2008 Physician Quality Reporting Initiative
Claims-Based Measures Groups Handbook

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) authorized CMS to establish for the 2008 PQRI program alternative methods for quality data reporting that include reporting on a group of clinically-related measures. Four measures groups have been established for 2008 PQRI: Diabetes Mellitus, End Stage Renal Disease (ESRD), Chronic Kidney Disease (CKD), and Preventive Care. These four groups, combined, include a total of 22 measures established for use in the 2008 PQRI, as required by applicable statutes, through formal notice-and-comment rulemaking in 2007. The measures groups may be reported through claims-based or registry-based submission. This handbook is specific to the reporting of measures groups through claims-based data submission.

The 2008 PQRI Claims-Based Measures Groups reporting alternative is available for the six-month reporting period from July 1 through December 31, 2008. Eligible professionals who successfully report under the claims-based measures group method may receive an incentive payment equivalent to 1.5% of total allowed Medicare Physician Fee Schedule (PFS) allowed charges for covered professional services furnished during this reporting period.

Please note: eligible professionals may choose to pursue more than one 2008 PQRI reporting option. Professionals who successfully report under more than one reporting option will receive a maximum of one incentive payment, which will be equivalent to 1.5% of their PFS allowed charges for all covered professional services furnished, during the longest reporting period for which he or she satisfied reporting requirements. This handbook describes how to implement 2008 claims-based reporting of measures groups to facilitate successful reporting of quality data by eligible professionals who wish to participate under this reporting alternative.

Eligible professionals identify their intent to report a measures group by submitting a measures group-specific G-code on a claim for covered professional services furnished to a patient enrolled in Medicare Part B Fee-For-Service. Medicare Part C (e.g., Medicare Advantage) claims will not be utilized for 2008 PQRI analysis. It is not necessary to submit the measures group-specific G-code on more than one claim. If the G-code for a given group is submitted multiple times during the reporting period, only the submission with the earliest date of service will be included in the PQRI analyses; subsequent submissions of that code will be ignored.

G8485: I intend to report the Diabetes measure grouping
G8488: I intend to report the End Stage Renal Disease (ESRD) measure grouping
G8487: I intend to report the Chronic Kidney Disease (CKD) measure grouping
G8486: I intend to report the Preventive Care measure grouping

There are two reporting methods for claims-based submission of measures groups:

Consecutive Patient Sample Method: Eligible professionals must report on all applicable measures within the selected measures group on claims for 15 consecutive Medicare Part B Fee-For-Service patients who meet patient sample criteria for the measures group, beginning with the first date of service for which the measures group-specific G-code is submitted. For example, an eligible professional can indicate intent to begin reporting the Diabetes Mellitus Measures Group by submitting G8485 on the first patient claim in the series of consecutive diabetic patients. All the applicable measures within the group must be reported at least once for each patient within the sample population seen during the reporting period.

OR

80% Patient Sample Method: Eligible professionals must report on all applicable measures within the selected measures group on claims for at least 80% of all Medicare Part B Fee-For-Service patients seen during the entire reporting period (July 1 – December 31, 2008) who meet the measures group

patient sample criteria. For this method, the measures group-specific G-code must be submitted once during the reporting period to indicate the eligible professional's selection of the measures group. All applicable measures within the group must be reported at least once for each patient within the sample population seen during the reporting period.

This handbook contains an overview for each measures group followed by specific reporting instructions for each measure within the group.

The patient sample for both the Consecutive Patient Sample Method and the 80% Patient Sample Method are determined by diagnosis and/or encounter parameters common to all measures within a selected measures group. All applicable measures within a group must be reported for each patient within the sample that meets the criteria (age, gender, or additional diagnosis) required in accordance with this handbook. For example, if an eligible professional is reporting on the Preventive Measures Group, the *Screening or Therapy for Osteoporosis* measure would only need to be reported on women within the patient sample. Denominator coding has been modified from the original measure as specified by the measure developer to allow for implementation as a measures group.

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#3. High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus
#117. Dilated Eye Exam in Diabetic Patient
#119. Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

INSTRUCTIONS FOR REPORTING:

- Indicate your intention to report the Diabetes Mellitus Measures Group by submitting the measures group-specific G-code on a patient claim. It is not necessary to submit the measures group-specific G-code on more than one claim.

  G8485: I intend to report the Diabetes measure grouping

- Select patient sample method:
  Consecutive Patient Sample Method: 15 consecutive patients meeting patient sample criteria for the measures group. Counting will begin with eligible patients seen on or after the service date indicated on the claim containing G8485.
  OR
  80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (July 1 through December 31, 2008).

