

2011 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups Specifications

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2011 Physician Quality Reporting System (Physician Quality Reporting) Measures Groups Specifications Manual

This manual contains specific guidance for reporting 2011 Physician Quality Reporting System Measures Groups ("Physician Quality Reporting," formerly known as Physician Quality Reporting Initiative or PQRI). Measures Groups are a subset of four or more Physician Quality Reporting measures that have a particular clinical condition or focus in common. Only those measures groups defined in this document can be utilized when reporting the measures group options. All other individual measures that are included in Physician Quality Reporting but not defined in this manual as included in a measures group cannot be grouped together to define a measures group.

14 measures groups have been established for 2011 Physician Quality Reporting: Diabetes Mellitus, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Bypass Graft (CABG), Rheumatoid Arthritis (RA), Perioperative Care, Back Pain, Hepatitis C, Heart Failure (HF), Coronary Artery Disease (CAD), Ischemic Vascular Disease (IVD), HIV/AIDS, Community-Acquired Pneumonia (CAP), and Asthma. These 14 groups, combined, include measures established for use in the 2011 Physician Quality Reporting, as required by applicable statutes, through formal notice-and-comment rulemaking in 2010. An eligible professional may choose to report one or more measures groups through claims-based and/or registry-based submission. Note that denominator coding has been modified from the original individual measures specified by the measure developer to allow for implementation in Physician Quality Reporting as a measures group. An overview for each measures group is included in this manual followed by specific reporting instructions for each measure within the group.

There are two reporting periods available for eligible professionals to report 2011 Physician Quality Reporting measures groups: a) 12-month reporting period from January 1 through December 31, 2011 (available for the 30 Patient Sample Method, the 50% Patient Sample Method via Claims, and the 80% Patient Sample Method via Registry) **OR** b) a 6-month reporting period from July 1 through December 31, 2011 (available only for the 50% Patient Sample Method via Claims and the 80% Patient Sample Method via Registry). The 6-month reporting period allows those eligible professionals who may have decided to participate later in the year to begin reporting. Those eligible professionals who satisfactorily report quality data under the measures groups reporting option may earn an incentive payment equal to 1.0% of their total estimated allowed charges for Medicare Part B Physician Fee Schedule (PFS) covered professional services furnished during the applicable reporting period.

Please note, eligible professionals may choose to pursue more than one 2011 Physician Quality Reporting option. However, an eligible professional who satisfactorily reports under more than one reporting option will earn a maximum of one incentive payment equal to 1.0% of their total estimated allowed charges for Medicare Part B PFS covered professional services furnished during the longest reporting period for which he or she satisfied reporting requirements. This manual describes how to implement 2011 reporting of Physician Quality Reporting measures groups to facilitate satisfactory reporting of quality-data by eligible professionals who wish to participate under this reporting alternative. Additional information describing how to implement 2011 measures groups can be found in the *Getting Started with 2011 Physician Quality Reporting of Measures Groups* and *Physician Quality Reporting Made Simple - Reporting the Preventive Care Measures Group* at: http://www.cms.gov/PQRS/30_EducationalResources.asp.

Measures Group Reporting via Claims and Registry:

The Diabetes Mellitus, CKD, Preventive Care, RA, Perioperative Care, Back Pain, Hepatitis C, IVD, CAP and Asthma measures groups can be submitted through claims or a qualified registry. To select a measures group reporting option via claims, the first step requires that eligible professionals identify their intent to report a measures group by submitting a measures group-specific intent G-code on a claim for covered professional

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services furnished to a patient enrolled in Medicare Part B PFS. The submission of the intent G-code serves as the indication that an eligible professional is choosing to report on a measures group and will initiate measures group analysis. It is not necessary to submit the measures group-specific intent 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 Physician Quality Reporting analyses; subsequent submissions of that code will be ignored.

- G8485: I intend to report the Diabetes Mellitus Measures Group
- G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group
- G8486: I intend to report the Preventive Care Measures Group
- G8490: I intend to report the Rheumatoid Arthritis Measures Group
- G8492: I intend to report the Perioperative Care Measures Group
- G8493: I intend to report the Back Pain Measures Group
- G8545: I intend to report the Hepatitis C Measures Group
- G8547: I intend to report the Ischemic Vascular Disease (IVD) Measures Group
- G8546: I intend to report the Community-Acquired Pneumonia (CAP) Measures Group
- G8645: I intend to report the Asthma Measures Group

Measures Group Reporting via Registry-only:

The CABG, HF, CAD and HIV/AIDS measures groups can only be submitted through a qualified registry. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group specific intent G-codes have been created for registry only measures groups for use by registries that utilize claims data.

- G8544: I intend to report the Coronary Artery Bypass Graft (CABG) Measures Group
- G8548: I intend to report the Heart Failure (HF) Measures Group
- G8489: I intend to report the Coronary Artery Disease (CAD) Measures Group
- G8491: I intend to report the HIV/AIDS Measures Group

Measures Groups Reporting Methods:

There are two reporting methods for submission of measures groups:

1) 30 Patient Sample Method – 12-month reporting period only:

- For **claims-based** and **registry-based** submissions, a participating eligible professional must report on all applicable measures within the selected measures group when billing measure-eligible claims for a minimum sample of 30 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group (include Medicare Secondary Payer claims and claims for Railroad Retirement beneficiaries; exclude Medicare Advantage beneficiaries). If the eligible professional does not have a minimum of 30 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group, the eligible professional will need to choose another measures group or choose another reporting option. Please refer to the *Getting Started with 2011 Physician Quality Reporting of Measures Groups* to determine the proper reporting option.
 - For **claims-based** submissions, the measures group-specific intent G-code must be submitted once during the reporting period to indicate the eligible professional's selection of the measures group.
- For both claims-based and registry-based submissions, all the applicable measures within the group must be reported during the reporting period (January 1 through December 31, 2011),

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according to each measures group's reporting instructions contained within each group's overview section.

OR

2) 50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry – 12-month and 6-month reporting periods available:

- For claims-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group on claims for at least 50% of all Medicare Part B FFS patients seen during the entire reporting period (January 1 through December 31, 2011 OR July 1 through December 31, 2011) who meet the measures group patient sample criteria.
 - For **claims-based** submissions, the eligible professional must report the measures group-specific intent G-code once during the reporting period to indicate the eligible professional's selection of the measures group that the eligible professional intends to report.
- For registry-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group for at least 80% of all Medicare Part B FFS patients seen during the entire reporting period (January 1 through December 31, 2011 OR July 1 through December 31, 2011) who meet the measures group patient sample criteria.
- Minimum Patient Sample Size
 - For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. If an eligible professional does not have the minimum number of patients for inclusion in the patient sample for the reporting period that eligible professional should report either another measures group or select reporting of individual measures that are applicable to the eligible professional's practice. If the minimum number of patients does not meet the measures group patient sample criteria, the eligible professional is not incentive eligible.
- For both claims-based and registry-based submissions, all applicable measures within the group must be reported according to each measures group's reporting instructions contained within each group's overview section.

The patient sample for the 30 Patient Sample Method, the 50% Patient Sample Method via claims and the 80% Patient Sample Method via registry are determined by diagnosis and/or specific 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 (eg, age or gender) required in accordance with this manual. For example, if an eligible professional is reporting on the Preventive Care Measures Group, the *Screening or Therapy for Osteoporosis* measure would only need to be reported on women within the eligible professional's patient sample.

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DIABETES MELLITUS MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN DIABETES MELLITUS MEASURES GROUP:

- #1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
- #2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
- #3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
- #117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- #119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
- #163. Diabetes Mellitus: Foot Exam

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Diabetes Mellitus Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8485: I intend to report the Diabetes Mellitus Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily.
- Patient sample criteria for the Diabetes Mellitus Measures Group are patients aged 18 through 75 years with 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, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

Accompanied by

One of the following patient encounter codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309,

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99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

- Report quality-data codes (QDCs) on **all** measures within the Diabetes Mellitus Measures Group for each patient within the 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. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. Please note that Measure #1 (Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus) is a poor control or inverse measure, therefore, the **composite G-code should only be reported** when the patient's **Most Recent Hemoglobin A1c Level \leq 9.0%** and all of the other quality actions for this measures group have been performed. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8494: All quality actions for the applicable measures in the Diabetes Mellitus Measures Group have been performed for this patient

- To report satisfactorily the Diabetes Mellitus Measures Group requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8485 (and G8494 if reported) as well as all other line items containing QDCs. N365 indicates 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

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◆ Measure #1: Diabetes Mellitus: Hemoglobin A1c Poor Control in 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: For performance, a lower rate indicates better performance/control.

