker at arrival

G-CODE
G8009

OR

Successful Reporting & Excluded from Performance:

Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure

G-CODE
G8011

OR

Successful Reporting & Performance Not Met:

Beta-blocker not received

G-CODE
G8010

Implementation Guidelines:

- Review clinical data regarding beta-blocker status for an encounter occurring during the reporting period (occurring between July 1 and December 31, 2007). Select and submit the appropriate G-code corresponding to the measure.
- Each episode of AMI (including 24 hours before or after hospital arrival) occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable G-code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #24: Osteoporosis: Communication with the Physician Managing Ongoing Care Post Fracture

- **Reporting Description:** Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture and applicable CPT II Category code reported after each fracture during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

Sample Clinical Scenario

A 74 year old female patient is treated by an orthopedist for a distal radial fracture, who sends a report to her family clinician indicating his findings and treatment. The orthopedist's report includes a recommendation that the patient should be evaluated for osteoporosis.

Eligible Cases:

Patient aged ≥ 50 years on date of encounter

AND

Treated for each occurrence of hip, spine or distal radial fracture

AND

Patient encounter during reporting period

OR

Surgical treatment for hip, spine or distal radial fracture

ICD-9
733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

CPT
22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

Reporting Options:

Successful Reporting & Performance:

Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

CPT II
5015F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis)	**CPT II** 5015F-1P **OR** 5015F-2P

OR

Successful Reporting & Performance Not Met: Post-fracture care not communicated, reason not specified	**CPT II** 5015F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of communicating that a fracture (hip, spine or distal radius) occurred and that the patient was or should be tested or treated for osteoporosis during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This measure should be reported at one of the following two instances if management following fracture has occurred or is planned within 3 months of fracture.
  1) During an office visit with ICD-9 diagnosis code for fracture of hip, spine or distal radius OR
  2) At the time of a procedure to repair a fracture
- Prior DXA status or already on pharmacologic therapy pre-fracture meets this measure.
- Communication may include: Documentation in the medical record indicating that the clinician treating the fracture communicated (e.g., verbally, by letter, DXA report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.
- Each fracture occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

- **Reporting Description:** Percentage of female patients aged 65 years and older seen by the clinician and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

Sample Clinical Scenario

A 67 year old female patient presents for continuing medical care. The clinician reviews the medical record and notes that the patient has not undergone DXA scanning nor is she currently taking pharmacologic therapy for osteoporosis. The clinician orders a DXA scan.

Eligible Cases:

Female patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period	**CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99387, 99397, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance: Central Dual-energy X-Ray Absorptiometry (DXA) ordered **OR** Central Dual-energy X-Ray Absorptiometry (DXA) results documented **OR** Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	**CPT II** 3096F **OR** 3095F **OR** 4005F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis	**CPT II** 3096F-1P **OR** 3095F-1P **OR** 4005F-1P **OR** 3096F-2P **OR** 3095F-2P **OR** 4005F-2P **OR** 3096F-3P **OR** 3095F-3P **OR** 4005F-3P

OR

Successful Reporting & Performance Not Met: Central DXA measurement not ordered or performed or pharmacologic therapy not prescribed, reason not specified	**CPT II** 3096F-8P **OR** 3095F-8P **OR** 4005F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of the central DXA measurement or pharmacologic therapy prescribed at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II codes(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #40: Osteoporosis: Management Following Fracture

- **Reporting Description:** Percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius and an applicable CPT Category II code reported after each fracture during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed

Sample Clinical Scenario

A 69 year old female patient presents to the clinician for continuing medical care following treatment by an orthopedist for a distal radial fracture. The clinician reviews the orthopedist's report, which includes a recommendation that the patient be evaluated for osteoporosis. The clinician documents an order a DXA scan. The results of the DXA scan reveal osteoporosis, the clinician orders pharmacologic therapy.

Eligible Cases:

Patient aged ≥ 50 years on date of encounter

AND

Diagnosis of fracture

ICD-9
733.12, 733.13, 733.14, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.10, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.18, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9

AND

AND

Patient encounter during reporting period

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

OR

OR

Procedure performed during the reporting period

CPT
22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

Reporting Options:

Successful Reporting & Performance:

Central Dual-energy X-Ray Absorptiometry (DXA) ordered
OR
Central Dual-energy X-Ray Absorptiometry (DXA) results documented
OR
Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

CPT II
3096F **OR** 3095F **OR** 4005F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis	**CPT II** 3096F-1P **OR** 3095F-1P **OR** 4005F-1P **OR** 3096F-2P **OR** 3095F-2P **OR** 4005F-2P **OR** 3096F-3P **OR** 3095F-3P **OR** 4005F-3P

OR

Successful Reporting & Performance Not Met: Central DXA measurement not ordered or performed or pharmacologic therapy not prescribed, reason not specified	**CPT II** 3096F-8P **OR** 3095F-8P **OR** 4005F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of the central DXA measurement or pharmacologic therapy at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- This measure should be reported at one of the following two instances if management following fracture has occurred or is planned within 3 months of fracture.
  1) During an office visit with ICD-9 diagnosis code for fracture of hip, spine or distal radius OR
  2) At the time of a procedure to repair a fracture
- Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Patients with documentation of prior central DXA measurement or already receiving pharmacologic therapy before the occurrence of the fracture would qualify for successful reporting of this measure.
- Each episode of a fracture in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.

- Failure to report applicable CPT Category II codes(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #41: Osteoporosis: Pharmacologic Therapy

- **Reporting Description:** Percentage of patients aged 50 years and older with osteoporosis and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months

Sample Clinical Scenario

A 69 year old female patient with osteoporosis presents to the clinician for continuing medical care. The clinician notes that she is currently taking pharmacologic therapy for osteoporosis and documents continued pharmacologic therapy.

Eligible Cases:

Patient aged ≥ 50 years on date of encounter **AND** Diagnosis of osteoporosis **AND** Patient encounter during reporting period	**ICD-9** 733.00, 733.01, 733.02, 733.03, 733.09 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99386, 99387, 99396, 99397, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	**CPT II** 4005F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reason(s) for not prescribing pharmacologic therapy for osteoporosis	**CPT II** 4005F-1P **OR** 4005F-2P **OR** 4005F-3P

OR

Successful Reporting & Performance Not Met: Pharmacologic therapy not prescribed, reason not specified	**CPT II** 4005F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of pharmacologic therapy at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II codes(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #42: Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise

- **Reporting Description:** Percentage of patients, regardless of age, with osteoporosis and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients, regardless of age, with a diagnosis of osteoporosis who are either receiving both calcium and vitamin D or have been counseled regarding both calcium and vitamin D intake, and exercise at least once within 12 months

Sample Clinical Scenario

A 70 year old female patient with osteoporosis presents for continuing medical care. The clinician advises the patient on the importance of taking calcium and vitamin D as well as regular exercise for her osteoporosis.

Eligible Cases:

Patients of ALL ages **AND** Diagnosis of osteoporosis **AND** Patient encounter during reporting period	**ICD-9** 733.00, 733.01, 733.02, 733.03, 733.09 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance: Documentation of receipt of counseling on exercise AND either both calcium and vitamin D use or counseling regarding both calcium and vitamin D use	**CPT II** 4019F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for patient not receiving both calcium and vitamin D or and not needing counseling regarding both calcium and vitamin D intake, and exercise (e.g., patient has dementia and is unable to receive counseling	**CPT II** 4019F-1P

OR

Successful Reporting & Performance Not Met:	**CPT II**
Calcium and vitamin D not received or no counseling regarding calcium, vitamin D use, and exercise, reason not specified	4019F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of counseling for vitamin D, calcium intake and exercise at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II codes(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #20: Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician

- **Reporting Description:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics and applicable CPT Category II code reported each time a procedure is performed during the reporting period
- **Performance Description:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required)

Sample Clinical Scenario

A 70 year old female patient presents to the operating room following injury requiring surgical intervention. Perioperative documentation includes the order for prophylactic antibiotics to be given within one hour of surgical incision time (two hours if fluoroquinolone or vancomycin).

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Surgical patients with indications for prophylactic antibiotic and procedure performed during reporting period

CPT
15734, 15738, 19260, 19271, 19272,19301, 19302, 19303, 19304, 19305, 19306, 19307,19361, 19364, 19366, 19367, 19368, 19369, 21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436, 21454, 21461, 21462, 21465, 21470, 21627, 21632, 21740, 21750, 21805, 21825, 22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27702, 27703, 27704, 27758, 27759, 27766, 27792, 27814, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33120, 33130, 33140, 33141, 33202, 33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33250, 33251, 33254, 33255, 33256, 33261, 33300, 33305, 33310, 33315, 33320, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 33877, 33880, 33881, 33883, 33886, 33891, 34051, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35021, 35081, 35091, 35102, 35131, 35141, 35151, 35211, 35216, 35241, 35246, 35271, 35276, 35301, 35311, 35481, 35526, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37616, 38115, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501

Eligible Cases:

CPT
43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136, 44140, 44141, 44143, 44144,44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44700, 44950, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 47133, 47135, 47136, 47140, 47141, 47142, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47719, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556, 49215, 49568, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51920, 51925, 52450, 52601, 52612, 52614, 52620, 52630, 52647, 52648, 54401, 54405, 54406, 54408, 54410, 54415, 54416, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 60521, 60522, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61520, 61526, 61530, 61548, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 61697, 61700, 61750, 61751, 61867 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64746, 69720, 69930, 69955, 69960, 69970

Reporting Options:

Successful Reporting & Performance:

Documentation of order for prophylactic antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

OR

Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

CPT II
4047F

OR

CPT II
4048F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not ordering antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)	**CPT II** 4047F-1P

OR

Successful Reporting & Performance Not Met: Order for or administration of prophylactic antibiotic not given, reason not specified	**CPT II** 4047F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of antibiotic prophylaxis timing for each applicable surgical procedure performed during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that antibiotic is to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) OR documentation that antibiotic *has* been given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).
- Each applicable surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #21: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin

- **Reporting Description:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic and an applicable CPT Category II code reported each time a procedure is performed during the reporting period
- **Performance Description:** Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis

Sample Clinical Scenario

A 68 year old female patient presents to the operating room for surgery with indications for prophylactic first or second generation cephalosporin to be given preoperatively. An order was documented in the medical record for administration of a prophylactic first or second generation cephalosporin.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Surgical patients undergoing procedures with indications for first or second generation cephalosporin and procedure performed during the reporting period