- Patient sample criteria for the Diabetes Mellitus Measures Group are found on claims for patients aged 18-75 years containing a specific diagnosis of diabetes accompanied by a specific patient encounter:

  one of the following diagnosis codes indicating diabetes: 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

  accompanied by

  one of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

- Report quality-data codes on **all** measures within the Diabetes Mellitus Measures Group for the patient sample.

- Instructions for quality-data code reporting for each of the measures within the Diabetes Mellitus Measures Group are displayed on the next several pages.

- Successful reporting of the Diabetes Mellitus Measures Group requires **all** measures for each patient within the sample to be reported a minimum of once during the reporting period.

- When using the 15 Consecutive Patient Sample Method, report each measure for 15 consecutive patients seen beginning with those patients meeting sample criteria on the date G8485 is submitted. When using the 80% Patient Sample Method, report each measure on at least 80% of the patient sample.

- The provider remittance advice will show a denial code for the claim containing G8485 as well as the claims containing quality-data codes. This denial code (N365) indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific G-code.

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

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

DESCRIPTION:
Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

NUMERATOR:
Patients with most recent hemoglobin A1c level > 9.0%

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

Numerator Coding:
Most Recent Hemoglobin A1c Level > 9.0%
CPT II 3046F: Most recent hemoglobin A1c level > 9.0%

OR

If patient is not eligible for this measure because hemoglobin A1c not performed, report:
Hemoglobin A1c not Performed
Append a reporting modifier (**8P**) to CPT Category II code **3046F** to report circumstances when the patient is not eligible for the measure.

- **8P:** Hemoglobin A1c level was not performed during the performance period (12 months)

OR

Most Recent Hemoglobin A1c Level ≤ 9.0%
CPT II 3044F: Most recent hemoglobin A1c (HbA1c) level < 7.0%
OR
CPT II 3045F: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

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

DESCRIPTION:
Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl)

NUMERATOR:
Patients with most recent LDL-C < 100 mg/dL

Numerator Coding:
Most Recent LDL-C Level < 100 mg/dL
CPT II 3048F: Most recent LDL-C < 100 mg/dL

OR

If patient is not eligible for this measure because LDL-C level not performed, report:
LDL-C Level not Performed
Append a reporting modifier (**8P**) to CPT Category II code **3048F** to report circumstances when the patient is not eligible for the measure.

- **8P:** LDL-C was not performed during the performance period (12 months)

OR

Most Recent LDL-C Level ≥ 100 mg/dL
CPT II 3049F: Most recent LDL-C 100-129 mg/dL
OR
CPT II 3050F: Most recent LDL-C ≥ 130 mg/dL

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

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

DESCRIPTION:
Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)

NUMERATOR:
Patients whose most recent blood pressure < 140/80 mmHg

Numerator Instructions: To describe both systolic and diastolic blood pressure values, two CPT II codes must be reported – 1) One to describe the systolic value; AND
2) One to describe the diastolic value. 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.

Numerator Coding:
Most Recent Blood Pressure Measurement Performed
Systolic codes **(Select one (1) code from this section):**

CPT II 3074F: Most recent systolic blood pressure < 130 mmHg
OR
CPT II 3075F: Most recent systolic blood pressure 130 - 139 mmHg
OR
CPT II 3077F: Most recent systolic blood pressure greater than or equal to 140 mmHg

AND
Diastolic code **(Select one (1) code from this section):**
CPT II 3078F: Most recent diastolic blood pressure less than 80 mmHg
OR
CPT II 3079F: Most recent diastolic blood pressure 80 - 89 mmHg
OR
CPT II 3080F: Most recent diastolic blood pressure greater than or equal to 90 mmHg

OR

If patient is not eligible for this measure because blood pressure measurement not performed, report 2000F-8P:
Blood Pressure Measurement not Performed
Append a reporting modifier (**8P**) to CPT Category II code **2000F** to report circumstances when the patient is not eligible for the measure.

- **8P:** No documentation of blood pressure measurement

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

Measure #117: Dilated Eye Exam in Diabetic Patient

DESCRIPTION:
Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam

NUMERATOR:
Patients who had a dilated eye exam for diabetic retinal disease at least once within 12 months

Numerator Instructions: This includes patients with diabetes who had one of the following: A retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the reporting period, or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the reporting period. For dilated eye exams performed 12 months prior to the reporting period, an automated result must be available.

Numerator Coding:

Dilated Eye Exam Performed by an Eye Care Professional

CPT II 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed

OR

CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed

OR

CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

OR

CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)

OR

Dilated Eye Exam not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2022F or 2024F or 2026F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Dilated eye exam was not performed, reason not otherwise specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

Measure #119: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

DESCRIPTION:
Percentage of patients aged 18 through 75 years of age with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months

NUMERATOR:
Patients who have a nephropathy screening during at least one office visit within 12 months

Numerator Instructions: This measure is looking for a nephropathy screening test or evidence of nephropathy.