NUMERATOR NOTE: *The performance period for this measure is 12 months.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Hemoglobin A1c Level > 9.0%

CPT II 3046F: Most recent hemoglobin A1c level > 9.0%

OR

Hemoglobin A1c not Performed

Append a reporting modifier (**8P**) to CPT Category II code **3046F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3046F with 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 specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

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◆ Measure #2: Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in 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 NOTE: The performance period for this measure is 12 months.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent LDL-C Level < 100 mg/dL

CPT II 3048F: Most recent LDL-C < 100 mg/dL

OR

Most Recent LDL-C Level \geq 100 mg/dL

CPT II 3049F: Most recent LDL-C 100-129 mg/dL

OR

CPT II 3050F: Most recent LDL-C \geq 130 mg/dL

OR

LDL-C Level not Performed

Append a reporting modifier (**8P**) to CPT Category II code **3048F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3048F with 8P: LDL-C was not performed during the performance period (12 months)

*Note: If unable to calculate LDL-C due to high triglycerides, CPT Category II code **3048F with 8P** should be reported*

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

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◆ Measure #3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg)

NUMERATOR:

Patients whose most recent blood pressure < 140/90 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 NOTE: *The performance period for this measure is 12 months.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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 ≥ 140 mmHg

AND

Diastolic code (Select one (1) code from this section):

CPT II 3078F: Most recent diastolic blood pressure < 80 mmHg

OR

CPT II 3079F: Most recent diastolic blood pressure 80 - 89 mmHg

OR

CPT II 3080F: Most recent diastolic blood pressure ≥ 90 mmHg

OR

Blood Pressure Measurement not Performed

Append a reporting modifier (**8P**) to CPT Category II code **2000F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2000F with 8P: No documentation of blood pressure measurement

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

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◆ Measure #117: Diabetes Mellitus: 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 measure 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 Quality-Data Coding Options for Reporting Satisfactorily:

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.

2022F or **2024F** or **2026F** **with 8P:** Dilated eye exam was not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of patients aged 18 through 75 years 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 Quality-Data Coding Options for Reporting Satisfactorily:

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

G8506: Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy

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.

3060F or 3061F or 3062F with 8P: Nephropathy screening was not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #163: Diabetes Mellitus: Foot Exam

DESCRIPTION:

The percentage of patients aged 18 through 75 years with diabetes who had a foot examination

NUMERATOR:

Patients who received a foot exam (visual inspection, sensory exam with monofilament, or pulse exam)

NUMERATOR NOTE: Patients who received a foot exam at least once within the prior 12 months.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Foot Exam Performed

CPT II 2028F: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when any of the three components are completed)

OR

Foot Exam not Performed for Medical Reason

Append a modifier (**1P**) to CPT Category II code **2028F** to report documented circumstances that appropriately exclude patients from the denominator.

2028F with 1P: Documentation of medical reason for not performing foot exam (i.e., patient with bilateral foot/leg amputation)

OR

Foot Exam not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2028F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2028F with 8P: Foot exam was not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

CHRONIC KIDNEY DISEASE (CKD) MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN THE CHRONIC KIDNEY DISEASE (CKD) MEASURES GROUP:

- #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)
- #153. Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the CKD Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily.

- Patient sample criteria for the CKD Measures Group are patients aged 18 years and older with 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

- Report quality-data codes on **all** measures within the CKD Measures Group for each patient within the eligible professional's patient sample. Report measures #122 and #123 once during the month the patient is included in the patient sample population. For these measures, subsequent months do not need to be reported.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- Instructions for quality-data code reporting for each of the measures within the CKD Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8495: All quality actions for the applicable measures in the CKD Measures Group have been performed for this patient

- To report satisfactorily the CKD Measures Group requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8487 (and G8495 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ 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 within 12 months: 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 Quality-Data Coding Options for Reporting Satisfactorily:

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

3278F with 1P: Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile

3278F with 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.

3278F with 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 specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ 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

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

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Visits with Blood Pressure < 130/80 mmHg

(One G-code [G8476] is required on the claim form to submit this numerator option)

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 numerator option)

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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Blood Pressure Measurement not Performed, Reason not Specified

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

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 \geq 130 mmHg and/or Diastolic Blood Pressure \geq 80 mmHg, Reason not Specified

(One CPT II code & one G-code [0513F-8P & G8477] are required on the claim form to submit this numerator option)

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 \geq 130 mmHg and/or a diastolic measurement of \geq 80 mmHg

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of 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 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

Definitions:

Documented Plan of Care – Should include reducing the ESA dose and repeating hemoglobin at a specified future date.

Erythropoiesis Stimulating Agents (ESA) – includes epoetin or darbepoetin

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hemoglobin level < 13 g/dL

(Two CPT II codes [3281F & 4171F] are required on the claim form to submit this numerator option)

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 Agents (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 numerator option)

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 Agents (ESA) therapy

OR

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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 numerator option)
CPT II 4172F: Patient not receiving Erythropoiesis-Stimulating Agents (ESA) therapy

OR

Hemoglobin Level Measurement not Performed, Reason not Specified
(Two CPT II codes [3281F-8P & 4171F] are required on the claim form to submit this numerator option)
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 Agents (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 numerator option)
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 Agents (ESA) therapy

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #153: Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula

DESCRIPTION:

Percentage of patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), who were referred for AV fistula at least once during the 12-month reporting period

NUMERATOR:

Patients who were referred for AV fistula at least once during the 12 month reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

AV Fistula Referred

CPT II 4051F: Referred for an arteriovenous (AV) fistula

OR

AV Fistula not Referred for Medical or Patient Reasons

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

OR

AV Fistula not Referred, Reason not Specified

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

4051F with 8P: AV fistula not referred, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

PREVENTIVE CARE MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN THE PREVENTIVE CARE MEASURES GROUP:

- # 39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- # 48. Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- #110. Preventive Care and Screening: Influenza Immunization for Patients \geq 50 Years Old
- #111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older
- #112. Preventive Care and Screening: Screening Mammography
- #113. Preventive Care and Screening: Colorectal Cancer Screening
- #128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- #173. Preventive Care and Screening: Unhealthy Alcohol Use – Screening
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Preventive Care Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8486: I intend to report the Preventive Care Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2008). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the Preventive Care Measures Group are for patients aged 50 years and older with 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 each patient within the eligible professional's 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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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.

Preventive Measures Group Demographic Criteria		
Age	Measures for Male Patients	Measures for Female Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 128, 173, 226	110, 112, 113, 128, 173, 226
65-69 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 112, 113, 128, 173, 226
70-75 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 113, 128, 173, 226
≥76 years	110, 111, 128, 173, 226	39, 48, 110, 111, 128, 173, 226

- Instructions for quality-data code reporting for each of the measures within the Preventive Care Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8496: All quality actions for the applicable measures in the Preventive Care Measures Group have been performed for this patient

- To report satisfactorily the Preventive Care Measures Group, it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all applicable measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8486 (and G8496 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QCD was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

***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 modulators 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 Quality-Data Coding Options for Reporting Satisfactorily:

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 specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

***Measure #48: Urinary Incontinence: 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 – Any involuntary leakage of urine.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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.

1090F with 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.

1090F with 8P: Presence or absence of urinary incontinence not assessed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #110: Preventive Care and Screening: Influenza Immunization 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 Instructions:

- If reporting this measure between January 1, 2011 and August 31, 2011, G-code G8482 should be reported when the influenza vaccination is ordered or administered to the patient during the months of September, October, November, December of 2010 or January and February of 2011 for the flu season ending February 28, 2011.
- If reporting this measure between September 1, 2011 and December 31, 2011, G-code G8482 should be reported when the influenza vaccination is ordered or administered to the patient during the months of September, October, November, and December of 2011 for the flu season ending February 28, 2012.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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 specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #111: Preventive Care and Screening: 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 Quality-Data Coding Options for Reporting Satisfactorily:

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.

4040F with 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.

4040F with 8P: Pneumococcal vaccine was not administered or previously received, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #112: Preventive Care and Screening: 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 Quality-Data Coding Options for Reporting Satisfactorily:

Mammogram Performed

CPT II 3014F: Screening mammography results documented and reviewed

OR

Mammogram not Performed for Medical Reasons

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

3014F with 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.

3014F with 8P: Screening mammography results were not documented and reviewed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #113: Preventive Care and Screening: Colorectal Cancer Screening

DESCRIPTION:

Percentage of patients aged 50 through 75 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) within the last 12 months
- Flexible sigmoidoscopy 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 Quality-Data Coding Options for Reporting Satisfactorily:

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

3017F with 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.

3017F with 8P: Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

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

DESCRIPTION:

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

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

NUMERATOR:

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

Definitions:

BMI – Body mass index (BMI), expressed as weight/height (BMI; kg/m²), is commonly used to classify overweight (BMI 25.0-29.9), obesity (BMI greater than or equal to 30.0) and extreme obesity (BMI greater than or equal to 40) among adults (CDC). BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared. The National Institutes of Health (NIH) provides a BMI calculator table at www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm. (AHRQ Preventive Guidelines 2009)

Elderly BMI – Most experts suggest use of a higher BMI threshold for underweight elderly individuals, compared to what is used for the general population (Chernoff, Cook, Mahan). *International Dietetics and Nutrition Terminology* defines underweight in persons >65 years of age as a BMI of < 23 . This BMI value is one indicator of malnutrition when forming a nutrition diagnosis for the elderly population (American Dietetic Association). A BMI of < 23 classifies an older adult (older than age 65) as underweight and may require nutrition intervention.