CPT
15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 21627, 21632, 21740, 21750, 21805, 21825, 22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27702, 27703, 27704, 27758, 27759, 27766, 27792, 27814, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 31760, 31766, 31770, 31775, 31786, 31805, 32035, 32036, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32200, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32540, 32601, 32602, 32603, 32604, 32605, 32606, 32650, 32651, 32652, 32653, 32654, 32655, 32656, 32657, 32658, 32659, 32660, 32661, 32662, 32663, 32664, 32665, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33120, 33130, 33140, 33141, 33202, 33203, 33250, 33251, 33254, 33255, 33256, 33261, 33300, 33305, 33310, 33315, 33320, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 33877, 33880, 33881, 33883, 33886, 33891, 34051, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35021, 35081, 35091, 35102, 35131, 35141, 35151, 35211, 35216, 35241, 35246, 35271, 35276, 35301, 35311, 35481, 35526, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 35820, 36830, 37616, 38100, 38101, 38115, 38120, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43651, 43652, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880

CPT
44005, 44010, 44020, 44021, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136, 47133, 47135, 47136, 47140, 47141, 47142, 47420, 47425, 47460, 47480, 47490, 47510, 47511, 47525, 47530, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47719, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48001, 48020, 48100, 48102, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556, 49000, 49002, 49010, 49180, 49200, 49201, 49215, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 60521, 60522, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64746

Reporting Options:

Successful Reporting & Performance:

Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis

CPT II
4041F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis

CPT II
4041F-1P

OR

Successful Reporting & Performance Not Met:

First or second generation cephalosporin not ordered, reason not specified

CPT II
4041F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of prophylactic antibiotic selection for each applicable surgical procedure performed during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CTP Category II code corresponding to the measure.
- There must be documentation of order (written order, verbal order, or standing order/protocol) for cefazolin or cefuroxime for antimicrobial prophylaxis OR documentation that cefazolin or cefuroxime was *given*.
- Each applicable surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic and applicable CPT Category II code(s) reported each time a procedure is performed during the reporting period
- **Performance Description:** Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time

Sample Clinical Scenario

A 70 year old female patient presents to the operating room for surgery with indications for prophylactic antibiotic administration. The medical record documents that the patient received prophylactic antibiotics one hour prior to the surgical incision. The clinician documents an order to discontinue the antibiotics within 24 hours of the surgical end time. The patient's prophylactic antibiotics were discontinued within 24 hours of surgical end time.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Non-cardiac surgical patients undergoing procedures with indications for prophylactic antibiotics AND who received a prophylactic antibiotic and procedure performed during the reporting period

CPT
15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436, 21454, 21461, 21462, 21465, 21470, 21627, 21632, 21740, 21750, 21805, 21825, 22325, 22524, 22554, 22558, 22600, 22612, 22630, 22800, 22802, 22804, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 27702, 27703, 27704, 27758, 27759, 27766, 27792, 27814, 27870, 28192, 28193, 28293, 28296, 28299, 28300, 28306, 28307, 28308, 28309, 28310, 28320, 28322, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255, 33300, 33310, 33320, 33877, 33880, 33881, 33883, 33886, 33891, 34051, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35021, 35081, 35091, 35102, 35131, 35141, 35151, 35216, 35246, 35276, 35301, 35311, 35481, 35526, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830, 37616, 38381, 38746, 38747, 39000, 39010, 39200, 39220, 39545, 39561, 41130, 41135, 41140, 41145, 41150, 41153, 41155, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43600, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44100, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136

Eligible Cases:

CPT
44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44700, 44950, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47719, 47720, 47721, 47740, 47741, 47760,47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48160, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48550, 48554, 48556, 49215, 49568, 50300, 50320, 50340, 50360, 50365, 50370, 50380, 51597, 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294, 60521, 60522, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61520, 61526, 61530, 61548, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276, 64746, 69720, 69930, 69955, 69960, 69970

Reporting Options:

Successful Reporting & Performance:

Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure
AND
Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

CPT II
4049F **AND** 4046F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time
AND
Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

OR

Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively

CPT II
4049F-1P **AND** 4046F

OR

CPT II
4042F

OR

Successful Reporting & Performance Not Met: Prophylactic antibiotics not discontinued, reason not specified **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively	**CPT II** 4049F-8P **AND** 4046F

Implementation Guidelines:

- At a non-cardiac procedure performed during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether there was documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively or documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively. For non-cardiac procedures where there was documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively, there should be documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time. Select and submit the appropriate CPT Category II code corresponding to the measure.
- There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 24 hours of surgical end time OR specifying a course of antibiotic administration limited to that 24-hour period (e.g., "to be given every 8 hours for three doses") OR documentation that prophylactic antibiotic *was* discontinued within 24 hours of surgical end time.
- For the purpose of this measure of antibiotic discontinuation, patients may be counted as having "received a prophylactic antibiotic" if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively.
- Each applicable surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated and applicable CPT Category II code reported each time a procedure is performed during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

Sample Clinical Scenario

A 70 year old female patient presents to the operating room for surgery. The clinician orders VTE prophylaxis.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Procedures for which VTE prophylaxis is indicated and procedure performed during reporting period

CPT
19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19328, 19330, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19370, 19371, 19380, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 38100, 38101, 38115, 38120, 38571, 38572, 38700, 38720, 38724, 38740, 38745, 38747, 38760, 38765, 38770, 38780, 39501, 39502, 39503, 39520, 39530, 39531, 39540, 39541, 39545, 39560, 39561, 43020, 43030, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43280, 43300, 43305, 43310, 43312, 43313, 43314, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43644, 43645, 43651, 43652, 43653, 43770, 43771, 43772, 43773, 43774, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43842, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 43880, 43886, 43887, 43888, 44005, 44010, 44020, 44021, 44025, 44050, 44055, 44110, 44111, 44120, 44125, 44126, 44127, 44130, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44180, 44186, 44187, 44188, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44227, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44680, 44700, 44800, 44820, 44850, 44900, 44950, 44960, 44970, 45000, 45020, 45100, 45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45170, 45190, 45395, 45397, 45400, 45402, 45500, 45505, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825, 46715, 46716, 46730, 46735, 46740, 46742, 46744, 46746, 46748, 46750, 46751, 46753, 46754, 46760, 46761, 46762, 47010, 47100, 47120, 47122, 47125, 47130, 47135, 47136, 47140, 47141, 47142, 47300, 47350, 47360, 47361, 47362, 47370, 47371, 47380, 47381, 47382, 47400, 47420, 47425, 47460, 47480, 47500, 47505, 47560, 47561, 47562, 47563, 47564, 47570, 47600, 47605, 47610, 47612, 47620, 47630, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47801, 47802, 47900, 48000, 48001, 48020, 48100, 48105, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49000, 49002, 49010, 49020, 49040, 49060, 49200, 49201, 49215, 49220, 49250, 49255, 49320, 49321, 49322, 49323, 49560, 49561, 49565, 49566, 49570, 50020, 50220, 50225, 50230,

CPT
50234, 50236, 50240, 50320, 50340, 50360, 50365, 50370, 50380, 50543, 50545, 50546, 50547, 50548, 50715, 50722, 50725, 50727, 50728, 50760, 50770, 50780, 50782, 50783, 50785, 50800, 50810, 50815, 50820, 50947, 50948, 51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51597, 51800, 51820, 51900, 51920, 51925, 51960, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845, 55866, 56630, 56631, 56632, 56633, 56634, 56637, 56640, 58200, 58210, 58240, 58285, 58951, 58953, 58954, 58956, 60200, 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, 60271, 60280, 60281, 60500, 60502, 60505, 60520, 60521, 60522, 60540, 60545, 60600, 60605, 60650, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276

Reporting Options:

Successful Reporting & Performance: Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time	CPT II: 4044F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not receiving VTE prophylaxis within 24 hours prior to incision time or 24 hours after surgery end time	CPT II: 4044F-1P

OR

Successful Reporting & Performance Not Met: VTE prophylaxis not ordered, reason not specified	CPT II: 4044F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of venous thromboembolism prophylaxis for each applicable surgical procedure performed during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- There must be documentation of order (written order, verbal order, or standing order/protocol) for VTE prophylaxis OR documentation that VTE prophylaxis was given.
- Each applicable surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #30: Perioperative Care: Timing of Prophylactic Antibiotic – Administering Physician

- **Reporting Description:** Percentage of surgical patients aged 18 and older who have an order for a parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours prior to the surgical incision (or start of procedure when no incision is required) and an applicable CPT II code reported each time a procedure is performed during the reporting period
- **Performance Description:** Percentage of surgical patients aged 18 and older who have an order for a parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) for whom administration of prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

Sample Clinical Scenario

A 76 year old male patient presents to the clinician for surgery with indications for prophylactic antibiotic administration. Following an order for prophylactic parenteral antibiotics to be given within one hour prior to surgical incision, the clinician administers the antibiotic and documents it in the medication administration record.

Eligible Cases:	
Patients aged 18 ≥ years on date of encounter **AND** Patients who have an order for prophylactic antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)	CPT II: 4047F

Reporting Options:	
Successful Reporting & Performance: Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)	CPT II: 4048F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure	NONE

OR

Successful Reporting & Performance Not Met:	**CPT II**
Prophylactic antibiotic not given, reason not specified	4048F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of antibiotic prophylaxis administration during the reporting period (occurring between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each applicable procedure (indicated by CPT Category II 4047F) occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #45: Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)

- **Reporting Description:** Percentage of patients aged 18 years and older undergoing cardiac surgery and applicable CPT Category II code(s) reported for each cardiac surgery during the reporting period
- **Performance Description:** Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time

Sample Clinical Scenario

A 76 year old male patient presents to the clinician for cardiac surgery with indications for prophylactic antibiotic administration. Following an order for prophylactic antibiotics to be given intraoperatively, the clinician administers the antibiotic intraoperatively, documents it in the medication administration record, and discontinues the antibiotic within 48 hours of surgical end time.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Cardiac surgery performed during reporting period

CPT
33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33300, 33305, 33310, 33315, 33320, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35021, 35211, 35216, 35241, 35246, 35271, 35276, 35311, 35820

Reporting Options:

Successful Reporting & Performance:

Documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedure
AND
Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

CPT II
4043F **AND** 4046F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 48 hours of surgical end time, cardiac procedure **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively **OR** Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively	**CPT II** 4043F-1P **AND** 4046F **OR** **CPT II** 4042F

OR

Successful Reporting & Performance Not Met: Prophylactic antibiotics not discontinued, reason not specified **AND** Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively	**CPT II** 4043F-8P **AND** 4046F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- At a cardiac procedure performed during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether there was documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively or documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively. For cardiac procedures where there was documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively, there should be documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- CPT Category II codes **4043F** may be provided for documentation that antibiotic discontinuation was ordered or that antibiotic discontinuation was accomplished. Report CPT Category II code **4043F** if antibiotics were discontinued within 48 hours.
- There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 48 hours of surgical end time OR specifying a course of antibiotic administration limited to that 48-hour period (e.g., "to be given every 8 hours for three doses") OR documentation that prophylactic antibiotic *was* discontinued within 48 hours of surgical end time.
- Each cardiac surgical procedure occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #66: Appropriate Testing for Children with Pharyngitis

- **Reporting Description:** Percentage of children aged 2 through 18 years and applicable CPT Category II code(s) reported for each new diagnosis of pharyngitis occurring during the reporting period
- **Performance Description:** Percentage of children aged 2 through 18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode

Sample Clinical Scenario

A two year old patient with pharyngitis presents to the clinician for medical care. During the encounter, the clinician diagnosed pharyngitis, performs a Group A Strep test, obtains the results, and prescribes antibiotic therapy.