Numerator Coding:
Nephropathy Screening Performed
CPT II 3060F: Positive microalbuminuria test result documented and reviewed
OR
CPT II 3061F: Negative microalbuminuria test result documented and reviewed
OR
CPT II 3062F: Positive macroalbuminuria test result documented and reviewed
OR
CPT II 3066F: Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)
OR
CPT II 4009F: Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed

OR

Nephropathy Screening not Performed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **3060F or 3061F or 3062F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Nephropathy screening was not performed, reason not otherwise specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

END STAGE RENAL DISEASE (ESRD) MEASURES GROUP OVERVIEW

2008 PQRI MEASURES IN THE ESRD MEASURES GROUP:

#78. Vascular Access for Patients Undergoing Hemodialysis
#79. Influenza Vaccination in Patients with End Stage Renal Disease (ESRD)
#80. Plan of Care for ESRD Patients with Anemia
#81. Plan of Care for Inadequate Hemodialysis in ESRD Patients

INSTRUCTIONS FOR REPORTING:

- Indicate your intention to report the ESRD Measures Group by submitting the measures group-specific G-code on a patient claim. It is not necessary to submit the measures group-specific G-code on more than one claim.

  G8488: I intend to report the End Stage Renal Disease (ESRD) measure grouping

- Select patient sample method:
  Consecutive Patient Sample Method: 15 consecutive patients meeting patient sample criteria for the measures group. Counting will begin with eligible patients seen on or after the service date indicated on the claim containing G8488.
  OR
  80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (July 1 through December 31, 2008).

- Patient sample criteria for the ESRD Measures Group are found on claims for patients aged 18 years and older containing a specific diagnosis of ESRD accompanied by a specific patient encounter:

  the following diagnosis indicating ESRD: 585.6

  accompanied by

  one of the following patient encounter codes: 90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319

- There are two types of patients that can be reported in the ESRD (End Stage Renal Disease) measures group; those that have ESRD and are undergoing hemodialysis, and those that have ESRD and are undergoing peritoneal dialysis. If an eligible professional chooses to report this measures group they should report the appropriate quality-data code for all four measures if the patient is receiving hemodialysis. However, if the patient is receiving peritoneal dialysis, only measures #79 and #80 should be reported as measures #78 and #81 do not apply to patients undergoing peritoneal dialysis.

- Report quality-data codes on **all applicable** measures within the ESRD Measures Group for the patient sample. Report measures #80 and #81 a minimum of once during the month the patient is included in the sample population.

- Instructions for quality-data code reporting for each of the measures within the ESRD Measures Group are displayed on the next several pages.

- Successful reporting of the ESRD Measures Group requires **all applicable** measures for each patient within the sample to be reported a minimum of once during the reporting period.

- When using the 15 Consecutive Patient Sample Method, report each measure for 15 consecutive patients seen beginning with those patients meeting sample criteria on the date G8488 is submitted. When using the 80% Patient Sample Method, report each measure on at least 80% of the patient sample.
- The provider remittance advice will show a denial code for the claim containing G8488 as well as the claims containing quality-data codes. This denial code (N365) indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific G-code.

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #78: Vascular Access for Patients Undergoing Hemodialysis

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) and receiving hemodialysis who have a functioning AV fistula OR patients who are referred for an AV fistula at least once during the 12-month reporting period

NUMERATOR:
Patients who have a functioning AV fistula OR patients who are referred for AV fistula at least once during the 12 month reporting period

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

Numerator Coding:
Patient with Functioning AV Fistula
(One CPT II code [4052F] is required on the claim form to submit this category)

CPT II 4052F: Hemodialysis via functioning arterio-venous (AV) fistula

OR

Patient Referred for AV Fistula
(Two CPT II codes [4051F & 4054F] are required on the claim form to submit this category)

CPT II 4051F: Referred for an arterio-venous (AV) fistula
AND
CPT II 4054F: Hemodialysis via catheter

OR

Patient not Referred for AV Fistula for Medical or Patient Reasons
(Two CPT II codes [*4051F-xP & 4054F*] are required on the claim form to submit this category)

Append a modifier (**1P or 2P**) to CPT Category II code **4051F** to report documented circumstances that appropriately exclude patients from the denominator.