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 (such as, a registered dietician, nutritionist, occupational therapy, primary care physician, exercise physiologist, mental health professional, surgeon, etc.), prescription/administration of medications/dietary supplements, etc.

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

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness – life expectancy less than 6 months
- 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

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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

G8420: Calculated BMI within normal parameters and documented

OR

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

OR

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

OR

Patient not Eligible for BMI Calculation for Documented Reasons

G8422: Patient not eligible for BMI calculation

OR

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

G8421: BMI not calculated

OR

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

▲ Measure #173: Preventive Care and Screening: Unhealthy Alcohol Use – Screening

DESCRIPTION:

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

NUMERATOR:

Patients who were screened for unhealthy alcohol use using a systematic screening method within 24 months

Definition:

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Unhealthy Alcohol Use Screening Performed

CPT II 3016F: Patient screened for unhealthy alcohol use using a systematic screening method

OR

Unhealthy Alcohol Use Screening not Performed, for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **3016F** to report documented circumstances that appropriately exclude patients from the denominator.

3016F with 1P: Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy)

OR

Unhealthy Alcohol Use Screening not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3016F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3016F with 8P: Unhealthy alcohol use screening not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

NUMERATOR:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:

Tobacco Use – Includes any type of tobacco

Cessation Counseling Intervention – Includes counseling or pharmacotherapy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user

OR

Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator

4004F with 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

OR

Tobacco Screening not Performed Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4004F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4004F with 8P: Tobacco Screening not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

CORONARY ARTERY BYPASS GRAFT (CABG) MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN CORONARY ARTERY BYPASS GRAFT (CABG) MEASURES GROUP:

- #43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery
- #44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
- #164. Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)
- #165. Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate
- #166. Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)
- #167. Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency
- #168. Coronary Artery Bypass Graft (CABG): Surgical Re-exploration
- #169. Coronary Artery Bypass Graft (CABG): Anti-platelet Medications at Discharge
- #170. Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge
- #171. Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling

INSTRUCTIONS FOR REPORTING: (These instructions apply to registry reporting. Do not report this measures group via claims.)

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

G8544: I intend to report the Coronary Artery Bypass Graft (CABG) Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) procedures (patients) meeting patient sample criteria for the measures group.

OR

80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the CABG Measures Group are patients aged 18 years and older that have a specific procedure for isolated CABG performed:

One of the following procedure codes indicating CABG: 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536

- Measure #166 need only be reported when the patient does not have a history of a prior CVA. Measure #167 need only be reported when the patient does not have a history renal insufficiency or a baseline serum creatinine > 2.0. Measure #169, #170, and #171 need only be reported when the patient is not deceased prior to discharge. Therefore, these measures are only applicable to a patient when these additional criteria are indicated.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- Report a numerator option on **all applicable** measures within the CABG Measures Group for each procedure (patient) within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the CABG Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8497: All quality actions for the applicable measures in the Coronary Artery Bypass Graft (CABG) Measures Group have been performed for this patient

- To report satisfactorily the CABG Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported each time an isolated CABG procedure is performed during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS procedures performed (patients seen) during the reporting period. When using the 80% Patient Sample Method, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery using an IMA graft

NUMERATOR:

Patients who received an IMA graft in isolated CABG

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

IMA Graft Performed

CPT II 4110F: Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure

OR

IMA Graft not Performed for Medical Reasons

Append a modifier (1P) to the CPT Category II code 4110F to report documented circumstances that appropriately exclude patients from the denominator.

4110F *with* 1P: Documentation of medical reason(s) for not performing an internal mammary artery graft for primary, isolated coronary artery bypass graft procedure

OR

IMA Graft not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4110F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4110F *with* 8P: Internal mammary artery graft not performed for primary, isolated coronary artery bypass graft procedure, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who received a beta-blocker within 24 hours prior to surgical incision

NUMERATOR:

Patients undergoing isolated CABG who received a beta-blocker within 24 hours prior to surgical incision

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Preoperative Beta-blocker Received

CPT II 4115F: Beta blocker administered within 24 hours prior to surgical incision

OR

Preoperative Beta-blocker not Received for Medical Reasons

Append a modifier (**1P**) to the CPT Category II code **4115F** to report documented circumstances that appropriately exclude patients from the denominator.

4115F with 1P: Documentation of medical reason(s) for not administering beta blocker within 24 hours prior to surgical incision

OR

Preoperative Beta-blocker not Received, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4115F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4115F with 8P: Beta blocker not administered within 24 hours prior to surgical incision, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #164: Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require intubation > 24 hours

NUMERATOR:

Patients undergoing isolated CABG who require intubation > 24 hours

Numerator Instructions: For performance, a lower rate indicates better performance.

Numerator Options:

Prolonged intubation (> 24 hrs) required (G8569)

OR

Prolonged intubation (> 24 hrs) not required (G8570)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #165: Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who developed deep sternal wound infection (involving muscle, bone, and/or mediastinum requiring operative intervention) within 30 days postoperatively

NUMERATOR:

Patients who developed a deep sternal wound infection within 30 days postoperatively (must have ALL of the following conditions: wound opened with excision of tissue [incision and drainage] or re-exploration of mediastinum, positive culture and treatment with antibiotics)

Numerator Instructions: For performance, a lower rate indicates better performance.

Numerator Options:

Development of deep sternal wound infection within 30 days postoperatively (G8571)

OR

No deep sternal wound infection (G8572)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #166: Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who had a stroke/CVA within 24 hours postoperatively

NUMERATOR:

Patients who have a stroke/CVA within 24 hours postoperatively

Numerator Instructions: For performance, a lower rate indicates better performance.

Numerator Options:

Stroke/CVA following isolated CABG surgery (G8573)

OR

No stroke/CVA following isolated CABG surgery (G8574)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #167: Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who develop postoperative renal insufficiency or require dialysis

NUMERATOR:

Patients who develop postop renal insufficiency or require dialysis (indicate whether the patient had acute or worsening renal insufficiency resulting in one or more of the following: 1) increase of serum creatinine to > 2.0, and 2x most recent preoperative creatinine level; 2) a new requirement for dialysis postoperatively)

Numerator Instructions: For performance, a lower rate indicates better performance.

Numerator Options:

Developed postoperative renal insufficiency or required dialysis (G8575)

OR

No postoperative renal insufficiency/dialysis not required (G8576)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Measure #168: Coronary Artery Bypass Graft (CABG): Surgical Re-exploration

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who require a return to the operating room (OR) for mediastinal bleeding/tamponade, graft occlusion (due to acute closure, thrombosis, technical or embolic origin), or other cardiac reason

NUMERATOR:

Patients who require a return to the OR for bleeding/tamponade, graft occlusion, or other cardiac reason

Numerator Instructions: For performance, a lower rate indicates better performance.

Numerator Options:

Reoperation required due to bleeding/tamponade, graft occlusion or other cardiac reason (G8577)

OR

Reoperation not required due to bleeding/tamponade, graft occlusion or other cardiac reason (G8578)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #169: Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have antiplatelet medication at discharge

NUMERATOR:

Patients who were discharged on antiplatelet medication

Numerator Options:

Antiplatelet medication at discharge (G8579)

OR

Antiplatelet medication contraindicated/not indicated (G8580)

OR

No antiplatelet medication at discharge (G8581)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #170: Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who were discharged on beta-blockers

NUMERATOR:

Patients who were discharged on beta-blockers

Numerator Options:

Beta-blocker at discharge (G8582)

OR

Beta-blocker contraindicated/not indicated (G8583)

OR

No beta-blocker at discharge (G8584)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #171: Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling

DESCRIPTION:

Percentage of patients aged 18 years and older undergoing isolated CABG surgery who have anti-lipid treatment at discharge

NUMERATOR:

Patients with an anti-lipid treatment at discharge

Numerator Options:

Anti-lipid treatment at discharge (G8585)

OR

Anti-lipid treatment contraindicated/not indicated (G8586)

OR

No anti-lipid treatment at discharge (G8587)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

RHEUMATOID (RA) ARTHRITIS MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN RHEUMATOID ARTHRITIS (RA) MEASURES GROUP:

- #108. Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy
- #176. Rheumatoid Arthritis (RA): Tuberculosis Screening
- #177. Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
- #178. Rheumatoid Arthritis (RA): Functional Status Assessment
- #179. Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
- #180. Rheumatoid Arthritis (RA): Glucocorticoid Management

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the RA Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8490: I intend to report the Rheumatoid Arthritis Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the RA Measures Group are patients aged 18 years and older with a specific diagnosis of RA accompanied by a specific patient encounter:

One of the following diagnosis codes indicating RA: 714.0, 714.1, 714.2, 714.81

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Report quality-data codes on **all** measures within the RA Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the RA Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8499: All quality actions for the applicable measures in the Rheumatoid Arthritis Measures Group have been performed for this patient

- To report satisfactorily the RA Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8490 (and G8499 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #108: Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy

DESCRIPTION:

Percentage of patients aged 18 years and older who were diagnosed with RA and were prescribed, dispensed, or administered at least one ambulatory prescription for a DMARD

NUMERATOR:

Patients who were prescribed, dispensed, or administered at least one disease modifying anti-rheumatic drug (DMARD)

Definitions:

Prescribed – May include prescription given to the patient for DMARD therapy at one or more visits in the 12-month period OR patient already taking DMARD therapy as documented in current medication list.