Eligible Cases:

Patient aged ≥ 2 and ≤ 18 years on date of encounter

AND

Diagnosis of pharyngitis

AND

Patient encounter during reporting period

ICD-9
034.0, 462, 463

AND

CPT
99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99499

Reporting Options:

Successful Reporting & Performance:

Group A Strep Test performed
AND
Antibiotic prescribed or dispensed

CPT II
3210F **AND** 4120F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical reason(s) for not performing Group A Strep Test
AND
Antibiotic prescribed or dispensed

OR

Antibiotic neither prescribed nor dispensed

CPT II
3210F-1P **AND** 4120F

OR

CPT II
4124F

OR

Successful Reporting & Performance Not Met: Group A Strep Test not performed, reason not specified **AND** Antibiotic prescribed or dispensed	**CPT II** 3210F-8P **AND** 4120F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- Report this measure for each new diagnosis of pharyngitis occurring in an eligible patient between July 1, 2007 and December 31, 2007.
- At an encounter occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether an antibiotic was prescribed or dispensed or was neither prescribed nor dispensed. For patients where an antibiotic was prescribed or dispensed, Group A Strep Test should be performed. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Each diagnosis of pharyngitis in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #56: Vital Signs for Community-Acquired Bacterial Pneumonia

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia and an applicable CPT Category II code reported once for each episode of CAP during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

Sample Clinical Scenario

A 66 year old female patient presents to the clinician with a cough, sputum production, and fever. Vital signs are documented in the medical record and reviewed by the clinician. The clinician documents a diagnosis of community-acquired bacterial pneumonia.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of community-acquired bacterial pneumonia

AND

Patient encounter during reporting period

ICD-9
481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291

Reporting Options:

Successful Reporting & Performance:

Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

CPT II
2010F

OR

Successful Reporting & Excluded from Performance:

There are no allowable performance exclusions for this measure

NONE

OR

Successful Reporting & Performance Not Met:

Vital signs not documented and reviewed, reason not specified

CPT II
2010F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of vital signs documentation and review for each episode of CAP occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record may include one of the following: clinician documented that vital signs were reviewed, dictation by the clinician including vital signs, clinician initials in the chart that vital signs were reviewed, or other indication that vital signs had been acknowledged by the clinician
- Each episode of CAP in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #57: Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia and an applicable CPT Category II code reported for each episode of CAP during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed

Sample Clinical Scenario

A 66 year old female patient presents to the clinician with a cough, sputum production and fever. The clinician determined that the patient has community-acquired bacterial pneumonia. Pulse oximetry is performed and documented in the medical record. The clinician reviews the oxygen saturation results and documents in the chart.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of community-acquired bacterial pneumonia

AND

Patient encounter during reporting period

ICD-9
481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

AND

CPT
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291

Reporting Options:

Successful Reporting & Performance:

Oxygen saturation results documented and reviewed

CPT II
3028F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical, patient, or system reasons for not documenting and reviewing oxygen saturation

CPT II
3028F-1P **OR** 3028F-2P **OR** 3028F-3P

OR

Successful Reporting & Performance Not Met:	CPT II
Oxygen saturation not documented and reviewed, reason not specified	3028F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of oxygen saturation documentation and review for each episode of CAP occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record may include one of the following: clinician documented that oxygen saturation was reviewed, dictation by the clinician including oxygen saturation, clinician initials in the chart that oxygen saturation was reviewed, or other indication that oxygen saturation had been acknowledged by the clinician
- Each episode of CAP in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #58: Assessment of Mental Status for Community-Acquired Bacterial Pneumonia

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia and an applicable CPT Category II code reported for each episode of CAP during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed

Sample Clinical Scenario

A 66 year old female patient presents to the clinician with a cough, sputum production, and fever. The clinician determines that the patient has community-acquired bacterial pneumonia. The clinician documents in the medical record whether the patient was oriented to person, place and/or time.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of community-acquired bacterial pneumonia **AND** Patient encounter during reporting period	**ICD-9** 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291

Reporting Options:

Successful Reporting & Performance: Mental status assessed	**CPT II** 2014F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure	NONE

OR

Successful Reporting & Performance Not Met: Mental status not assessed, reason not specified	**CPT II** 2014F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of mental status assessment for each episode of CAP occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record may include documentation by clinician that patient's mental status was noted (e.g., patient is oriented or disoriented).
- Each episode of CAP in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #59: Empiric Antibiotic for Community-Acquired Bacterial Pneumonia

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia and an applicable CPT Category II code reported for each episode of CAP during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

Sample Clinical Scenario

A 66 year old female patient presents to the clinician with a cough, sputum production and fever. The clinician determines that patient has community-acquired bacterial pneumonia. During the encounter, the clinician prescribes an empiric antibiotic.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter **AND** Diagnosis of community-acquired bacterial pneumonia **AND** Patient encounter during reporting period	**ICD-9** 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99281, 99282, 99283, 99284, 99285, 99291

Reporting Options:

Successful Reporting & Performance: Appropriate empiric antibiotic prescribed	**CPT II** 4045F

OR

Successful Reporting & Excluded from Performance: Documentation of medical, patient, or system reasons for not prescribing appropriate empiric antibiotic	**CPT II** 4045F-1P **OR** 4045F-2P **OR** 4045F-3P

OR

Successful Reporting & Performance Not Met:	CPT II
Appropriate empiric antibiotic not prescribed, reason not specified	4045F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of an appropriate empiric antibiotic prescription for each episode of CAP occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Appropriate empiric antibiotic for treatment of community-acquired bacterial pneumonia (CAP) should include any medication from one of the following four drug classes: Fluoroquinolones, Macrolides, Doxycycline, Beta Lactam with Macrolide or Doxycycline (as defined by current ATS/IDSA guidelines)
- "Prescribed" includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.
- Each episode of CAP in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #74: Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery

- **Reporting Description:** Percentage of female patients aged 18 through 70 years with breast cancer and an applicable G-code reported a minimum of once during the reporting period at the time of the initial office visit
- **Performance Description:** Percentage of invasive female breast cancer patients aged 18 to 70 years old who have undergone breast conserving surgery and who have received recommendation for radiation therapy within 12 months of the first office visit

Sample Clinical Scenario

A 67 year old female patient with breast cancer presents for her initial office visit following breast conserving surgery. The clinician documents the recommendation for radiation therapy.

Eligible Cases:

Female patient aged ≥ 18 and ≤ 70 years on date of encounter **AND** Diagnosis of breast cancer **AND** Patient initial encounter during reporting period	**ICD-9** 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 **AND** **CPT** 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance: Documentation of radiation therapy recommended within 12 months of first office visit	**G-CODE** G8379

OR

Successful Reporting & Excluded from Performance: Clinician documentation that patient was not an eligible candidate for radiation therapy measure	**G-CODE** G8378

OR

Successful Reporting & Performance Not Met: No documentation of radiation therapy recommended within 12 months of first office visit	**G-CODE** G8383

Implementation Guidelines:

- Review clinical data regarding the recommendation of radiation therapy at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate G-code corresponding to the measure.
- Radiation therapy may include external beam radiation or brachytherapy.
- The numerator code should be reported at the time of radiation therapy services.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable G-code in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy and applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

Sample Clinical Scenario

A 69 year old female patient with known diagnosis of diabetic retinopathy presents to the eye care clinician for continuing care. The clinician performs a dilated macular exam, which includes documentation of macular edema and the severity of retinopathy.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of diabetic retinopathy

AND

Patient encounter during reporting period

ICD-9
362.01, 362.02, 362.03, 362.04, 362.05, 362.06

AND

CPT
92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance:

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

CPT II
2021F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical or patient reason(s) for not performing a dilated macular or fundus examination

CPT II
2021F-1P **OR** 2021F-2P

OR

Successful Reporting & Performance Not Met:	CPT II
Macular or fundus exam not performed, reason not specified	2021F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of documentation related to macular edema and level of severity of retinopathy at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Medical record must include: Documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy and applicable CPT Category II code(s) reported a minimum of once during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes regarding the findings of the macular or fundus exam at least once within 12 months

Sample Clinical Scenario

A 69 year old female patient with diagnosis of diabetic retinopathy presents to the eye care clinician for continuing medical care. The clinician performed a dilated macular or fundus exam, including documentation of the presence or absence of macular edema and level of severity of retinopathy. The clinician documents the findings and communicates this information to her primary care clinician managing ongoing diabetes care.

Eligible Cases:

Patient aged ≥ 18 years on date of encounter

AND

Diagnosis of diabetic retinopathy

AND

Patient encounter during reporting period

ICD-9
362.01, 362.02, 362.03, 362.04, 362.05, 362.06

AND

CPT
92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

Reporting Options:

Successful Reporting & Performance:

Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care
AND
Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

CPT II
5010F **AND** 2021F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes **AND** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy **OR** Dilated macular or fundus exam not performed, reason not specified	**CPT II** 5010F-1P **OR** 5010F-2P **AND** 2021F **OR** **CPT II** 2021F-8P

OR

Successful Reporting & Performance Not Met: Dilated macular or fundus exam findings not communicated, reason not specified **AND** Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy	**CPT II** 5010F-8P **AND** 2021F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- At each encounter during the reporting period (between July 1 and December 31, 2007), review clinical data (within the last 12 months of each encounter) to determine whether a dilated macular or fundus exam was performed (including documentation of the presence or absence of macular edema AND level of severity of retinopathy) or patient did not have a dilated macular or fundus exam performed. For patients where a dilated macular or fundus exam was performed, the findings of dilated macular or fundus exam should be communicated to the physician managing the diabetes care. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Communication may include: Documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or intracranial hemorrhage and applicable CPT Category II code reported for each episode of stroke occurring during the reporting period and reported by the end of hospital day two
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who received DVT prophylaxis by end of hospital day two

Sample Clinical Scenario

A 76 year old male patient is hospitalized for ischemic stroke. The clinician orders DVT prophylaxis. Following the clinician's order, the patient receives DVT prophylaxis by end of hospital day two.