- **4051F** *with* **1P:** Documentation of medical reason(s) for not referring for an AV fistula
- **4051F** *with* **2P:** Documentation of patient reason(s) for not referring for an AV fistula

AND
CPT II 4054F: Hemodialysis via catheter

OR

If patient is not eligible for this measure because patient has a functioning arterio-venous (AV) graft, report:
(One CPT II code [4053F] is required on the claim form to submit this category)

CPT II 4053F: Hemodialysis via functioning arterio-venous (AV) graft

OR

Patient not Referred for AV Fistula, Reason not Specified
(Two CPT II codes [4051F-8P & 4054F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II codes **4051F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **4051F** *with* **8P:** Patient was not referred for an AV fistula, reason not otherwise specified

AND

CPT II 4054F: Hemodialysis via catheter

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #79: Influenza Vaccination in Patients with End Stage Renal Disease (ESRD)

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of ESRD and receiving dialysis who received the influenza immunization during the flu season (September through February)

NUMERATOR:
Patients who received the influenza immunization during the flu season (September through February)

Numerator Coding:
Influenza Immunization Received
CPT II 4037F: Influenza immunization ordered or administered

OR

Influenza Immunization not Received for Medical, Patient, or System Reasons
Append a modifier (**1P, 2P, or 3P**) to CPT Category II code **4037F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for patient not receiving the influenza immunization
- **2P:** Documentation of patient reason(s) for patient not receiving the influenza immunization
- **3P:** Documentation of system reason(s) for patient not receiving the influenza immunization

OR

Influenza Immunization not Received, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4037F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Influenza immunization not ordered or administered, reason not otherwise specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #80: Plan of Care for ESRD Patients with Anemia

DESCRIPTION:
Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) who are receiving dialysis have a Hgb ≥ 11g/dL OR have a Hgb < 11 g/dL with a documented plan of care for anemia

MEASURES GROUPS REPORTING INSTRUCTIONS:
Report this measure one time per patient during the reporting month that brings the patient into the ESRD measures group sample population.

NUMERATOR:
Number of patient calendar months during which patients have a Hgb ≥ 11 g/dL OR have a Hgb < 11 g/dL with a documented plan of care for anemia

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

Numerator Coding:
Patient has Hemoglobin Level ≥ 11 g/dL
(One CPT II code [32xxF] is required on the claim form to submit this category)

CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL
OR
CPT II 3280F: Hemoglobin level 11 g/dL to 12.9 g/dL

OR

Patient has Hemoglobin < 11 g/dL with a Documented Plan of Care
(Two CPT II codes [3281F & 0516F] are required on the claim form to submit this category)

CPT II 3281F: Hemoglobin less than 11 g/dL
AND
CPT II 0516F: Anemia plan of care documented

OR

Hemoglobin Level not Performed or Documented
(Two CPT II codes [3279F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3279F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3279F** ***with*** **8P:** Hemoglobin level was not performed or documented, reason not otherwise specified

OR

Patient has Hemoglobin Level < 11 g/dL <u>without</u> a Documented Plan of Care, Reason Not Specified
(Two CPT II codes [0516F-8P & 3281F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II codes **0516F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0516F** *with* **8P:** Anemia plan of care <u>not</u> documented, reason not otherwise specified

<u>AND</u>
CPT II 3281F: Hemoglobin less than 11g/dL

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #81: Plan of Care for Inadequate Hemodialysis in ESRD Patients

DESCRIPTION:
Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of end stage renal disease (ESRD) receiving hemodialysis have a Kt/V ≥ 1.2 OR patients who have a Kt/V < 1.2 with a documented plan of care for inadequate hemodialysis

MEASURES GROUPS REPORTING INSTRUCTIONS:
Report this measure one time per patient during the reporting month that brings the patient into the ESRD measures group sample population.

NUMERATOR:
Number of patient calendar months during which patients have a Kt/V ≥1.2 OR have Kt/V <1.2 with a documented plan of care for inadequate hemodialysis

Definition: A documented plan of care may include checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the time of dialysis sessions, adjusting dialysis prescription, or documenting residual renal function.

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

Numerator Coding:
Kt/V ≥ 1.2
(One CPT II code [30xxF] is required on the claim form to submit this category)

CPT II 3083F: Kt/V equal to or greater than 1.2 and less than 1.7 (Clearance of urea (Kt)/volume(V))
OR
CPT II 3084F: Kt/V ≥1.7 (Clearance of urea (Kt)/volume(V))

OR
Kt/V < 1.2 with a Documented Plan of Care
(Two CPT II codes [3082F & 0505F] are required on the claim form to submit this category)

CPT II 3082F: Kt/V < 1.2 (Clearance of urea (Kt)/volume(V))
AND
CPT II 0505F: Hemodialysis plan of care documented

OR

Kt/V Measurement not Performed or Documented
(One CPT II code [3084F-8P] is required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3084F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified

- **3084F *with* 8P:** Kt/V was not performed or documented, reason not otherwise specified

OR

Patient has Kt/V < 1.2 without a Documented Plan of Care, Reason not Specified
(Two CPT II codes [0505F-8P & 3082F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II codes **0505F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0505F *with* 8P:** Hemodialysis plan of care not documented, reason not otherwise specified

AND
CPT II 3082F: Kt/V < 1.2 (Clearance of urea (Kt)/volume(V))

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

CHRONIC KIDNEY DISEASE (CKD) MEASURES GROUP OVERVIEW

2008 PQRI MEASURES IN THE CKD MEASURES GROUP:

#120. ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD
#121. Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
#122. Chronic Kidney Disease (CKD): Blood Pressure Management
#123. Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)

INSTRUCTIONS FOR REPORTING:

- Indicate your intention to report the CKD Measures Group by submitting the measures group-specific G-code on a patient claim. It is not necessary to submit the measures group-specific G-code on more than one claim.

  G8487: I intend to report the Chronic Kidney Disease (CKD) measure grouping

- Select patient sample method:
  Consecutive Patient Sample Method: 15 consecutive patients meeting patient sample criteria for the measures group. Counting will begin with eligible patients seen on or after the service date indicated on the claim containing G8487.
  OR
  80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (July 1 through December 31, 2008).

- Patient sample criteria for the CKD Measures Group are found on claims for patients aged 18 years and older containing a specific diagnosis of CKD accompanied by a specific patient encounter:

  one of the following diagnosis codes indicating CKD: 585.4, 585.5

  accompanied by

  one of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

- Report quality-data codes on **all applicable** measures within the CKD Measures Group for the patient sample. Report measures #122 and #123 a minimum of once during the month the patient is included in the sample population.

- Measure #120 need only be reported when the patient also has diagnosis codes for hypertension and proteinuria. Therefore, this measure is only applicable to a patient who not only has CKD but also has hypertension and proteinuria. These codes are defined as:

  one of the following diagnosis codes indicating hypertension: 401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93

  accompanied by

  diagnosis code indicating proteinuria: 791.0

- Instructions for quality-data code reporting for each of the measures within the CKD Measures Group are displayed on the next several pages.

- Successful reporting of the CKD Measures Group requires **all applicable** measures for each patient within the sample to be reported a minimum of once during the reporting period.
- When using the 15 Consecutive Patient Sample Method, report each measure for 15 consecutive patients seen beginning with those patients meeting sample criteria on the date G8487 is submitted. When using the 80% Patient Sample Method, report each measure on at least 80% of the patient sample.
- The provider remittance advice will show a denial code for the claim containing G8487 as well as the claims containing quality-data codes. This denial code (N365) indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific G-code.

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #120: ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of advanced chronic kidney disease (CKD) (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), and hypertension and proteinuria who were prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy during the 12-month reporting period

NUMERATOR:

Patients who were prescribed ACE inhibitor or ARB therapy during the 12 month reporting period

Numerator Coding:

ACE Inhibitor or ARB Therapy Prescribed

G8479: Clinician prescribed angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

OR

ACE Inhibitor or ARB Therapy not Prescribed for Documented Reasons

G8480: Clinician documented that patient was not an eligible candidate for angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

OR

ACE Inhibitor or ARB Therapy not Prescribed, Reason not Specified

G8481: Clinician did not prescribe angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy, reason not specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #121: Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), who had the following laboratory testing ordered at least once during the 12-month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile

NUMERATOR:

Patients who had the following laboratory testing ordered at least once during the 12 month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile

Numerator Coding:

Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile Ordered

CPT II 3278F: Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile ordered

OR

Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile not Ordered for Medical or Patient Reasons

Append a modifier (**1P or 2P**) to CPT Category II code **3278F** to report documented circumstances that appropriately exclude patients from the denominator

- **1P:** Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile
- **2P:** Documentation of patient reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile

OR

Serum Levels of Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile not Ordered, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3278F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile not ordered, reason not otherwise specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #122: Chronic Kidney Disease (CKD): Blood Pressure Management

DESCRIPTION:
Percentage of patient visits for patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), with a blood pressure < 130/80 mmHg OR blood pressure ≥ 130/80 mmHg with a documented plan of care

MEASURES GROUPS REPORTING INSTRUCTIONS:
Report this measure one time per patient during the reporting month that brings the patient into the CKD measures group sample population.

NUMERATOR:
Patients visits with blood pressure <130/80 mmHg OR ≥130/80 mmHg with a documented plan of care

Definition: A documented plan of care should include one or more of the following: recheck blood pressure at specified future date; initiate or alter pharmacologic therapy; initiate or alter non-pharmacologic therapy; documented review of patient's home blood pressure log which indicates that patient's blood pressure is or is not well controlled.