Biologic DMARD Therapy – Includes Adalimumab, Etanercept, Infliximab, Abatacept, Anakinra and Rituximab

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

DMARD Prescribed, Dispensed, or Administered

CPT II 4187F: Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered

OR

DMARD not Prescribed, Dispensed, or Administered for Medical Reasons

Append a modifier (1P) to CPT Category II code 4187F to report documented circumstances that appropriately exclude patients from the denominator.

4187F with 1P: Documentation of medical reason(s) for not prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy

OR

DMARD not Prescribed, Dispensed, or Administered, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4187F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4187F with 8P: Disease modifying anti-rheumatic drug therapy was not prescribed, dispensed, or administered, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

⌘ Measure #176: Rheumatoid Arthritis (RA): Tuberculosis Screening

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of RA who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)

NUMERATOR:

Patients for whom a TB screening was performed and results interpreted within six months prior to receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)

Numerator Instructions: Patients are considered to be receiving a first course of therapy using a biologic DMARD only if they have never previously been prescribed or dispensed a biologic DMARD.

Definition:

Biologic DMARD Therapy – Includes Adalimumab, Etanercept, Infliximab, Abatacept, Anakinra (Rituximab is excluded)

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Tuberculosis Screening Performed and Results Interpreted

(Two CPT II codes [3455F & 4195F] are required on the claim form to submit this numerator option)

CPT II 3455F: TB screening performed and results interpreted within six months prior to initiation of first-time biologic disease modifying anti-rheumatic drug therapy for RA

AND

CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

TB Screening not Performed or Results not Interpreted for Medical Reasons

(Two CPT II codes [3455F-1P & 4195F] are required on the claim form to submit this numerator option)

Append a modifier (**1P**) to CPT Category II code **3455F** to report documented circumstances that appropriately exclude patients from the denominator.

3455F with 1P: Documentation of medical reason for not screening for TB or interpreting results (i.e., patient positive for TB and documentation of past treatment; patient has recently completed a course of anti-TB therapy)

AND

CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

If patient does not meet denominator inclusion because biologic DMARD prescription is Rituximab or this is not the first course of biologic DMARD therapy for RA, report:

(One CPT II code [4196F] is required on the claim form to submit this numerator option)

CPT II 4196F: Patient not receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

OR

TB Screening not Performed or Results not Interpreted, Reason not Specified

(Two CPT II codes [3455F-8P & 4195F] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **3455F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3455F with 8P: TB screening not performed or results not interpreted, reason not otherwise specified

AND

CPT II 4195F: Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

⌘ Measure #177: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of RA who have an assessment and classification of disease activity within 12 months

NUMERATOR:

Patients with disease activity assessed by a standardized descriptive or numeric scale or composite index and classified into one of the following categories: low, moderate or high, at least once within 12 months

Definition:

Assessment and Classification of Disease Activity – Assesses if physicians are utilizing a standardized, systematic approach for evaluating the level of disease activity. The scales/instruments listed are examples of how to define activity level and cut-off points can differ by scale. Standardized descriptive or numeric scales and/or composite indexes could include but are not limited to: DAS28, SDAI, CDAI, RADAI, RAPID.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Disease Activity Assessed and Classified

CPT II 3470F: Rheumatoid arthritis (RA) disease activity, low

OR

CPT II 3471F: Rheumatoid arthritis (RA) disease activity, moderate

OR

CPT II 3472F: Rheumatoid arthritis (RA) disease activity, high

OR

Disease Activity not Assessed and Classified, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3470F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3470F with 8P: Disease activity not assessed and classified, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

⌘ Measure #178: Rheumatoid Arthritis (RA): Functional Status Assessment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of RA for whom a functional status assessment was performed at least once within 12 months

NUMERATOR:

Patients for whom a functional status assessment was performed at least once within 12 months

Definitions:

Functional Status Assessment – This measure assesses if physicians are using a standardized descriptive or numeric scale, standardized questionnaire, or notation of assessment of the impact of RA on patient activities of daily living. Examples of tools used to assess functional status include but are not limited to: Health Assessment Questionnaire (HAQ), Modified HAQ, HAQ-2; American College of Rheumatology's Classification of Functional Status in Rheumatoid Arthritis.

Activities of Daily Living – Could include a description of any of the following: dressing/grooming, rising from sitting, walking/running/ability to ambulate, stair climbing, reaching, gripping, shopping/running errands/house or yard work.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Functional Status Assessed

CPT II 1170F: Functional status assessed

OR

Functional Status not Assessed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 1170F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1170F *with* 8P: Functional status not assessed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

⌘ Measure #179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of RA who have an assessment and classification of disease prognosis at least once within 12 months

NUMERATOR:

Patients with at least one documented assessment and classification (good/poor) of disease prognosis utilizing clinical markers of poor prognosis at least once within 12 months

Numerator Instructions: This measure evaluates if physicians are assessing and classifying disease prognosis using a standardized, systematic approach. Disease prognosis should be classified as either poor or good.

Definitions:

Poor Prognosis – RA patients with features of poor prognosis have active disease with high tender and swollen joint counts, often have evidence of radiographic erosions, elevated levels of rheumatoid factor (RF) and/or anti-cyclic citrullinated peptide (anti-CCP) antibodies, and an elevated erythrocyte sedimentation rate, and an elevated C-reactive protein level.

Clinically Important Markers of Poor Prognosis – Classification should be based upon at a minimum the following: functional limitation (e.g., HAQ Disability Index), extraarticular disease (e.g. vasculitis, Sjorgen’s syndrome, RA lung disease, rheumatoid nodules), RF positivity, positive anti-CCP antibodies (both characterized dichotomously, per CEP recommendation), and/or bony erosions by radiography.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Disease Prognosis Assessed and Classified

CPT II 3475F: Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented

OR

CPT II 3476F: Disease prognosis for rheumatoid arthritis assessed, good prognosis documented

OR

Disease Prognosis not Assessed and Classified, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3475F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3475F with 8P: Disease prognosis for rheumatoid arthritis not assessed and classified, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures’ full specifications in the document “2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures” available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

⌘ Measure #180: Rheumatoid Arthritis (RA): Glucocorticoid Management

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of RA who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months

NUMERATOR:

Patients who have been assessed for glucocorticoid use and for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of a glucocorticoid management plan within 12 months

Definitions:

Prolonged Dose – Doses > 6 months in duration

Prednisone Equivalents – Determine using the following:

1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone

Glucocorticoid Management Plan – Includes documentation of attempt to taper steroids OR documentation of a new prescription for a non-glucocorticoid disease-modifying antirheumatic drug (DMARD) OR increase in dose of non-glucocorticoid DMARD dose for persistent RA disease activity at current or reduced dose

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Glucocorticoid Use Assessed

(One CPT II code [419xF] is required on the claim form to submit this numerator option)

CPT II 4192F: Patient not receiving glucocorticoid therapy

OR

CPT II 4193F: Patient receiving < 10 mg daily prednisone (or equivalent), or RA disease activity is worsening, or glucocorticoid use is for less than 6 months

OR

Glucocorticoid Use Assessed and Management Plan Documented

(Two CPT II codes [4194F and 0540F] are required on the claim form to submit this numerator option)

CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

AND

CPT II 0540F: Glucocorticoid Management Plan documented

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Glucocorticoid Plan not Documented for Medical Reasons

(Two CPT II codes [0540F-1P and 4194F] are required on the claim form to submit this numerator option)

Append a modifier (1P) to CPT Category II code 0540F to report documented circumstances that appropriately exclude patients from the denominator.

0540F with 1P: Documentation of medical reason(s) for not documenting glucocorticoid dose and documenting management plan (i.e., glucocorticoid prescription is for a medical condition other than RA)

AND

CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

OR

Glucocorticoid Dose not Documented, Reason not Specified

(One CPT II code [4194F-8P] is required on the claim form to submit this category)

Append a reporting modifier (8P) to CPT Category II code 4194F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4194F with 8P: Glucocorticoid dose was not documented, reason not otherwise specified

OR

Glucocorticoid Plan not Documented, Reason not Specified

(Two CPT II codes [0540F-8P and 4194F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 0540F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0540F with 8P: Glucocorticoid plan not documented, reason not otherwise specified

AND

CPT II 4194F: Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

PERIOPERATIVE CARE MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN PERIOPERATIVE CARE MEASURES GROUP:

- #20. Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician
- #21. Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
- #22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
- #23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Perioperative Care Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8492: I intend to report the Perioperative Care Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) procedures (patients) meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the Perioperative Care Measures Group are patients aged 18 years and older that have a specific surgical procedure performed:

One of the following surgical procedure codes: 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 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, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 44005, 44010,

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44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49215, 50320, 50340, 50360, 50365, 50370, 50380, 60521, 60522, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276

NOTE: CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population. Both surgeons participating in Physician Quality Reporting will be fully accountable for the clinical action described in the measure.