Eligible Cases:

Patients aged 18 ≥ years on date of encounter

AND

Diagnosis of ischemic stroke or intracranial hemorrhage

AND

Patient encounter during reporting period

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

AND

CPT
99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99291

Reporting Options:

Successful Reporting & Performance:

Deep vein thrombosis (DVT) prophylaxis by the end of hospital day two

CPT II
4070F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical or patient reason(s) for not receiving DVT prophylaxis by end of hospital day 2

CPT II
4070F-1P **OR** 4070F-2P

OR

Successful Reporting & Performance Not Met:

DVT Prophylaxis not received, reason not specified

CPT II
4070F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of DVT prophylaxis during a hospital stay occurring within the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For purposes of this measure, DVT prophylaxis can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), intravenous Heparin, low-dose subcutaneous heparin, or intermittent pneumatic compression devices.
- Each episode of ischemic stroke or intracranial hemorrhage occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or TIA and an applicable CPT Category II code reported at discharge from a hospital during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA who were prescribed antiplatelet therapy at discharge

Sample Clinical Scenario

A 72 year old male patient is discharged from a hospital where he had been under active treatment for stroke. The clinician documents discharge orders that include antiplatelet therapy.

Eligible Cases:

Patients aged 18 ≥ years on date of encounter

AND

Diagnosis of ischemic stroke or transient ischemic attack (TIA)

AND

Patient encounter during reporting period

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

AND

CPT
99238, 99239, 99251, 99252, 99253, 99254, 99255

Reporting Options:

Successful Reporting & Performance:

Oral antiplatelet therapy prescribed at discharge

CPT II
4073F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical or patient reason(s) for not prescribing oral antiplatelet therapy at discharge, including identification from medical record that patient on anticoagulation therapy

CPT II
4073F-1P **OR** 4073F-2P

OR

Successful Reporting & Performance Not Met:

Oral antiplatelet therapy prescription not prescribed, reason not specified

CPT II
4073F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of antiplatelet therapy (at discharge) occurring during the reporting period (occurring between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Antiplatelet therapy: aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine
- Each episode of ischemic stroke or TIA with a discharge occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or TIA with documented permanent, persistent, or paroxysmal atrial fibrillation and an applicable CPT Category II code reported at each discharge from a hospital during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

Sample Clinical Scenario

A 66 year old female patient is discharged from the hospital with a diagnosis of TIA and permanent atrial fibrillation. At discharge, the clinician documents orders that include anticoagulant therapy.

Eligible Cases:

Patients aged 18 ≥ years on date of encounter

AND

Diagnosis of ischemic stroke or transient ischemic attack (TIA)

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

AND

AND

Diagnosis of atrial fibrillation

ICD-9
427.31

AND

AND

Patient encounter during reporting period

CPT
99238, 99239, 99251, 99252, 99253, 99254, 99255

Reporting Options:

Successful Reporting & Performance:

Anticoagulant therapy prescribed at discharge

CPT II
4075F

OR

Successful Reporting & Excluded from Performance:

Documentation of medical or patient reason(s) for not prescribing anticoagulant therapy at discharge

CPT II
4075F-1P **OR** 4075F-2P

OR

Successful Reporting & Performance Not Met:	**CPT II**
Anticoagulant prescription not prescribed at discharge, reason not specified	4075F-8P

Implementation Guidelines:

- At a hospital discharge encounter occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine whether atrial fibrillation (permanent, persistent, or paroxysmal) is present or absent. For patients with a presence of permanent, persistent, or paroxysmal atrial fibrillation, anticoagulant therapy is recommended following discharge. Select and submit the appropriate CPT Category II code corresponding to the measure.
- Persistent Atrial Fibrillation: recurrent atrial fibrillation, not self-terminating or terminated electrically or pharmacologically; Paroxysmal Atrial Fibrillation: recurrent atrial fibrillation, self-terminating; Permanent Atrial Fibrillation**:** long-standing atrial fibrillation (>1 year), cardioversion failed or not attempted
- Each episode of ischemic stroke or TIA with atrial fibrillation (permanent, persistent, or paroxysmal) with a hospital discharge occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke and an applicable CPT Category II code reported once for each hospital stay during the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration

Sample Clinical Scenario

A 75 year old male patient presents to the ED with symptoms of ischemic stroke which began approximately less than 3 hours prior to arrival. The clinician documents that t-PA is administered.

Eligible Cases:

Patients aged 18 ≥ years on date of encounter

AND

Diagnosis of ischemic stroke

AND

Patient encounter during reporting period

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

AND

CPT
99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255, 99291

Reporting Options:

Successful Reporting & Performance:

Documentation that tissue plasminogen activator (t-PA) administration was considered
AND
Ischemic stroke symptom onset of less than 3 hours prior to arrival

CPT II
4077F **AND** 1065F

OR

Successful Reporting & Excluded from Performance:

Ischemic stroke symptom onset greater than or equal to 3 hours prior to arrival

CPT II
1066F

OR

Successful Reporting & Performance Not Met:	**CPT II**
t-PA administration or consideration not documented, reason not specified **AND** Ischemic stroke symptom onset of less than 3 hours prior to arrival	4077F-8P **AND** 1065F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- At an encounter occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine timing of symptom onset to hospital arrival. For patients with symptom onset occurring less than 3 hours prior to arrival, it is recommended t-PA administration be considered. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- For purposes of this measure, patients "considered for t-PA administration" includes patients to whom t-PA was given or patients for whom reasons for not being a candidate for t-PA therapy are documented.
- Each episode of ischemic stroke occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with ischemic stroke or intracranial hemorrhage and applicable CPT Category II code(s) reported during each hospital stay within the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth

Sample Clinical Scenario

A 72 year old patient was admitted with intracranial hemorrhage. The clinician determines that there had been sufficient improvement in her condition to plan for removal of her NPO order. The clinician orders a dysphagia screening test prior to resumption of oral intake.

Eligible Cases:

Patients aged 18 ≥ years on date of encounter

AND

Diagnosis of ischemic stroke or intracranial hemorrhage

AND

Patient encounter during reporting period

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

AND

CPT
99221, 99222, 99223, 99251, 99252, 99253, 99254, 99255

Reporting Options:

Successful Reporting & Performance:

Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth

AND

Patient receiving or eligible to receive food, fluids or medication by mouth

CPT II
6010F **AND** 6015F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not conducting dysphagia screening prior to taking any foods, fluids or medication by mouth **AND** Patient receiving or eligible to receive food, fluids or medication by mouth **OR** NPO (nothing by mouth) ordered	**CPT II** 6010F-1P **AND** 6015F **OR** **CPT II** 6020F

OR

Successful Reporting & Performance Not Met: Dysphagia screening not conducted, reason not specified **AND** Patient receiving or eligible to receive food, fluids or medication by mouth	**CPT II** 6010F-8P **AND** 6015F

Implementation Guidelines:

- Successful reporting depends on the correct combination of coding as demonstrated in the boxes above.
- At an encounter occurring during the reporting period (between July 1 and December 31, 2007), review clinical data to determine if patient is receiving or eligible to receive food, fluids, or medication by mouth. For patients receiving food, fluids, or medication by mouth, dysphagia screening is recommended. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.
- Dysphagia Screening: use of a tested and validated dysphagia screening tool (e.g. Burke dysphagia screening test, 3 oz. water swallow test, Mann assessment of swallowing ability [MASA], standardized bedside swallowing assessment [SSA]) OR a dysphagia screening tool approved by the hospital's speech/language pathology (SLP) services.
- Each episode of ischemic stroke or intracranial hemorrhage occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

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

- **Reporting Description:** Percentage of patients aged 18 years and older with active treatment for ischemic stroke or intracranial hemorrhage and an applicable CPT Category II code reported for each hospital discharge within the reporting period
- **Performance Description:** Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom consideration of rehabilitation services is documented at discharge

Sample Clinical Scenario

A 75 year old patient suffered an ischemic stroke and has been recovering in the hospital. His clinician evaluated him upon discharge and concluded that the patient is an appropriate candidate for rehabilitation services. The clinician's order for rehabilitation services referral was documented.

Eligible Cases:

Patients aged 18 ≥ years on date of encounter

AND

Diagnosis of ischemic stroke or intracranial hemorrhage

AND

Patient encounter during reporting period

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

AND

CPT
99238, 99239, 99251, 99252, 99253, 99254, 99255

Reporting Options:

Successful Reporting & Performance:

Documentation that rehabilitation services were considered

CPT II
4079F

OR

Successful Reporting & Excluded from Performance:

There are no allowable performance exclusions for this measure

NONE

OR

Successful Reporting & Performance Not Met:

Rehabilitation services not ordered or considered, reason not specified

CPT II
4079F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of consideration of rehabilitation services during a hospital discharge occurring within the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For purposes of this measure, "consideration of rehabilitation services" includes an order for rehabilitation services or documentation that rehabilitation was not indicated.
- Each episode of ischemic stroke or intracranial hemorrhage with a hospital discharge occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #55: Electrocardiogram Performed for Syncope

- **Reporting Description:** Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope and an applicable CPT Category II code reported for each episode of syncope occurring during the reporting period
- **Performance Description:** Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had an ECG performed

Sample Clinical Scenario

A 68 year old male patient presents to the emergency department with syncope. The clinician performs a diagnostic work-up that includes a 12-lead ECG. The patient is discharged from the ED.

Eligible Cases:

Patient aged ≥ 60 years on date of encounter **AND** Discharge diagnosis of syncope **AND** Patient encounter during reporting period	**ICD-9**: 780.2 **AND** **CPT**: 99281, 99282, 99283, 99284, 99285, 99291

Reporting Options:

Successful Reporting & Performance: 12-Lead ECG performed	**CPT II**: 3120F

OR

Successful Reporting & Excluded from Performance: Documentation of medical or patient reasons for not performing an ECG	**CPT II**: 3120F-1P **OR** 3120F-2P

OR

Successful Reporting & Performance Not Met: 12-Lead ECG not performed, reason not specified	**CPT II**: 3120F-8P

Implementation Guidelines:

- Review clinical data regarding the presence or absence of an ECG for each episode of an emergency department discharge diagnosis of syncope occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each episode of an emergency department discharge diagnosis of syncope in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #65: Appropriate Treatment for Children with Upper Respiratory Infection (URI)

- **Reporting Description:** Percentage of children aged 3 months through 18 years with URI and an applicable CPT Category II code reported for each diagnosis of URI occurring during the reporting period
- **Performance Description:** Percentage of children aged 3 months through 18 years with a diagnosis of upper respiratory infection (URI) who were not dispensed an antibiotic prescription on or 3 days after the episode date

Sample Clinical Scenario

A one year old child with symptoms of upper respiratory infection presents to the clinician for medical care. The clinician does not prescribe an antibiotic.