Numerator Instructions: If multiple blood pressure measurements are taken at a single visit, use the most recent measurement taken at that visit.

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

Numerator Coding:
Patient Visits with Blood Pressure < 130/80 mmHg
(One G-code [G8476] is required on the claim form to submit this category)

G8476: Most recent blood pressure has a systolic measurement of <130 mmHg and a diastolic measurement of <80 mmHg

OR
Blood Pressure Plan of Care Documented for Patient Visits with Systolic Blood Pressure ≥ 130 mmHG and/or Diastolic Blood Pressure ≥ 80 mmHg (If either systolic blood pressure is ≥ 130 mmHg OR diastolic blood pressure is ≥ 80 mmHg, patient requires a plan of care)
(One G-code & one CPT II code [G8477 & 0513F] are required on the claim form to submit this category)

G8477: Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥80 mmHg
AND
CPT II 0513F: Elevated blood pressure plan of care documented

OR

Blood Pressure Measurement not Performed

(One G-code [G8478] is required on the claim form to submit this category)

G8478: Blood pressure measurement not performed or documented, reason not specified

OR

Elevated Blood Pressure Plan of Care not Documented for Patient Visits with Systolic Blood Pressure ≥ 130 mmHg and/or Diastolic Blood Pressure ≥ 80 mmHg, Reason not Specified
(One CPT II code & one G-code [0513F-8P & G8477] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **0513F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0513F** *with* **8P:** No documentation of elevated blood pressure plan of care, reason not otherwise specified

AND
G8477: Most recent blood pressure has a systolic measurement of ≥130 mmHg and/or a diastolic measurement of ≥80 mmHg

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #123: Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

DESCRIPTION:
Percentage of patient calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), receiving ESA therapy, have a hemoglobin < 13 g/dL OR patients whose hemoglobin is ≥ 13 g/dL and have a documented plan of care

MEASURES GROUPS REPORTING INSTRUCTIONS:
Report this measure one time per patient during the reporting month that brings the patient into the CKD measures group sample population.

NUMERATOR:
Number of patient calendar months during which patients with a hemoglobin level of < 13 g/dL OR patients whose hemoglobin level is ≥ 13 g/dL have a documented plan of care

Definition: A documented plan of care should include reducing the ESA dose and repeating hemoglobin at a specified future date.

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

Numerator Coding:
Hemoglobin level < 13 g/dL
(Two CPT II codes [328xF & 4171F] are required on the claim form to submit this category)

CPT II 3281F: Hemoglobin level less than 11 g/dL
OR
CPT II 3280F: Hemoglobin level 11 g/dL to 12.9 g/dL

AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

OR

Hemoglobin level ≥ 13 g/dL with a Documented Plan of Care
(Three CPT II codes [3279F & 0514F & 4171F] are required on the claim form to submit this category)

CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL
AND
CPT II 0514F: Plan of care for elevated hemoglobin level documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

OR

If patient is not eligible for this measure because, patient was not receiving erythropoiesis-stimulating agent (ESA) therapy, report:
(One CPT II code [4172F] is required on the claim form to submit this category)

CPT II 4172F: Patient not receiving Erythropoiesis-Stimulating Agent (ESA) therapy

OR

Hemoglobin Level Measurement not Performed
(Two CPT II codes [3281F-8P & 4171F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **3281F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **3281F** *with* **8P:** Hemoglobin level measurement not documented, reason not otherwise specified

AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

OR

Plan of Care for Elevated Hemoglobin Level not Documented for Patient Receiving Erythropoiesis-Stimulating Agent (ESA) Therapy, Reason not Specified
(Three CPT II codes [0514F-8P & 3279F & 4171F] are required on the claim form to submit this category)

Append a reporting modifier (**8P**) to CPT Category II code **0514F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0514F** *with* **8P:** Plan of care for elevated hemoglobin level not documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy, reason not otherwise specified

AND
CPT II 3279F: Hemoglobin level greater than or equal to 13 g/dL
AND
CPT II 4171F: Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

PREVENTIVE CARE MEASURES GROUP OVERVIEW

2008 PQRI MEASURES IN THE PREVENTIVE CARE MEASURES GROUP:

#39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
#48. Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
#110. Influenza Vaccination for Patients ≥ 50 Years Old
#111. Pneumonia Vaccination for Patients 65 years and Older
#112. Screening Mammography
#113. Colorectal Cancer Screening
#114. Inquiry Regarding Tobacco Use
#115. Advising Smokers to Quit
#128. Universal Weight Screening and Follow-Up

INSTRUCTIONS FOR REPORTING:

- Indicate your intention to report the Preventive Care Measures Group by submitting the measures group-specific G-code on a patient claim. It is not necessary to submit the measures group-specific G-code on more than one claim.