- Report quality-data codes on **all** measures within the Perioperative Care Measures Group for each procedure (patient) within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the Perioperative Care Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8501: All quality actions for the applicable measures in the Perioperative Care Measures Group have been performed for this patient

- To report satisfactorily the Perioperative Care Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported each time a surgical procedure is performed during the reporting period.
- When using the 30 Patient Sample Method, report all measures for 30 unique Medicare Part B FFS procedures performed (patients seen). When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8492 (and G8501 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

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 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)

NUMERATOR:

Surgical patients who have an order for prophylactic 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)

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral 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 prophylactic parenteral 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).

Note: *In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Table 1A: The antimicrobial drugs listed below are considered prophylactic parenteral antibiotics for the purposes of this measure. G8632 should be reported when antibiotics from this table were not ordered.

<ul style="list-style-type: none">• Ampicillin/sulbactam• Aztreonam• Cefazolin• Cefmetazole• Cefotetan• Cefoxitin	<ul style="list-style-type: none">• Cefuroxime• Ciprofloxacin• Clindamycin• Ertapenem• Erythromycin base• Gatifloxacin	<ul style="list-style-type: none">• Gentamicin• Levofloxacin• Metronidazole• Moxifloxacin• Neomycin• Vancomycin
--	---	--

Documentation of Order for Prophylactic Parenteral Antibiotic (written order, verbal order, or standing order/protocol)

G8629: Documentation of order for prophylactic parenteral 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 Parenteral Antibiotic *has* been Given within One Hour Prior to the Surgical Incision (or start of procedure when no incision is required)

G8630: Documentation that administration of prophylactic parenteral antibiotic was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Order for Prophylactic Parenteral Antibiotic not Given for Medical Reasons

G8631: Clinician documented that patient was not an eligible candidate for ordering prophylactic parenteral 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)

OR

Order for Administration of Prophylactic Parenteral Antibiotic not Given, Reason not Specified

G8632: Prophylactic parenteral antibiotics were not ordered to be given or given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required), reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

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

NUMERATOR:

Surgical patients who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis

Numerator Instructions: 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*.

Note: *In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Acceptable First and Second Generation Cephalosporin Prophylactic Antibiotics

First generation cephalosporin: cefazolin

Second generation cephalosporin: cefuroxime

Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis (written order, verbal order, or standing order/protocol)

CPT II 4041F: Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis

Note: *CPT Category II code 4041F is provided for antibiotic ordered or antibiotic given. Report CPT Category II code 4041F if cefazolin OR cefuroxime was given for antimicrobial prophylaxis.*

OR

Order for First or Second Generation Cephalosporin not Ordered for Medical Reasons

Append a modifier (1P) to CPT Category II code 4041F to report documented circumstances that appropriately exclude patients from the denominator.

4041F with 1P: Documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis

OR

Order for First or Second Generation Cephalosporin not Ordered, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 4041F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4041F with 8P: Order for cefazolin OR cefuroxime for antimicrobial prophylaxis was not documented, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time

NUMERATOR:

Non-cardiac surgical patients who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral 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 for "one time" IV dose orders) OR documentation that prophylactic parenteral was discontinued within 24 hours of surgical end time.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Documentation of Order for Discontinuation of Prophylactic Parenteral Antibiotics (written order, verbal order, or standing order/protocol) Within 24 Hours of Surgical End Time

(Two CPT II codes [4049F & 4046F] are required on the claim form to submit this numerator option)

CPT II 4049F: Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure

Note: *CPT Category II code 4049F is provided for documentation that antibiotic discontinuation was ordered or that antibiotic discontinuation was accomplished. Report CPT Category II code 4049F if antibiotics were discontinued within 24 hours.*

AND

CPT II 4046F: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

OR

Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons

(Two CPT II codes [4049F-1P & 4046F] are required on the claim form to submit this numerator option)

Append a modifier (1P) to CPT Category II code 4049F to report documented circumstances that appropriately exclude patients from the denominator.

4049F with 1P: Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time

AND

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CPT II 4046F: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

OR

If patient is not eligible for this measure because patient did not receive prophylactic parenteral antibiotics within specified timeframe, report:
(One CPT II code [4042F] is required on the claim form to submit this numerator option)
CPT II 4042F: Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively

OR

Prophylactic Parenteral Antibiotics not Discontinued, Reason not Specified
(Two CPT II codes [4049F-8P & 4046F] are required on the claim form to submit this numerator option)
Append a reporting modifier (**8P**) to CPT Category II code **4049F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4049F with 8P: Order was not given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure, reason not otherwise specified

AND

CPT II 4046F: Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

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

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

NUMERATOR:

Surgical patients who had an order for LMWH, 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

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) for VTE prophylaxis OR documentation that VTE prophylaxis was given.

Definition:

Mechanical Prophylaxis – Does not include TED hose.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Appropriate VTE Prophylaxis Ordered

CPT II 4044F: 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

Note: A single CPT Category II code is provided for VTE prophylaxis ordered or VTE prophylaxis given. If VTE prophylaxis is given, report 4044F.

OR

VTE Prophylaxis not Ordered for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4044F** to report documented circumstances that appropriately exclude patients from the denominator.

4044F with 1P: Documentation of medical reason(s) for patient not receiving any form of VTE prophylaxis (LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis) within 24 hours prior to incision time or 24 hours after surgery end time

OR

VTE Prophylaxis not Ordered, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4044F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4044F with 8P: Order was not given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

BACK PAIN MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN BACK PAIN MEASURES GROUP:

- #148. Back Pain: Initial Visit
- #149. Back Pain: Physical Exam
- #150. Back Pain: Advice for Normal Activities
- #151. Back Pain: Advice Against Bed Rest

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Back Pain Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8493: I intend to report the Back Pain Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the Back Pain Measures Group are patients aged 18 through 79 years with a specific diagnosis for back pain accompanied by a specific patient encounter **OR** patients aged 18-79 years that have a specific back surgical procedure performed:

One of the following diagnosis codes indicating back pain: 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

Accompanied by

One of the following patient encounter codes: 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

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

- Report quality-data codes on **all** measures within the Back Pain Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the Back Pain Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8502: All quality actions for the applicable measures in the Back Pain Measures Group have been performed for this patient

- To satisfactorily report the Back Pain Measures Group for the 30 Patient Sample Method it requires **all** measures for each patient within the sample to be reported where the initial visit to the clinician for each episode of back pain or each surgery for back pain that occurred during the corresponding reporting period. If the patient's initial visit for this episode of back pain occurred prior to the beginning of the reporting period, report that the visit in the sample is a subsequent visit for the episode and this will **not** count toward the 30 patient sample. This measures group may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.
- To satisfactorily report the Back Pain Measures Group for the 50% Patient Sample Method via Claims or the 80% Patient Sample Method via Registry it requires **all** measures for each patient within the eligible professional's patient sample to be reported on the first visit to the clinician for each episode of back pain or each surgery for back pain occurring during the corresponding reporting period. If the patient's initial visit for this episode of back pain occurred prior to the beginning of the corresponding reporting period, report that the first visit of the reporting period is a subsequent visit for the episode. This measures group may be reported by more than one clinician if multiple clinicians evaluate or treat the patient for the back pain episode.
- When using the 30 Patient Sample Method, report all measures for 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8493 (and G8502 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is

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accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

♦ Measure #148: Back Pain: Initial Visit

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

OR

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

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

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

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

OR

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

- Eating
- Bathing
- Using the toilet
- Dressing

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- Getting up from bed or a chair

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

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

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

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

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

- Sickness Impact Profile
- Multidimensional Pain Inventory

OR

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

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

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary

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care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Back Pain and Function Assessed

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

OR

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

CPT II 0526F: Subsequent visit for episode

OR

Back Pain and Function not Assessed, Reason not Specified

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

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◆ Measure #149: Back Pain: Physical Exam

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

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

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

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

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

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Physical Exam Performed

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

OR

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

CPT II 0526F: Subsequent visit for episode

OR

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Physical Exam not Performed, Reason not Specified

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

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

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Advice for Normal Activities Performed

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

OR

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

CPT II 0526F: Subsequent visit for the episode

OR

Advice for Normal Activities not Performed, Reason not Specified

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

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

DESCRIPTION:

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

NUMERATOR:

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

Definitions:

Episode – Patient with back pain who has not been seen or treated for back pain by any practitioner during the 4 months prior to the first clinical encounter with a diagnosis of back pain. If a patient has a four-month period without treatment, and then sees both a primary care physician and a specialist, both visits are considered the initial visit with that clinician. A new episode can either be a recurrence for a patient with prior back pain or a patient with a new onset of back pain. The first clinical encounter after the four months without being seen or treated for back pain is considered the beginning of the new episode.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Advice Against Bed Rest Performed

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

OR

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

CPT II 0526F: Subsequent visit for episode

OR

Advice Against Bed Rest not Performed, Reason not Specified

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

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

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

HEPATITIS C MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN HEPATITIS C MEASURES GROUP:

- #84. Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment
- #85. Hepatitis C: HCV Genotype Testing Prior to Treatment
- #86. Hepatitis C: Antiviral Treatment Prescribed
- #87. Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment
- #89. Hepatitis C: Counseling Regarding Risk of Alcohol Consumption
- #90. Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy
- #183. Hepatitis C: Hepatitis A Vaccination in Patients with HCV
- #184. Hepatitis C: Hepatitis B Vaccination in Patients with HCV

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Hepatitis C Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8545: I intend to report the Hepatitis C Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the Hepatitis C Measures Group are patients aged 18 years and older with a specific diagnosis of chronic hepatitis C accompanied by a specific patient encounter:

One of the following diagnosis code indicating chronic hepatitis C: 070.54

Accompanied by

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 Hepatitis C Measures Group for each patient within the eligible professional's patient sample.