Eligible Cases:	
Patient aged ≥ 3 months and ≤ 18 years on date of encounter **AND** Diagnosis of URI **AND** Patient encounter during reporting period	**ICD-9** 460, 465.0, 465.8, 465.9 **AND** **CPT** 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245, 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99499

Reporting Options:	
Successful Reporting & Lowers Performance Rate: Antibiotic prescribed or dispensed	**CPT II** 4120F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for prescribing or dispensing antibiotic	**CPT II** 4124F-1P

OR

Successful Reporting & Increases Performance Rate: Antibiotic neither prescribed nor dispensed	**CPT II** 4124F

Implementation Guidelines:

- Review clinical data for each episode of URI regarding the presence or absence of an antibiotic prescription to be dispensed or was dispensed on or three days after the date of an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- For performance, the numerator will be calculated as the difference between patients in the denominator and patients for whom a CPT Category II code was reported for antibiotic prescribed or dispensed. **A higher score indicates appropriate treatment of children with URI** (i.e., the proportion for whom antibiotics *were not* prescribed).
- Each diagnosis of URI in an eligible patient occurring during the reporting period will be counted when calculating the reporting and performance rates.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

- **Reporting Description:** Percentage of female patients aged 65 years and older seen by a clinician and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

Sample Clinical Scenario

A 68 year old female patient presents to the clinician for continuing medical care. The clinician assesses the patient for urinary incontinence.

Eligible Cases:	
Female patient aged ≥ 65 years on date of encounter **AND** Patient encounter during reporting period	**CPT** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99387, 99397, 99401, 99402, 99403, 99404

Reporting Options:	
Successful Reporting & Performance: Presence or absence of urinary incontinence assessed	**CPT II** 1090F

OR

Successful Reporting & Excluded from Performance: Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence	**CPT II** 1090F-1P

OR

Successful Reporting & Performance Not Met: Presence or absence of urinary incontinence not assessed, reason not specified	**CPT II** 1090F-8P

Implementation Guidelines:

- There is no diagnosis associated with this measure. The entire female population aged 65 years and older must be reported a minimum of once per patient seen from July 1 through December 31, 2007.
- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of an assessment of urinary incontinence at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Urinary incontinence is defined as any involuntary leakage of urine.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II codes(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #49: Characterization of Urinary Incontinence in Women Aged 65 Years and Older

- **Reporting Description:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months

Sample Clinical Scenario

A 68 year old female patient with a diagnosis of urinary incontinence presents to the clinician for ongoing care. The clinician reviewed the medical record and noted that the last time urinary incontinence had been characterized was during a visit within the past 12 months.

Eligible Cases:

Female patient aged ≥ 65 years on date of encounter **AND** Diagnosis of urinary incontinence **AND** Patient encounter during reporting period	**ICD-9**: 307.6, 625.6, 788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 **AND** **CPT**: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99387, 99397, 99401, 99402, 99403, 99404

Reporting Options:

Successful Reporting & Performance: Urinary incontinence was characterized (may include one or more of the following: frequency, volume, timing, type of symptoms and how bothersome to the patient)	**CPT II**: 1091F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure	NONE

OR

Successful Reporting & Performance Not Met: Urinary incontinence not characterized, reason not specified	**CPT II**: 1091F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of urinary incontinence characterization at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

Measure #50: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

- **Reporting Description:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence and an applicable CPT Category II code reported a minimum of once during the reporting period
- **Performance Description:** Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

Sample Clinical Scenario

A 68 year old female patient with urinary incontinence presents to the clinician for continuing medical care. The clinician documents a plan of care for managing urinary incontinence.

Eligible Cases:	
Female patient aged ≥ 65 years on date of encounter **AND** Diagnosis of urinary incontinence **AND** Patient encounter during reporting period	**ICD-9**: 307.6, 625.6, 788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 **AND** **CPT**: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99387, 99397, 99401, 99402, 99403, 99404

Reporting Options:	
Successful Reporting & Performance: Urinary incontinence plan of care documented	**CPT II**: 0509F

OR

Successful Reporting & Excluded from Performance: There are no allowable performance exclusions for this measure	NONE

OR

Successful Reporting & Performance Not Met: Plan of care for urinary incontinence not documented, reason not specified	**CPT II**: 0509F-8P

Implementation Guidelines:

- Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of urinary incontinence plan of care documentation at an encounter occurring during the reporting period (between July 1 and December 31, 2007). Select and submit the appropriate CPT Category II code corresponding to the measure.
- Plan of care may include behavioral interventions (e.g., bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.
- Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure. The measure may be reported again at a subsequent visit during the reporting period. If the measure is reported more than once for an eligible patient during the reporting period, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.
- Failure to report applicable CPT Category II code(s) in an eligible case will result in both a reporting and performance failure.
- Medical record documentation is required for all clinical actions described in a measure.

APPENDIX A

2007 Physician Quality Reporting Initiative (PQRI)
Glossary of Terms

CPT Category II Codes	A set of supplemental CPT codes intended to be used for performance measurement. These codes may be used to facilitate data collection about the quality of care rendered by coding certain services, test results or clinical actions that support nationally established performance measures and that the evidence has demonstrated contribute to quality patient care.[2] For PQRI, CPT Category II codes are used to report quality measures on a claim for measurement calculation.
Denominator	The lower part of a fraction used to calculate a rate, proportion, or ratio. The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements. PQRI measure denominators are ICD-9, CPT I, and HCPCS codes, as well as patient demographics (age, gender, etc).
Denominator Statement	A statement that describes the population evaluated by the performance measure. For example, "Patients aged 18-75 years with a diagnosis of diabetes."
Eligible Professional	The Tax Relief and Health Care Act of 2006, Section 101 defines "eligible professional" as the following: 1. Medicare physician, as defined in Social Security Act (SSA) section 1861(r) • Doctor of Medicine • Doctor of Osteopathy • Doctor of Podiatric Medicine • Doctor of Optometry • Doctor of Oral Surgery • Doctor of Dental Medicine • Chiropractor 2. Practitioners described in SSA section 1842(b)(18)(C) • Physician Assistant • Nurse Practitioner

	• Clinical Nurse Specialist • Certified Registered Nurse Anesthetist • Certified Nurse Midwife • Clinical Social Worker • Clinical Psychologist • Registered Dietician • Nutrition Professional 3. Therapists • Physical Therapist • Occupational Therapist • Qualified Speech-Language Therapist
G-codes for PQRI	A set of CMS-defined temporary HCPCS codes used to report quality measures on a claim when CPT Category II codes are not yet available. G-codes are maintained by CMS.
ICD-9-CM Diagnosis Codes	The International Classification of Diseases, 9th Revision, Clinical Modification[6] is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office visits for reporting in PQRI.
Measure	Performance measure • A quantitative tool (*e.g.,* rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process or outcome. • See also process measure and outcome measure.[1, 7] Types of Measures • Process measure: A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.[7] • Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function(s) or process(es).[7]
Numerator	The upper portion of a fraction used to calculate a rate, proportion, or ratio. A clinical action to be counted as meeting a measure's requirements (*i.e.,* patients who received the particular service or obtained a particular outcome that is being measured).[7] PQRI measure numerators are CPT Category II codes and G-codes.

Numerator Statement	A statement that describes the clinical action that satisfies the conditions of the performance measure. For example, "Patients who were screened for future fall risk."
Performance Timeframe	A designated timeframe within which the action described in a performance measure should be completed. This timeframe is generally included in the measure description and may or may not coincide with the measure's data reporting frequency requirement.
Performance Measure Exclusion Modifiers	Modifiers developed exclusively for use with CPT Category II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure's denominator. [2]
Performance Measure Reporting Modifier 8P	The 8P reporting modifier is intended to be used as a "reporting modifier" to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified. 8P reporting modifier - action not performed, reason not otherwise specified (AMA)
Quality-Data Code	Specified CPT Category II codes with or without modifiers (and G-codes where CPT II codes are not yet available) used for submission of PQRI data. CMS PQRI Quality Measures Specifications document contains all codes associated with each PQRI measure and instructions for data submission through the administrative claims system.
Rationale	A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results. [5]
Reporting Frequency	The number of times quality data codes specified for a quality measure must be submitted on claims during the reporting period. The reporting frequency for each measure is described in the 2007 PQRI Quality Measures Specifications document posted on the CMS Web site, www.cms.hhs.gov/PQRI
Reporting Period	The period during which PQRI measures are to be reported for covered professional services provided. For 2007 PQRI, the reporting period is dates of service July 1, 2007 – December 31, 2007.
TRHCA	Tax Relief and Health Care Act of 2006.

Sources:

1. Agency for Health Care Research & Quality (AHRQ) National Quality Measures Clearinghouse Glossary, http://www.qualitymeasures.ahrq.gov/resources/glossary.aspx, accessed on 2/2/07.

IBID, PSNet, Patient Safety Network Glossary, http://www.psnet.ahrq.gov/glossary.aspx#S, accessed on 4/24/07.

2. American Medical Association (AMA), CPT® Appendix H, http://www.ama-assn.org/ama/pub/category/10616.html, accessed on 3/29/07.

3. CMS Medicare Learning Network, MedLearn Matters Article MM 4183, CR 4183, Physician *Voluntary Reporting Program Using G Codes*, http://www.cms.hhs.gov/ContractorLearningResources/downloads/JA4183.pdf ; CMS Manual System, Pub 100-20, Transmittal 199, 12/30/2005, http://www.cms.hhs.gov/Transmittals/Downloads/R199OTN.pdf, accessed on 3/29/07.

4. Institute of Medicine (IOM), Performance Measurement Accelerating Improvement, Glossary, National Academies Press, http://www.nap.edu/catalog.php?record_id=11517#toc, accessed on 2/2/07.

5. Joint Commission on Accreditation of Health Care Organizations (JCAHO) http://www.jointcommission.org/NR/rdonlyres/9B31EDE2-B7CF-4927-88EE-FAB24BE03541/0/glossary.pdf.

6. National Center for Health Statistics (NCHS) of the Centers for Disease Control (CDC) http://www.cdc.gov/nchs/icd9.htm accessed on 3/15/07.

7. QualityNet, QMIS Specification Manual for National Hospital Quality Measures, Appendix D-3, Glossary of Terms version 2.2, 12-31-2006, http://www.QualityNet.org, accessed 3/30/2007

APPENDIX B
2007 Physician Quality Reporting Initiative (PQRI)
2007 PQRI Code Master

The following table provides a master list of all ICD-9-CM (I9) and CPT® (CPT4)* codes included in 2007 PQRI including associated CPT II exclusion modifiers.