  G8486: I intend to report the Preventive Care measure grouping

- Select patient sample method:
  Consecutive Patient Sample Method: 15 consecutive patients meeting patient sample criteria for the measures group. Counting will begin with eligible patients seen on or after the service date indicated on the claim containing G8486.
  OR
  80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (July 1 through December 31, 2008).

- Patient sample criteria for the Preventive Care Measures Group are found on claims for patients aged 50 years and older containing a specific patient encounter:

  one of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

- Report quality-data codes on **all applicable** measures within the Preventive Care Measures Group for the patient sample.

- Applicable measures contain patient demographic criteria specific to the measure. For example, Screening or Therapy for Osteoporosis is applicable to *women aged 65 years and older* within the sample population, while the Influenza Vaccination measure within this group is applicable to *all patients* aged 50 years and older. Eligible professionals may find it more efficient to report all measures in the group for each patient within their sample. Reporting measure(s) from the group that are inapplicable to an individual patient will not affect the eligible provider's reporting or performance rate.

- Instructions for quality-data code reporting for each of the measures within the Preventive Care Measures Group are displayed on the next several pages.

- Successful reporting of the Preventive Care Measures Group requires **all applicable** measures for each patient within the sample to be reported a minimum of once during the reporting period.

- When using the 15 Consecutive Patient Sample Method, report each measure for 15 consecutive patients seen beginning with those patients meeting sample criteria on the date G8486 is submitted. When using the 80% Patient Sample Method, report each measure on at least 80% of the patient sample.
- The provider remittance advice will show a denial code for the claim containing G8486 as well as the claims containing quality-data codes. This denial code (N365) indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of a measures group-specific G-code.

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

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

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

NUMERATOR:

Patients who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

Definitions:

- 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.

Numerator Coding:

Central DXA Measurement Ordered or Performed or Pharmacologic Therapy Prescribed

G8399: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed for Documented Reasons

G8401: Clinician documented that patient was not an eligible candidate for screening or therapy for osteoporosis for women measure

OR

Central DXA Measurement not Ordered or Performed or Pharmacologic Therapy not Prescribed, Reason not Specified

G8400: Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented or not ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

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

DESCRIPTION:
Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

NUMERATOR:
Patients who were assessed for the presence or absence of urinary incontinence within 12 months

Definition: Urinary incontinence is defined as any involuntary leakage of urine.

Numerator Coding:
Presence or Absence of Urinary Incontinence Assessed
CPT II 1090F: Presence or absence of urinary incontinence assessed

OR

Presence or Absence of Urinary Incontinence not Assessed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **1090F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence

OR

Presence or Absence of Urinary Incontinence not Assessed, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **1090F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Presence or absence of urinary incontinence not assessed, reason not otherwise specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #110: Influenza Vaccination for Patients ≥ 50 Years Old

DESCRIPTION:

Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February)

NUMERATOR:

Patients who received an influenza immunization during the flu season (September through February)

Numerator Coding:

Influenza Immunization Administered

G8482: Influenza immunization was ordered or administered

OR

Influenza Immunization not Administered for Documented Reasons

G8483: Influenza immunization was not ordered or administered for reasons documented by clinician

OR

Influenza Immunization not Administered, Reason not Specified

G8484: Influenza immunization was not ordered or administered, reason not specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

♦Measure #111: Pneumonia Vaccination for Patients 65 Years and Older

DESCRIPTION:
Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine

NUMERATOR:
Patients who have ever received a pneumococcal vaccination

Numerator Coding:
Pneumonia Vaccination Administered or Previously Received
CPT II 4040F: Pneumococcal vaccine administered or previously received

OR

Pneumonia Vaccination not Administered or Previously Received for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **4040F** to report documented circumstances that appropriately exclude patients from the denominator.

- **1P:** Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccination

OR

Pneumonia Vaccination not Administered or Previously Received, Reason not Specified
Append a reporting modifier (**8P**) to CPT Category II code **4040F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Pneumococcal vaccine was not administered or previously received, reason not otherwise specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

Measure #112: Screening Mammography

DESCRIPTION:

Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months

NUMERATOR:

Patients who had a mammogram at least once within 24 months

Numerator Coding:

Mammogram Performed

CPT II 3014F: Screening mammography results documented and reviewed

OR

Mammogram not Performed for Medical Reasons

Append a modifier (**1P**) to the above CPT Category II code **3014F** to report documented circumstances that appropriately exclude patients from the denominator

- **1P:** Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies).