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Applicable measures contain patient demographic criteria specific to the measure. For example, Counseling Regarding Use of Contraception Prior to Antiviral Therapy is applicable to female patients *aged 18 through 44 years and all men aged 18 years and older* within the sample population, while the Antiviral Treatment Prescribed measure within this group is applicable to *all patients* aged 18 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 Hepatitis C Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8549: All quality actions for the applicable measures in the Hepatitis C Measures Group have been performed for this patient

- To report satisfactorily the Hepatitis C Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all applicable measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8545 (and G8549 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #84: Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of antiviral treatment

NUMERATOR:

Patients for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of antiviral treatment

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

RNA Testing Performed within Six Months

(Two CPT II codes [3218F & 4150F] are required on the claim form to submit this numerator option)

CPT II 3218F: RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C

AND

CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

OR

RNA Testing not Performed within Six Months for Medical Reason

(Two CPT II codes [3218F-1P & 4150F] are required on the claim form to submit this numerator option)

Append a modifier (**1P**) to CPT Category II code **3218F** to report documented circumstances that appropriately exclude patients from the denominator.

3218F with 1P: Documentation of medical reason(s) for not performing RNA testing within six months prior to initiation of antiviral treatment for Hepatitis C (eg, if patient is first seen by physician after initiation of treatment)

AND

CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:

(One CPT II code [4151F] is required on the claim form to submit this numerator option)

CPT II 4151F: Patient not receiving antiviral treatment for Hepatitis C

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

RNA Testing not Performed within Six Months, Reason not Specified

(Two CPT II codes [3218F-8P & 4150F] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **3218F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3218F with 8P: RNA testing for Hepatitis C was not documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified

AND

CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #85: Hepatitis C: HCV Genotype Testing Prior to Treatment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom HCV genotype testing was performed prior to initiation of antiviral treatment

NUMERATOR:

Patients for whom HCV genotype testing was performed within 6 months prior to initiation of antiviral treatment

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis C Genotype Testing Performed

(One CPT II code & one G-code [3266F & G8459] are required on the claim form to submit this numerator option)

CPT II 3266F: Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for Hepatitis C

AND

G8459: Clinician documented that patient is receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:

(One G-code [G8458] is required on the claim form to submit this numerator option)

G8458: Clinician documented that patient is not an eligible candidate for genotype testing; patient not receiving antiviral treatment for Hepatitis C

OR

Genotype Testing not Performed, Reason not Specified

(One CPT II code & one G-code [3266F-8P & G8459] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **3266F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3266F with 8P: Hepatitis C genotype testing was not documented as performed prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified

AND

G8459: Clinician documented that patient is receiving antiviral treatment for Hepatitis C

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #86: Hepatitis C: Antiviral Treatment Prescribed

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who were prescribed peginterferon and ribavirin therapy within the 12-month reporting period

NUMERATOR:

Patients who were prescribed peginterferon and ribavirin therapy within the 12 month reporting period

Definition:

Prescribed – May include prescription given to the patient for peginterferon and ribavirin therapy at one or more visits in the 12-month period OR patient already taking peginterferon and ribavirin therapy as documented in current medication list.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Peginterferon and Ribavirin Therapy Prescribed

CPT II 4153F: Combination peginterferon and ribavirin therapy prescribed

OR

Peginterferon and Ribavirin Therapy not Prescribed for Medical, Patient or System Reasons

Append a modifier (**1P**, **2P** or **3P**) to CPT Category II code **4153F** to report documented circumstances that appropriately exclude patients from the denominator.

4153F with 1P: Documentation of medical reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient was not a candidate for therapy, could not tolerate).

4153F with 2P: Documentation of patient reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient declined).

4153F with 3P: Documentation of system reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (eg, patient has no insurance coverage, therapy not covered).

OR

Peginterferon and Ribavirin Therapy not Prescribed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4153F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4153F with 8P: Combination peginterferon and ribavirin therapy was not prescribed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #87: Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

NUMERATOR:

Patients for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

Definition:

12 Weeks from Initiation – Patients for whom testing was performed between 11-13 weeks from the initiation of antiviral treatment will meet the numerator for this measure.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis C Quantitative RNA Testing at 12 weeks

(One CPT II code & one G-code [3220F & G8461] are required on the claim form to submit this numerator option)

CPT II 3220F: Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks for Medical or Patient Reasons

(One CPT II code & one G-code [3220F-xP & G8461] are required on the claim form to submit this numerator option)

Append a modifier (**1P** or **2P**) to CPT Category II code **3220F** to report documented circumstances that appropriately exclude patients from the denominator.

3220F with 1P: Documentation of medical reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment

3220F with 2P: Documentation of patient reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:

(One G-code [G8460] is required on the claim form to submit this numerator option)

G8460: Clinician documented that patient is not an eligible candidate for quantitative RNA testing at week 12; patient not receiving antiviral treatment for Hepatitis C

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

OR

Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks, Reason not Specified

(One CPT II code & one G-code [3220F-8P & G8461] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **3220F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3220F with 8P: Hepatitis C quantitative RNA testing was not documented as performed at 12 weeks from initiation of antiviral treatment, reason not otherwise specified

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #89: Hepatitis C: Counseling Regarding Risk of Alcohol Consumption

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who were counseled about the risks of alcohol use at least once within 12-months

NUMERATOR:

Patients who were counseled about the risks of alcohol use at least once within the 12 month reporting period

Definition:

Counseling – May include documentation of a discussion regarding the risks of alcohol, or notation to decrease or abstain from alcohol intake.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Counseling Regarding Risk of Alcohol Consumption

CPT II 4158F: Patient counseled about risks of alcohol use

OR

Counseling Regarding Risk of Alcohol Consumption not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4158F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4158F with 8P: Patient counseled about risks of alcohol use not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #90 Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy

DESCRIPTION:

Percentage of female patients aged 18 through 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment who were counseled regarding contraception prior to the initiation of treatment

NUMERATOR:

Patients who were counseled regarding contraception prior to the initiation of treatment

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Counseling Regarding Contraception Received

(One CPT II code & one G-code [4159F & G8463] are required on the claim form to submit this numerator option)

CPT II 4159F: Counseling regarding contraception received prior to initiation of antiviral treatment

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

Counseling Regarding Contraception not Received for Medical Reason

(One CPT II code & one G-code [4159F-1P & G8463] are required on the claim form to submit this numerator option)

Append a modifier (**1P**) to CPT Category II code **4159F** to report documented circumstances that appropriately exclude patients from the denominator.

4159F with 1P: Documentation of medical reason(s) for not counseling patient regarding contraception

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:

(One G-code [G8462] is required on the claim form to submit this numerator option)

G8462: Clinician documented that patient is not an eligible candidate for counseling regarding contraception prior to antiviral treatment; patient not receiving antiviral treatment for Hepatitis C

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Counseling Regarding Contraception not Received, Reason not Specified

(One CPT II code & one G-code [4159F-8P & G8463] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **4159F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4159F with 8P: Counseling regarding contraception not received prior to initiation of antiviral treatment, reason not otherwise specified

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #183: Hepatitis C: Hepatitis A Vaccination in Patients with HCV

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A

NUMERATOR:

Patients who have received at least one injection of hepatitis A vaccine, or who have documented immunity to hepatitis A

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis A Vaccine Injection Received or Patient Has Documented Immunity to Hepatitis A

CPT II 4148F: Hepatitis A vaccine injection administered or previously received

OR

CPT II 3215F: Patient has documented immunity to Hepatitis A

OR

Hepatitis A Vaccine Injection not Received for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **4148F** to report documented circumstances that appropriately exclude patients from the denominator.