*CPT® Copyright 2006, American Medical Association

CODING SYSTEM	CODE	CPT II MODIFIER
I9	034.0	
I9	140.0	
I9	140.1	
I9	140.3	
I9	140.4	
I9	140.5	
I9	140.6	
I9	140.8	
I9	140.9	
I9	141.0	
I9	141.1	
I9	141.2	
I9	141.3	
I9	141.4	
I9	141.5	
I9	141.6	
I9	141.8	
I9	141.9	
I9	142.0	
I9	142.1	
I9	142.2	
I9	142.8	
I9	142.9	
I9	143.0	
I9	143.1	
I9	143.8	
I9	143.9	
I9	144.0	
I9	144.1	
I9	144.8	
I9	144.9	
I9	145.0	
I9	145.1	
I9	145.2	
I9	145.3	
I9	145.4	
I9	145.5	
I9	145.6	
I9	145.8	
I9	145.9	
I9	146.0	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	146.1	
I9	146.2	
I9	146.3	
I9	146.4	
I9	146.5	
I9	146.6	
I9	146.7	
I9	146.8	
I9	146.9	
I9	147.0	
I9	147.1	
I9	147.2	
I9	147.3	
I9	147.8	
I9	147.9	
I9	148.0	
I9	148.1	
I9	148.2	
I9	148.3	
I9	148.8	
I9	148.9	
I9	149.0	
I9	149.1	
I9	149.8	
I9	149.9	
I9	150.0	
I9	150.1	
I9	150.2	
I9	150.3	
I9	150.4	
I9	150.5	
I9	150.8	
I9	150.9	
I9	151.0	
I9	151.1	
I9	151.2	
I9	151.3	
I9	151.4	
I9	151.5	
I9	151.6	
I9	151.8	
I9	151.9	
I9	152.0	
I9	152.1	
I9	152.2	
I9	152.3	
I9	152.8	
I9	152.9	
I9	153.0	
I9	153.1	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	153.2	
I9	153.3	
I9	153.4	
I9	153.5	
I9	153.6	
I9	153.7	
I9	153.8	
I9	153.9	
I9	154.0	
I9	154.1	
I9	154.2	
I9	154.3	
I9	154.8	
I9	155.0	
I9	155.1	
I9	155.2	
I9	156.0	
I9	156.1	
I9	156.2	
I9	156.8	
I9	156.9	
I9	157.0	
I9	157.1	
I9	157.2	
I9	157.3	
I9	157.4	
I9	157.8	
I9	157.9	
I9	158.0	
I9	158.8	
I9	158.9	
I9	159.0	
I9	159.1	
I9	159.8	
I9	159.9	
I9	160.0	
I9	160.1	
I9	160.2	
I9	160.3	
I9	160.4	
I9	160.5	
I9	160.8	
I9	160.9	
I9	161.0	
I9	161.1	
I9	161.2	
I9	161.3	
I9	161.8	
I9	161.9	
I9	162.0	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	162.2	
I9	162.3	
I9	162.4	
I9	162.5	
I9	162.8	
I9	162.9	
I9	163.0	
I9	163.1	
I9	163.8	
I9	163.9	
I9	164.0	
I9	164.1	
I9	164.2	
I9	164.3	
I9	164.8	
I9	164.9	
I9	165.0	
I9	165.8	
I9	165.9	
I9	170.0	
I9	170.1	
I9	170.2	
I9	170.3	
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I9	170.5	
I9	170.6	
I9	170.7	
I9	170.8	
I9	170.9	
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I9	171.3	
I9	171.4	
I9	171.5	
I9	171.6	
I9	171.7	
I9	171.8	
I9	171.9	
I9	172.0	
I9	172.1	
I9	172.2	
I9	172.3	
I9	172.4	
I9	172.5	
I9	172.6	
I9	172.7	
I9	172.8	
I9	172.9	
I9	173.0	
I9	173.1	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	173.2	
I9	173.3	
I9	173.4	
I9	173.5	
I9	173.6	
I9	173.7	
I9	173.8	
I9	173.9	
I9	174.0	
I9	174.1	
I9	174.2	
I9	174.3	
I9	174.4	
I9	174.5	
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I9	174.8	
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I9	176.1	
I9	176.2	
I9	176.3	
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I9	176.5	
I9	176.8	
I9	176.9	
I9	179	
I9	180.0	
I9	180.1	
I9	180.8	
I9	180.9	
I9	181	
I9	182.0	
I9	182.1	
I9	182.8	
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I9	183.2	
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I9	183.9	
I9	184.0	
I9	184.1	
I9	184.2	
I9	184.3	
I9	184.4	
I9	184.8	
I9	184.9	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	185	
I9	186.0	
I9	186.9	
I9	187.1	
I9	187.2	
I9	187.3	
I9	187.4	
I9	187.5	
I9	187.6	
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I9	188.9	
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I9	189.3	
I9	189.4	
I9	189.8	
I9	189.9	
I9	190.0	
I9	190.1	
I9	190.2	
I9	190.3	
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I9	190.5	
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I9	190.7	
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I9	190.9	
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I9	191.3	
I9	191.4	
I9	191.5	
I9	191.6	
I9	191.7	
I9	191.8	
I9	191.9	
I9	192.0	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	192.1	
I9	192.2	
I9	192.3	
I9	192.8	
I9	192.9	
I9	193	
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I9	194.4	
I9	194.5	
I9	194.6	
I9	194.8	
I9	194.9	
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I9	195.1	
I9	195.2	
I9	195.3	
I9	195.4	
I9	195.5	
I9	195.8	
I9	196.0	
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I9	196.2	
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I9	196.5	
I9	196.6	
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I9	196.9	
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I9	197.3	
I9	197.4	
I9	197.5	
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I9	197.8	
I9	198.0	
I9	198.1	
I9	198.2	
I9	198.3	
I9	198.4	
I9	198.5	
I9	198.6	
I9	198.7	
I9	198.81	
I9	198.82	
I9	198.89	
I9	199.0	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	199.1	
I9	200.00	
I9	200.01	
I9	200.02	
I9	200.03	
I9	200.04	
I9	200.05	
I9	200.06	
I9	200.07	
I9	200.08	
I9	200.10	
I9	200.11	
I9	200.12	
I9	200.13	
I9	200.14	
I9	200.15	
I9	200.16	
I9	200.17	
I9	200.18	
I9	200.20	
I9	200.21	
I9	200.22	
I9	200.23	
I9	200.24	
I9	200.25	
I9	200.26	
I9	200.27	
I9	200.28	
I9	200.80	
I9	200.81	
I9	200.82	
I9	200.83	
I9	200.84	
I9	200.85	
I9	200.86	
I9	200.87	
I9	200.88	
I9	201.00	
I9	201.01	
I9	201.02	
I9	201.03	
I9	201.04	
I9	201.05	
I9	201.06	
I9	201.07	
I9	201.08	
I9	201.10	
I9	201.11	
I9	201.12	
I9	201.13	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	201.14	
I9	201.15	
I9	201.16	
I9	201.17	
I9	201.18	
I9	201.20	
I9	201.21	
I9	201.22	
I9	201.23	
I9	201.24	
I9	201.25	
I9	201.26	
I9	201.27	
I9	201.28	
I9	201.40	
I9	201.41	
I9	201.42	
I9	201.43	
I9	201.44	
I9	201.45	
I9	201.46	
I9	201.47	
I9	201.48	
I9	201.50	
I9	201.51	
I9	201.52	
I9	201.53	
I9	201.54	
I9	201.55	
I9	201.56	
I9	201.57	
I9	201.58	
I9	201.60	
I9	201.61	
I9	201.62	
I9	201.63	
I9	201.64	
I9	201.65	
I9	201.66	
I9	201.67	
I9	201.68	
I9	201.70	
I9	201.71	
I9	201.72	
I9	201.73	
I9	201.74	
I9	201.75	
I9	201.76	
I9	201.77	
I9	201.78	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	201.90	
I9	201.91	
I9	201.92	
I9	201.93	
I9	201.94	
I9	201.95	
I9	201.96	
I9	201.97	
I9	201.98	
I9	202.00	
I9	202.01	
I9	202.02	
I9	202.03	
I9	202.04	
I9	202.05	
I9	202.06	
I9	202.07	
I9	202.08	
I9	202.10	
I9	202.11	
I9	202.12	
I9	202.13	
I9	202.14	
I9	202.15	
I9	202.16	
I9	202.17	
I9	202.18	
I9	202.20	
I9	202.21	
I9	202.22	
I9	202.23	
I9	202.24	
I9	202.25	
I9	202.26	
I9	202.27	
I9	202.28	
I9	202.30	
I9	202.31	
I9	202.32	
I9	202.33	
I9	202.34	
I9	202.35	
I9	202.36	
I9	202.37	
I9	202.38	
I9	202.40	
I9	202.41	
I9	202.42	
I9	202.43	
I9	202.44	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	202.45	
I9	202.46	
I9	202.47	
I9	202.48	
I9	202.50	
I9	202.51	
I9	202.52	
I9	202.53	
I9	202.54	
I9	202.55	
I9	202.56	
I9	202.57	
I9	202.58	
I9	202.60	
I9	202.61	
I9	202.62	
I9	202.63	
I9	202.64	
I9	202.65	
I9	202.66	
I9	202.67	
I9	202.68	
I9	202.80	
I9	202.81	
I9	202.82	
I9	202.83	
I9	202.84	
I9	202.85	
I9	202.86	
I9	202.87	
I9	202.88	
I9	202.90	
I9	202.91	
I9	202.92	
I9	202.93	
I9	202.94	
I9	202.95	
I9	202.96	
I9	202.97	
I9	202.98	
I9	203.00	
I9	203.01	
I9	203.10	
I9	203.11	
I9	203.80	
I9	203.81	
I9	204.00	
I9	204.01	
I9	204.10	
I9	204.11	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	204.20	
I9	204.21	
I9	204.80	
I9	204.81	
I9	204.90	
I9	204.91	
I9	205.00	
I9	205.01	
I9	205.10	
I9	205.11	
I9	205.20	
I9	205.21	
I9	205.30	
I9	205.31	
I9	205.80	
I9	205.81	
I9	205.90	
I9	205.91	
I9	206.00	
I9	206.01	
I9	206.10	
I9	206.11	
I9	206.20	
I9	206.21	
I9	206.80	
I9	206.81	
I9	206.90	
I9	206.91	
I9	207.00	
I9	207.01	
I9	207.10	
I9	207.11	
I9	207.20	
I9	207.21	
I9	207.80	
I9	207.81	
I9	208.00	
I9	208.01	
I9	208.10	
I9	208.11	
I9	208.20	
I9	208.21	
I9	208.80	
I9	208.81	
I9	208.90	
I9	208.91	
I9	210.0	
I9	210.1	
I9	210.2	
I9	210.3	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	210.4	
I9	210.5	
I9	210.6	
I9	210.7	
I9	210.8	
I9	210.9	
I9	211.0	
I9	211.1	
I9	211.2	
I9	211.3	
I9	211.4	
I9	211.5	
I9	211.6	
I9	211.7	
I9	211.8	
I9	211.9	
I9	212.0	
I9	212.1	
I9	212.2	
I9	212.3	
I9	212.4	
I9	212.5	
I9	212.6	
I9	212.7	
I9	212.8	
I9	212.9	
I9	213.0	
I9	213.1	
I9	213.2	
I9	213.3	
I9	213.4	
I9	213.5	
I9	213.6	
I9	213.7	
I9	213.8	
I9	213.9	
I9	214.0	
I9	214.1	
I9	214.2	
I9	214.3	
I9	214.4	
I9	214.8	
I9	214.9	
I9	215.0	
I9	215.2	
I9	215.3	
I9	215.4	
I9	215.5	
I9	215.6	
I9	215.7	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	215.8	
I9	215.9	
I9	216.0	
I9	216.1	
I9	216.2	
I9	216.3	
I9	216.4	
I9	216.5	
I9	216.6	
I9	216.7	
I9	216.8	
I9	216.9	
I9	217	
I9	218.0	
I9	218.1	
I9	218.2	
I9	218.9	
I9	219.0	
I9	219.1	
I9	219.8	
I9	219.9	
I9	220	
I9	221.0	
I9	221.1	
I9	221.2	
I9	221.8	
I9	221.9	
I9	222.0	
I9	222.1	
I9	222.2	
I9	222.3	
I9	222.4	
I9	222.8	
I9	222.9	
I9	223.0	
I9	223.1	
I9	223.2	
I9	223.3	
I9	223.81	
I9	223.89	
I9	223.9	
I9	224.0	
I9	224.1	
I9	224.2	
I9	224.3	
I9	224.4	
I9	224.5	
I9	224.6	
I9	224.7	
I9	224.8	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	224.9	
I9	225.0	
I9	225.1	
I9	225.2	
I9	225.3	
I9	225.4	
I9	225.8	
I9	225.9	
I9	226	
I9	227.0	
I9	227.1	
I9	227.3	
I9	227.4	
I9	227.5	
I9	227.6	
I9	227.8	
I9	227.9	
I9	228.00	
I9	228.01	
I9	228.02	
I9	228.03	
I9	228.04	
I9	228.09	
I9	228.1	
I9	229.0	
I9	229.8	
I9	229.9	
I9	230.0	
I9	230.1	
I9	230.2	
I9	230.3	
I9	230.4	
I9	230.5	
I9	230.6	
I9	230.7	
I9	230.8	
I9	230.9	
I9	231.0	
I9	231.1	
I9	231.2	
I9	231.8	
I9	231.9	
I9	232.0	
I9	232.1	
I9	232.2	
I9	232.3	
I9	232.4	
I9	232.5	
I9	232.6	
I9	232.7	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	232.8	
I9	232.9	
I9	233.0	
I9	233.1	
I9	233.2	
I9	233.3	
I9	233.4	
I9	233.5	
I9	233.6	
I9	233.7	
I9	233.9	
I9	234.0	
I9	234.8	
I9	234.9	
I9	235.0	
I9	235.1	
I9	235.2	
I9	235.3	
I9	235.4	
I9	235.5	
I9	235.6	
I9	235.7	
I9	235.8	
I9	235.9	
I9	236.0	
I9	236.1	
I9	236.2	
I9	236.3	
I9	236.4	
I9	236.5	
I9	236.6	
I9	236.7	
I9	236.90	
I9	236.91	
I9	236.99	
I9	237.0	
I9	237.1	
I9	237.2	
I9	237.3	
I9	237.4	
I9	237.5	
I9	237.6	
I9	237.70	
I9	237.71	
I9	237.72	
I9	237.9	
I9	238.0	
I9	238.1	
I9	238.2	
I9	238.3	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	238.4	
I9	238.5	
I9	238.6	
I9	238.71	
I9	238.72	
I9	238.73	
I9	238.74	
I9	238.75	
I9	238.76	
I9	238.79	
I9	238.8	
I9	238.9	
I9	239.0	
I9	239.1	
I9	239.2	
I9	239.3	
I9	239.4	
I9	239.5	
I9	239.6	
I9	239.7	
I9	239.8	
I9	239.9	
I9	250.00	
I9	250.01	
I9	250.02	
I9	250.03	
I9	250.10	
I9	250.11	
I9	250.12	
I9	250.13	
I9	250.20	
I9	250.21	
I9	250.22	
I9	250.23	
I9	250.30	
I9	250.31	
I9	250.32	
I9	250.33	
I9	250.40	
I9	250.41	
I9	250.42	
I9	250.43	
I9	250.50	
I9	250.51	
I9	250.52	
I9	250.53	
I9	250.60	
I9	250.61	
I9	250.62	
I9	250.63	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	250.70	
I9	250.71	
I9	250.72	
I9	250.73	
I9	250.80	
I9	250.81	
I9	250.82	
I9	250.83	
I9	250.90	
I9	250.91	
I9	250.92	
I9	250.93	
I9	296.20	
I9	296.21	
I9	296.22	
I9	296.23	
I9	296.24	
I9	296.30	
I9	296.31	
I9	296.32	
I9	296.33	
I9	296.34	
I9	298.0	
I9	300.4	
I9	307.6	
I9	309.1	
I9	311	
I9	362.01	
I9	362.02	
I9	362.03	
I9	362.04	
I9	362.05	
I9	362.06	
I9	362.50	
I9	362.51	
I9	362.52	
I9	365.01	
I9	365.10	
I9	365.11	
I9	365.12	
I9	365.15	
I9	366.00	
I9	366.01	
I9	366.02	
I9	366.03	
I9	366.04	
I9	366.09	
I9	366.10	
I9	366.11	
I9	366.12	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	366.13	
I9	366.14	
I9	366.15	
I9	366.16	
I9	366.17	
I9	366.19	
I9	366.20	
I9	366.22	
I9	366.34	
I9	366.41	
I9	366.42	
I9	366.43	
I9	366.45	
I9	366.46	
I9	402.01	
I9	402.11	
I9	402.91	
I9	404.01	
I9	404.03	
I9	404.11	
I9	404.13	
I9	404.91	
I9	404.93	
I9	410.00	
I9	410.01	
I9	410.02	
I9	410.10	
I9	410.11	
I9	410.12	
I9	410.20	
I9	410.21	
I9	410.22	
I9	410.30	
I9	410.31	
I9	410.32	
I9	410.40	
I9	410.41	
I9	410.42	
I9	410.50	
I9	410.51	
I9	410.52	
I9	410.60	
I9	410.61	
I9	410.62	
I9	410.70	
I9	410.71	
I9	410.72	
I9	410.80	
I9	410.81	
I9	410.82	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	410.90	
I9	410.91	
I9	410.92	
I9	411.0	
I9	411.1	
I9	411.81	
I9	411.89	
I9	412	
I9	413.0	
I9	413.1	
I9	413.9	
I9	414.00	
I9	414.01	
I9	414.02	
I9	414.03	
I9	414.04	
I9	414.05	
I9	414.06	
I9	414.07	
I9	414.8	
I9	414.9	
I9	427.31	
I9	428.0	
I9	428.1	
I9	428.20	
I9	428.21	
I9	428.22	
I9	428.23	
I9	428.30	
I9	428.31	
I9	428.32	
I9	428.33	
I9	428.40	
I9	428.41	
I9	428.42	
I9	428.43	
I9	428.9	
I9	431	
I9	433.01	
I9	433.11	
I9	433.21	
I9	433.31	
I9	433.81	
I9	433.91	
I9	434.01	
I9	434.11	
I9	434.91	
I9	435.0	
I9	435.1	
I9	435.2	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	435.3	
I9	435.8	
I9	435.9	
I9	460	
I9	462	
I9	463	
I9	465.0	
I9	465.8	
I9	465.9	
I9	481	
I9	482.0	
I9	482.1	
I9	482.2	
I9	482.30	
I9	482.31	
I9	482.32	
I9	482.39	
I9	482.40	
I9	482.41	
I9	482.49	
I9	482.81	
I9	482.82	
I9	482.83	
I9	482.84	
I9	482.89	
I9	482.9	
I9	483.0	
I9	483.1	
I9	483.8	
I9	485	
I9	486	
I9	487.0	
I9	491.0	
I9	491.1	
I9	491.20	
I9	491.21	
I9	491.22	
I9	491.8	
I9	491.9	
I9	492.0	
I9	492.8	
I9	493.00	
I9	493.01	
I9	493.02	
I9	493.10	
I9	493.11	
I9	493.12	
I9	493.20	
I9	493.21	
I9	493.22	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	493.81	
I9	493.82	
I9	493.90	
I9	493.92	
I9	496	
I9	530.10	
I9	530.11	
I9	530.12	
I9	530.19	
I9	530.81	
I9	585.6	
I9	625.6	
I9	648.00	
I9	648.01	
I9	648.02	
I9	648.03	
I9	648.04	
I9	733.00	
I9	733.01	
I9	733.02	
I9	733.03	
I9	733.09	
I9	733.12	
I9	733.13	
I9	733.14	
I9	780.2	
I9	786.50	
I9	786.51	
I9	786.52	
I9	786.59	
I9	787.1	
I9	788.30	
I9	788.31	
I9	788.32	
I9	788.33	
I9	788.34	
I9	788.35	
I9	788.36	
I9	788.37	
I9	788.38	
I9	788.39	
I9	805.00	
I9	805.01	
I9	805.02	
I9	805.03	
I9	805.04	
I9	805.05	
I9	805.06	
I9	805.07	
I9	805.08	