OR

Mammogram not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3014F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Screening mammography results were not documented and reviewed, reason not otherwise specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

♦Measure #113: Colorectal Cancer Screening

DESCRIPTION:
Percentage of patients aged 50 through 80 years who received the appropriate colorectal cancer screening

NUMERATOR:
Patients who had at least one or more screenings for colorectal cancer during or prior to the reporting period

Numerator Instructions: Patients are considered to have appropriate screening for colorectal cancer if any of the following are documented:

- Fecal occult blood test (FOBT) during the reporting period
- Flexible sigmoidoscopy during the reporting period or the four years prior to the
- reporting period
- Double contrast barium enema (DCBE) or air contrast barium enema during the reporting period or the four years prior to the reporting period
- Colonoscopy during the reporting period or the nine years prior to the reporting period

Numerator Coding:

Colorectal Cancer Screening

CPT II 3017F: Colorectal cancer screening results documented and reviewed

OR

Colorectal Cancer Screening not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **3017F** to report documented circumstances that appropriately exclude patients from the denominator

- **1P:** Documentation of medical reason(s) for not performing a colorectal cancer screening

OR

Colorectal Cancer Screening not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3017F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **8P:** Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

▲Measure #114: Inquiry Regarding Tobacco Use

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

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

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

Numerator Coding:
Tobacco Use Assessed
(Two CPT II codes [1000F & 10xxF] are required on the claim form to submit this category)

CPT II 1000F: Tobacco use assessed
AND

CPT II 1034F: Current tobacco smoker
OR
CPT II 1035F: Current smokeless tobacco user
OR
CPT II 1036F: Current tobacco non-user

OR

Tobacco Use not Assessed, Reason not Specified
(One CPT II code [1000F-8P] is required on the claim form to submit this category)

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

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

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

♦Measure #115: Advising Smokers to Quit

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

NUMERATOR:
Patients who received advice to quit smoking

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

Numerator Coding:
Identify Tobacco Smokers Receiving Cessation Intervention
(Two G-codes [G8455 & G8402] are required on the claim form to submit this category)

G8455: Current tobacco smoker
AND
G8402: Tobacco (smoke) use cessation intervention, counseling

OR

If patient is not eligible for this measure because patient is a smokeless tobacco user or a non tobacco user, report:
(One G-code [G84xx] is required on the claim form to submit this category)

Smokeless Tobacco User
G8456: Current smokeless tobacco user
OR
Tobacco Non-User
G8457: Tobacco non-user

OR

Tobacco Smokers not Advised to Quit, Reason not Specified
(Two G-codes [G8455 & G8403] are required on the claim form to submit this category)

G8455: Current tobacco smoker
AND
G8403: Tobacco (smoke) use cessation intervention not counseled

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

♠Measure #128: Universal Weight Screening and Follow-Up

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

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

Definitions:
BMI – Body Mass Index (BMI) is a number calculated from a person's weight and height. BMI provides a reliable indicator of body fatness for most people and is used to screen for weight categories that may lead to health problems. BMI is calculated by dividing a person's weight (in kilograms) by his/her height (in meters, squared). BMI can also be calculated by multiplying weight (in pounds) by 705, then dividing by height (in inches) twice. A simpler method to calculate the BMI involves the use of a chart. The weight is plotted on one axis and the height is plotted on the other axis. The BMI can then be read where the two points intersect. Example BMI charts are widely available via the internet.
Calculated BMI – Requires that both the height and weight are actually measured. Values merely reported by the patient cannot be used.
Follow-up plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education, referral, prescription/administration of medications/dietary supplements, etc.
Not eligible for BMI measurement – Patients can be considered not eligible in the following situations:

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

Numerator Coding:
BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented
G8420: BMI < 30 AND ≥ 22 was calculated and documented
OR
G8417: BMI ≥ 30 was calculated and a follow-up plan was documented in the medical record
OR
G8418: BMI < 22 was calculated and a follow-up plan was documented in the medical record

OR

Patient not Eligible for BMI Calculation for Documented Reasons

G8422: Patient not eligible for BMI calculation

OR

BMI not Performed and/or Calculated BMI ≥ 30 or < 22, Follow-up Plan not Documented, Reason not Specified
G8421: BMI not calculated
OR
G8419: BMI ≥ 30 OR < 22 was calculated, but no follow-up plan documented in the medical record

NOTE: The detailed instructions in this handbook apply exclusively to the reporting and analysis of the included measures under the claims-based measures groups option. For all other claims-based reporting options, please see the measures' full specifications in the document "2008 PQRI Measures Specifications" available for download from the CMS PQRI website.

Symbol and Copyright Information

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

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