4148F with 1P: Documentation of medical reason(s) for not administering at least one injection of hepatitis A vaccine

4148F with 2P: Documentation of patient reason(s) for not administering at least one injection of hepatitis A vaccine

OR

Hepatitis A Vaccine Injection not Received, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4148F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4148F with 8P: Hepatitis A Vaccine not received, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #184: Hepatitis C: Hepatitis B Vaccination in Patients with HCV

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who received at least one injection of hepatitis B vaccine, or who have documented immunity to hepatitis B

NUMERATOR:

Patients who have received at least one injection of hepatitis B vaccine or who have documented immunity to hepatitis B

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis B Vaccine Injection Received or Patient Has Documented Immunity to Hepatitis B

CPT II 4149F: Hepatitis B vaccine injection administered or previously received

OR

CPT II 3216F: Patient has documented immunity to Hepatitis B

OR

Hepatitis B Vaccine Injection not Received for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **4149F** to report documented circumstances that appropriately exclude patients from the denominator.

4149F with 1P: Documentation of medical reason(s) for not administering at least one injection of hepatitis B vaccine

4149F with 2P: Documentation of patient reason(s) for not administering at least one injection of Hepatitis B vaccine

OR

Hepatitis B Vaccine not Received, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4149F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4149F with 8P: Hepatitis B Vaccine not received, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

HEART FAILURE (HF) MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN HEART FAILURE (HF) MEASURES GROUP:

- #5. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- # 8. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- #198. Heart Failure: Left Ventricular Function (LVF) Assessment
- #199. Heart Failure: Patient Education
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

INSTRUCTIONS FOR REPORTING: (These instructions apply to registry reporting. Do not report this measures group via claims.)

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.

G8548: I intend to report the Heart Failure (HF) Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the HF Measures Group are patients aged 18 years and older with a specific diagnosis of HF accompanied by a specific patient encounter:

One of the following diagnosis codes indicating HF: 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

Accompanied by

One of the following patient encounter codes: 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

- Report a numerator option on **all applicable** measures within the HF Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the HF Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8551: All quality actions for the applicable measures in the Heart Failure (HF) Measures Group have been performed for this patient

- To report satisfactorily the HF Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 80% Patient Sample Method, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy

NUMERATOR:

Patients who were prescribed ACE inhibitor or ARB therapy

Numerator Instructions: The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients.

Definition:

Prescribed – May include prescription given to the patient for ACE inhibitor or ARB therapy at one or more visits in the 12-month period OR patient already taking ACE inhibitor or ARB therapy as documented in current medication list.

Numerator Options:

ACE Inhibitor or ARB Therapy Prescribed

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy prescribed (4009F)

AND

Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

OR

Documentation of medical reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 1P)

OR

Documentation of patient reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 2P)

OR

Documentation of system reason(s) for not prescribing angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy (4009F *with* 3P)

AND

Left ventricular ejection fraction (LVEF) < 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Left ventricular ejection fraction (LVEF) \geq 40% or documentation as normal or mildly depressed left ventricular systolic function (3022F)

OR

Left ventricular ejection fraction (LVEF) not performed or documented (3021F *with* 8P)

OR

Angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy was not prescribed, reason not otherwise specified (4009F *with* 8P)

AND

Left ventricular ejection fraction $<$ 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #8: Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy

NUMERATOR:

Patients who were prescribed beta-blocker therapy

Numerator Instructions: The LVSD may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of LVSD or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function. Any current or prior ejection fraction study documenting LVSD can be used to identify patients.

Definition:

Prescribed – May include prescription given to the patient for beta-blocker therapy at one or more visits in the 12-month period OR patient already taking beta-blocker therapy as documented in current medication list.

Numerator Options:

Beta-blocker therapy prescribed for patients with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function (G8450)

OR

Clinician documented patient with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function was not eligible candidate for beta-blocker therapy (G8451)

OR

Left ventricular ejection fraction (LVEF) \geq 40% or documentation as normal or mildly depressed left ventricular systolic function (G8395)

OR

Left ventricular ejection fraction (LVEF) not performed or documented (G8396)

OR

Beta-blocker therapy not prescribed for patients with left ventricular ejection fraction (LVEF) <40% or documentation as moderately or severely depressed left ventricular systolic function (G8452)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #198: Heart Failure: Left Ventricular Function (LVF) Assessment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of Heart Failure who have quantitative or qualitative results of LVF assessment recorded

NUMERATOR:

Patients with quantitative or qualitative results of LVF assessment recorded

Numerator Instructions: The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic function or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic function.

Numerator Options:

Left ventricular function (LVF) assessment (eg, echocardiography, nuclear test, or ventriculography) documented in the medical record (Includes: Quantitative or qualitative assessment results) (3020F)

OR

Quantitative or qualitative results of LVF assessment not Performed or Assessed, Reason Not Specified (3020F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #199: Heart Failure: Patient Education

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one or more visit(s) within 12 months

NUMERATOR:

Patients who were provided with patient education on disease management and health behavior changes* during one or more visits within 12 months

Definition: *Patient education should include one or more of the following: Weight monitoring; Diet (sodium restriction); Symptom management; Physical activity; Smoking cessation; Medication instruction; Minimizing or avoiding use of NSAIDs; Referral for visiting nurse, or specific educational or management programs; Prognosis/end-of-life issues

Numerator Options:

Patient education, written/oral, appropriate for patients with heart failure performed (4003F)

OR

Patient education, written/oral, appropriate for patients with heart failure not performed, Reason Not Specified (4003F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

NUMERATOR:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:

Tobacco Use – Includes any type of tobacco

Cessation Counseling Intervention – Includes counseling or pharmacotherapy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user

OR

Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator

4004F with 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

OR

Tobacco Screening not Performed Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4004F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4004F with 8P: Tobacco Screening not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

CORONARY ARTERY DISEASE (CAD) MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN CORONARY ARTERY DISEASE (CAD) MEASURES GROUP:

- #6. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
- #196. Coronary Artery Disease (CAD): Symptom and Activity Assessment
- #197. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

INSTRUCTIONS FOR REPORTING: (These instructions apply to registry reporting. Do not report this measures group via claims.)

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group specific intent G-code has been created for registry only measure groups for use by registries that utilize claims data.

G8489: I intend to report the Coronary Artery Disease (CAD) Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the CAD Measures Group are patients aged 18 years and older with a specific diagnosis of CAD accompanied by a specific patient encounter:

One of the following diagnosis codes indicating CAD: 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

Accompanied by

One of the following patient encounter codes: 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

- Report a numerator option on **all applicable** measures within the CAD Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the CAD Measures Group are displayed on the next several pages. The following composite G-code

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

Composite G-code G8498: All quality actions for the applicable measures in the Coronary Artery Disease (CAD) Measures Group have been performed for this patient

- To report satisfactorily for the CAD Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 80% Patient Sample Method, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy

NUMERATOR:

Patients who were prescribed oral antiplatelet therapy

Numerator Instructions: Oral antiplatelet therapy consists of aspirin, clopidogrel or combination of aspirin and extended release dipyridamole.

Definition:

Prescribed – May include prescription given to the patient for aspirin or clopidogrel at one or more visits in the 12-month period OR patient already taking aspirin or clopidogrel as documented in current medication list.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Oral Antiplatelet Therapy Prescribed

CPT II 4011F: Oral antiplatelet therapy prescribed

OR

Oral Antiplatelet Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P** or **3P**) to Category II code **4011F** to report documented circumstances that appropriately exclude patients from the denominator.

4011F with 1P: Documentation of medical reason(s) for not prescribing oral antiplatelet therapy

4011F with 2P: Documentation of patient reason(s) for not prescribing oral antiplatelet therapy

4011F with 3P: Documentation of system reason(s) for not prescribing oral antiplatelet therapy

OR

Oral Antiplatelet Therapy not Prescribed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4011F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4011F with 8P: Oral antiplatelet therapy was not prescribed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

Measure #196: Coronary Artery Disease (CAD): Symptom and Activity Assessment

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of CAD who were evaluated for both level of activity and anginal symptoms during one or more visits.

NUMERATOR:

Patients evaluated for both level of activity and anginal symptoms during one or more office visits

Numerator Options:

Anginal symptoms and level of activity assessed (1002F)

OR

Anginal symptoms and level of activity assessed not assessed, reason not specified (1002F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #197: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines)

NUMERATOR:

Patients who were prescribed lipid-lowering therapy

NUMERATOR NOTE: For those registries that utilize claims data, the quality-data code 4002F may be used for this measure.

Definition:

Prescribed – May include prescription given to the patient for a lipid-lowering therapy at one or more visits in the 12 month period OR patient already taking a lipid-lowering therapy as documented in the current medication list.