CODING SYSTEM	CODE	CPT II MODIFIER
I9	805.10	
I9	805.11	
I9	805.12	
I9	805.13	
I9	805.14	
I9	805.15	
I9	805.16	
I9	805.17	
I9	805.18	
I9	805.2	
I9	805.4	
I9	805.6	
I9	805.8	
I9	813.40	
I9	813.41	
I9	813.42	
I9	813.44	
I9	813.45	
I9	813.50	
I9	813.51	
I9	813.52	
I9	813.54	
I9	820.00	
I9	820.01	
I9	820.02	
I9	820.03	
I9	820.09	
I9	820.10	
I9	820.11	
I9	820.13	
I9	820.20	
I9	820.21	
I9	820.22	
I9	820.8	
I9	820.9	
I9	V10.82	
I9	V45.81	
I9	V45.82	
C4	15734	
C4	15738	
C4	19260	
C4	19271	
C4	19272	
C4	19301	
C4	19302	
C4	19303	
C4	19304	
C4	19305	
C4	19306	
C4	19307	

CODING SYSTEM	CODE	CPT II MODIFIER
C4	19316	
C4	19318	
C4	19324	
C4	19325	
C4	19328	
C4	19330	
C4	19342	
C4	19350	
C4	19355	
C4	19357	
C4	19361	
C4	19364	
C4	19366	
C4	19367	
C4	19368	
C4	19369	
C4	19370	
C4	19371	
C4	19380	
C4	21346	
C4	21347	
C4	21348	
C4	21422	
C4	21423	
C4	21432	
C4	21433	
C4	21435	
C4	21436	
C4	21454	
C4	21461	
C4	21462	
C4	21465	
C4	21470	
C4	21627	
C4	21632	
C4	21740	
C4	21750	
C4	21805	
C4	21825	
C4	22305	
C4	22310	
C4	22315	
C4	22318	
C4	22319	
C4	22325	
C4	22326	
C4	22327	
C4	22520	
C4	22521	
C4	22523	

CODING SYSTEM	CODE	CPT II MODIFIER
C4	22524	
C4	22554	
C4	22558	
C4	22600	
C4	22612	
C4	22630	
C4	22800	
C4	22802	
C4	22804	
C4	25600	
C4	25605	
C4	25606	
C4	25607	
C4	25608	
C4	25609	
C4	27125	
C4	27130	
C4	27132	
C4	27134	
C4	27137	
C4	27138	
C4	27230	
C4	27232	
C4	27235	
C4	27236	
C4	27238	
C4	27240	
C4	27244	
C4	27245	
C4	27246	
C4	27248	
C4	27440	
C4	27441	
C4	27442	
C4	27443	
C4	27445	
C4	27446	
C4	27447	
C4	27702	
C4	27703	
C4	27704	
C4	27758	
C4	27759	
C4	27766	
C4	27792	
C4	27814	
C4	27870	
C4	28192	
C4	28193	
C4	28293	

CODING SYSTEM	CODE	CPT II MODIFIER
C4	28296	
C4	28299	
C4	28300	
C4	28306	
C4	28307	
C4	28308	
C4	28309	
C4	28310	
C4	28320	
C4	28322	
C4	28415	
C4	28420	
C4	28445	
C4	28465	
C4	28485	
C4	28505	
C4	28525	
C4	28531	
C4	28555	
C4	28585	
C4	28615	
C4	28645	
C4	28675	
C4	28705	
C4	28715	
C4	28725	
C4	28730	
C4	28735	
C4	28737	
C4	28740	
C4	28750	
C4	28755	
C4	28760	
C4	31360	
C4	31365	
C4	31367	
C4	31368	
C4	31370	
C4	31375	
C4	31380	
C4	31382	
C4	31390	
C4	31395	
C4	31760	
C4	31766	
C4	31770	
C4	31775	
C4	31786	
C4	31805	
C4	32035	

CODING SYSTEM	CODE	CPT II MODIFIER
C4	32036	
C4	32095	
C4	32100	
C4	32110	
C4	32120	
C4	32124	
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CODING SYSTEM	CODE	CPT II MODIFIER
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CODING SYSTEM	CODE	CPT II MODIFIER
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CODING SYSTEM	CODE	CPT II MODIFIER
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CODING SYSTEM	CODE	CPT II MODIFIER
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CODING SYSTEM	CODE	CPT II MODIFIER
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CODING SYSTEM	CODE	CPT II MODIFIER
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C4	43843	

CODING SYSTEM	CODE	CPT II MODIFIER
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CODING SYSTEM	CODE	CPT II MODIFIER
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C4	45110	
C4	45111	
C4	45112	
C4	45113	
C4	45114	

CODING SYSTEM	CODE	CPT II MODIFIER
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C4	45135	
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CODING SYSTEM	CODE	CPT II MODIFIER
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C4	47721	

CODING SYSTEM	CODE	CPT II MODIFIER
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C4	47785	
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C4	49060	
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C4	49201	
C4	49215	
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C4	49250	

CODING SYSTEM	CODE	CPT II MODIFIER
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C4	49322	
C4	49323	
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C4	51550	
C4	51555	
C4	51565	

CODING SYSTEM	CODE	CPT II MODIFIER
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C4	51580	
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C4	51595	
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CODING SYSTEM	CODE	CPT II MODIFIER
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C4	61510	
C4	61512	
C4	61518	

CODING SYSTEM	CODE	CPT II MODIFIER
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C4	70498	
C4	70547	

CODING SYSTEM	CODE	CPT II MODIFIER
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CODING SYSTEM	CODE	CPT II MODIFIER
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C4	97004	
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C4	97804	
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C4	99304	

CODING SYSTEM	CODE	CPT II MODIFIER
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C4	99420	
C4	99429	
C4	99499	
C4	0042T	
C4	0509F	8P
C4	0509F	
C4	1005F	8P
C4	1005F	

CODING SYSTEM	CODE	CPT II MODIFIER
C4	1038F	
C4	1039F	
C4	1050F	1P
C4	1050F	2P
C4	1050F	3P
C4	1050F	8P
C4	1050F	
C4	1055F	1P
C4	1055F	8P
C4	1055F	
C4	1065F	
C4	1066F	
C4	1070F	1P
C4	1070F	8P
C4	1070F	
C4	1071F	1P
C4	1071F	8P
C4	1071F	
C4	1080F	2P
C4	1080F	8P
C4	1080F	
C4	1090F	1P
C4	1090F	8P
C4	1090F	
C4	1091F	8P
C4	1091F	
C4	1100F	1P
C4	1100F	8P
C4	1100F	
C4	1101F	1P
C4	1101F	
C4	1110F	
C4	1111F	8P
C4	1111F	
C4	2000F	8P
C4	2010F	8P
C4	2010F	
C4	2014F	8P
C4	2014F	
C4	2019F	1P
C4	2019F	2P
C4	2019F	8P
C4	2019F	
C4	2020F	2P
C4	2020F	8P
C4	2020F	
C4	2021F	1P
C4	2021F	2P
C4	2021F	8P
C4	2021F	

CODING SYSTEM	CODE	CPT II MODIFIER
C4	2027F	1P
C4	2027F	8P
C4	2027F	
C4	2029F	1P
C4	2029F	2P
C4	2029F	3P
C4	2029F	8P
C4	2029F	
C4	3021F	8P
C4	3021F	
C4	3022F	
C4	3023F	1P
C4	3023F	2P
C4	3023F	3P
C4	3023F	8P
C4	3023F	
C4	3025F	8P
C4	3025F	
C4	3027F	
C4	3028F	1P
C4	3028F	2P
C4	3028F	3P
C4	3028F	8P
C4	3028F	
C4	3044F	
C4	3045F	
C4	3046F	8P
C4	3046F	
C4	3048F	8P
C4	3048F	
C4	3049F	
C4	3050F	
C4	3073F	1P
C4	3073F	8P
C4	3073F	
C4	3074F	
C4	3075F	
C4	3077F	
C4	3078F	
C4	3079F	
C4	3080F	
C4	3095F	1P
C4	3095F	2P
C4	3095F	3P
C4	3095F	8P
C4	3095F	
C4	3096F	1P
C4	3096F	2P
C4	3096F	3P
C4	3096F	8P

CODING SYSTEM	CODE	CPT II MODIFIER
C4	3096F	
C4	3100F	1P
C4	3100F	8P
C4	3100F	
C4	3110F	8P
C4	3110F	
C4	3111F	
C4	3112F	
C4	3120F	1P
C4	3120F	2P
C4	3120F	8P
C4	3120F	
C4	3130F	1P
C4	3130F	2P
C4	3130F	3P
C4	3130F	8P
C4	3130F	
C4	3132F	1P
C4	3132F	2P
C4	3132F	3P
C4	3132F	8P
C4	3132F	
C4	3140F	
C4	3141F	
C4	3142F	1P
C4	3142F	
C4	3150F	1P
C4	3150F	8P
C4	3150F	
C4	3155F	1P
C4	3155F	2P
C4	3155F	3P
C4	3155F	8P
C4	3155F	
C4	3160F	3P
C4	3160F	8P
C4	3160F	
C4	3170F	1P
C4	3170F	2P
C4	3170F	3P
C4	3170F	8P
C4	3170F	
C4	3200F	
C4	3200F	8P
C4	3210F	1P
C4	3210F	8P
C4	3210F	
C4	4005F	1P
C4	4005F	2P
C4	4005F	3P

CODING SYSTEM	CODE	CPT II MODIFIER
C4	4005F	8P
C4	4005F	
C4	4006F	1P
C4	4006F	2P
C4	4006F	3P
C4	4006F	8P
C4	4006F	
C4	4007F	1P
C4	4007F	8P
C4	4007F	
C4	4009F	1P
C4	4009F	2P
C4	4009F	3P
C4	4009F	8P
C4	4009F	
C4	4011F	1P
C4	4011F	2P
C4	4011F	3P
C4	4011F	8P
C4	4011F	
C4	4015F	2P
C4	4015F	8P
C4	4015F	
C4	4019F	1P
C4	4019F	8P
C4	4019F	
C4	4025F	1P
C4	4025F	2P
C4	4025F	3P
C4	4025F	8P
C4	4025F	
C4	4041F	1P
C4	4041F	8P
C4	4041F	
C4	4042F	
C4	4043F	1P
C4	4043F	8P
C4	4043F	
C4	4044F	1P
C4	4044F	8P
C4	4044F	
C4	4045F	1P
C4	4045F	2P
C4	4045F	3P
C4	4045F	8P
C4	4045F	
C4	4046F	
C4	4047F	1P
C4	4047F	8P
C4	4047F	

CODING SYSTEM	CODE	CPT II MODIFIER
C4	4048F	8P
C4	4048F	
C4	4049F	1P
C4	4049F	8P
C4	4049F	
C4	4070F	1P
C4	4070F	2P
C4	4070F	8P
C4	4070F	
C4	4073F	1P
C4	4073F	2P
C4	4073F	8P
C4	4073F	
C4	4075F	1P
C4	4075F	2P
C4	4075F	8P
C4	4075F	
C4	4077F	8P
C4	4077F	
C4	4079F	8P
C4	4079F	
C4	4084F	1P
C4	4084F	2P
C4	4084F	8P
C4	4084F	
C4	4090F	
C4	4095F	
C4	4100F	1P
C4	4100F	2P
C4	4100F	8P
C4	4100F	
C4	4110F	1P
C4	4110F	8P
C4	4110F	
C4	4115F	1P
C4	4115F	8P
C4	4115F	
C4	4120F	
C4	4124F	1P
C4	4124F	
C4	5005F	1P
C4	5005F	2P
C4	5005F	3P
C4	5005F	8P
C4	5005F	
C4	5010F	1P
C4	5010F	2P
C4	5010F	8P
C4	5010F	
C4	5015F	1P

CODING SYSTEM	CODE	CPT II MODIFIER
C4	5015F	2P
C4	5015F	8P
C4	5015F	
C4	6010F	1P
C4	6010F	8P
C4	6010F	
C4	6015F	
C4	6020F	
HCPCS	G0270	
HCPCS	G0271	
HCPCS	G0314	
HCPCS	G0315	
HCPCS	G0316	
HCPCS	G0317	
HCPCS	G0318	
HCPCS	G0319	
HCPCS	G0322	
HCPCS	G0323	
HCPCS	G0326	
HCPCS	G0327	
HCPCS	G8009	
HCPCS	G8010	
HCPCS	G8011	
HCPCS	G8075	
HCPCS	G8076	
HCPCS	G8077	
HCPCS	G8078	
HCPCS	G8079	
HCPCS	G8080	
HCPCS	G8126	
HCPCS	G8127	
HCPCS	G8128	
HCPCS	G8371	
HCPCS	G8372	
HCPCS	G8373	
HCPCS	G8374	
HCPCS	G8376	
HCPCS	G8377	
HCPCS	G8378	
HCPCS	G8379	
HCPCS	G8380	
HCPCS	G8381	
HCPCS	G8383	
HCPCS	G8387	
HCPCS	G8388	

END

APPENDIX C
Sample Implementation Flow Chart