Numerator Options:

Lipid-lowering therapy prescribed

OR

Lipid-lowering therapy not prescribed for medical reason

OR

Lipid-lowering therapy not prescribed for patient reason

OR

Lipid-lowering therapy not prescribed for system reason

OR

Lipid-lowering therapy not prescribed, reason not specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

NUMERATOR:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:

Tobacco Use – Includes any type of tobacco

Cessation Counseling Intervention – Includes counseling or pharmacotherapy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user

OR

Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator

4004F with 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

OR

Tobacco Screening not Performed Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4004F with 8P: Tobacco Screening not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP:

- #201. Ischemic Vascular Disease (IVD): Blood Pressure Management Control
- #202. Ischemic Vascular Disease (IVD): Complete Lipid Profile
- #203. Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control
- #204. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the IVD Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8547: I intend to report the Ischemic Vascular Disease (IVD) Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.

OR

50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the IVD Measures Group are patients aged 18 years and older with a specific diagnosis of IVD accompanied by a specific patient encounter **OR** patients aged 18 years and older with a coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) surgical procedure:

One of the following diagnosis codes indicating IVD: 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91, 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, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89

Accompanied by

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456

OR

One of the following coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) surgical procedure codes: 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92980, 92982, 92995

- Report quality-data codes on **all applicable** measures within the IVD Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the IVD Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all the measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G code G8552: All quality actions for the applicable measures in the Ischemic Vascular Disease (IVD) Measures Group have been performed for this patient

- To report satisfactorily the IVD Measures Group requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all applicable measures for the 30 unique Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all applicable measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all applicable measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8547 (and G8552 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #201: Ischemic Vascular Disease (IVD): Blood Pressure Management Control

DESCRIPTION:

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who had most recent blood pressure in control (less than 140/90 mmHg)

NUMERATOR:

Patients whose most recent blood pressure < 140/90 mmHg

Numerator Instructions: To describe both systolic and diastolic blood pressure values, each must be reported separately. 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 NOTE: *The performance period for this measure is 12 months*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Blood Pressure Measurement Performed

Systolic Pressure (Select one (1) code from this section):

G8588: Most recent systolic blood pressure < 140 mmHg

OR

G8589: Most recent systolic blood pressure ≥ 140 mmHg

AND

Diastolic Pressure (Select one (1) code from this section):

G8590: Most recent diastolic blood pressure < 90 mmHg

OR

G8591: Most recent diastolic blood pressure ≥ 90 mmHg

OR

Blood Pressure Measurement not Documented, Reason not Specified

G8592: No documentation of blood pressure measurement

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #202: Ischemic Vascular Disease (IVD): Complete Lipid Profile

DESCRIPTION:

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) who received at least one lipid profile within 12 months

NUMERATOR:

Patients who received at least one lipid profile (or ALL component tests)

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Lipid Profile Performed

G8593: Lipid profile results documented and reviewed (must include total cholesterol, HDL-C, triglycerides and calculated LDL-C)

Note: *If LDL-C could not be calculated due to high triglycerides, count as complete lipid profile.*

OR

Lipid Profile not Performed, Reason not Specified

G8594: Lipid profile not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

♦ Measure #203: Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control

DESCRIPTION:

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) 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 NOTE: The performance period for this measure is 12 months.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent LDL-C <100 mg/dL

G8595: Most recent LDL-C < 100 mg/dL

OR

LDL-C was not Performed

G8596: LDL-C was not performed

OR

Most Recent LDL-C ≥100 mg/dL

G8597: Most recent LDL-C ≥ 100 mg/dL

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

◆ Measure #204: Ischemic Vascular Disease (IVD): Use Aspirin or Another Antithrombotic

DESCRIPTION:

Percentage of patients aged 18 years and older with Ischemic Vascular Disease (IVD) with documented use of aspirin or other antithrombotic

NUMERATOR:

Patients who are using aspirin or another antithrombotic therapy

Numerator Instructions: Oral antithrombotic therapy consists of aspirin, clopidogrel or combination of aspirin and extended release dipyridamole

NUMERATOR NOTE: *The performance period for this measure is 12 months*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Aspirin or Another Antithrombotic Therapy Used

G8598: Aspirin or another antithrombotic therapy used

OR

Aspirin or Another Antithrombotic Therapy not Used, Reason not Specified

G8599: Aspirin or another antithrombotic therapy not used, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

▲ Measure #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

DESCRIPTION:

Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user

NUMERATOR:

Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:

Tobacco Use – Includes any type of tobacco

Cessation Counseling Intervention – Includes counseling or pharmacotherapy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use

CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user

OR

Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco

CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **4004F** to report documented circumstances that appropriately exclude patients from the denominator

4004F with 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)

OR

Tobacco Screening not Performed Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4004F with 8P: Tobacco Screening not performed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

HIV/AIDS MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: REGISTRY ONLY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN HIV/AIDS MEASURES GROUP:

- #159. HIV/AIDS: CD4+ Cell Count or CD4+ Percentage
- #160. HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
- #161. HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy
- #162. HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy
- #205. HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea
- #206. HIV/AIDS: Screening for High Risk Sexual Behaviors
- #207. HIV/AIDS: Screening for Injection Drug Use
- #208. HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis

INSTRUCTIONS FOR REPORTING: (These instructions apply to registry reporting. Do not report this measures group via claims.)

- It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-code has been created for registry only measures groups for use by registries that utilize claims data.
G8491: I intend to report the HIV/AIDS Measures Group
- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
80% Patient Sample Method: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the HIV/AIDS Measures Group are patients aged 13 years and older with a specific diagnosis of HIV/AIDS accompanied by a specific patient encounter:
One of the following diagnosis codes indicating HIV/AIDS: 042, 079.53, V08
Accompanied by
One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
- Report a numerator option on **all** measures within the HIV/AIDS Measures Group for each patient within the eligible professional's patient sample.
- Instructions for qualifying numerator option reporting for each of the measures within the HIV/AIDS Measures Group are displayed on the next several pages. The following composite G-code has been created for registry only measures groups for use by registries that utilize claims data. This composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group, if all quality actions for the patient have been

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

performed for all the measures within the group. However, it is not necessary to submit the following composite G-code for registry-based submissions.

Composite G code G8500: All quality actions for the applicable measures in the HIV/AIDS Measures Group have been performed for this patient

- To report satisfactorily for the HIV/AIDS Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period. Measure #159 will be reported once during the reporting period for measures group purposes.
- When using the 30 Patient Sample Method, report all measures for the 30 unique Medicare Part B FFS patients seen. When using the 80% Patient Sample Method, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #159: HIV/AIDS: CD4+ Cell Count or CD4+ Percentage

DESCRIPTION:

Percentage of patients aged 6 months and older with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ cell percentage was performed at least once every 6 months

NUMERATOR:

Patients with CD4+ cell count or CD4+ cell percentage performed at least once every 6 months

NUMERATOR NOTE: Report this measure once during the reporting period for measures group purposes

Numerator Options:

CD4+ cell count or CD4+ cell percentage documented as performed (3500F)

OR

CD4+ cell count or percentage not documented as performed, reason not specified (3500F with 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

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□ Measure #160: HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis

DESCRIPTION:

Percentage of patients aged 6 years and older with a diagnosis of HIV/AIDS and CD4+ cell count <200 cells/mm³ who were prescribed PCP prophylaxis within 3 months of low CD4+ cell count

NUMERATOR:

Patients who were prescribed PCP prophylaxis within 3 months of low CD4+ cell count

Definition:

Prescribed – May include prescription given to the patient for PCP prophylaxis therapy at one or more visits in the 12-month period OR patient already taking PCP prophylaxis therapy as documented in current medication list.

Numerator Options:

Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count or percentage (4280F)

AND

CD4+ cell count <200 cells/mm³ (3494F)

OR

Pneumocystis jiroveci pneumonia prophylaxis not prescribed within 3 months of low CD4+ cell count or percentage for medical reason (4280F *with* 1P)
(i.e., patient's CD4+ cell count above threshold within 3 months after CD4+ cell count below threshold, indicating that the patient's CD4+ levels are within an acceptable range and the patient does not require PCP prophylaxis)

AND

CD4+ cell count <200 cells/mm³ (3494F)

OR

CD4+ cell count 200 – 499 cells/mm³ (3495F)

OR

CD4+ cell count ≥500 cells/mm³ (3496F)

OR

CD4+ cell count not performed, reason not specified (3494F *with* 8P)

OR

PCP prophylaxis was not prescribed within 3 months of low CD4+ cell count, reason not specified (4280F *with* 8P)

AND

CD4+ cell count <200 cells/mm³ (3494F)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #161: HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy

DESCRIPTION:

Percentage of patients with a diagnosis of HIV/AIDS aged 13 years and older: who have a history of a nadir CD4+ cell count below 350/mm³ or who have a history of an AIDS-defining condition, regardless of CD4+ cell count; who were prescribed potent antiretroviral therapy

NUMERATOR:

Patients who were prescribed potent antiretroviral therapy

Numerator Instructions: Nadir (lowest ever) CD4+ cell count may be the present count

Definitions:

Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - <http://www.aids.gov>.

AIDS-defining Condition – Conditions included in the 1993 AIDS surveillance case definition:

- Candidiasis of bronchi, trachea, or lungs;
- Candidiasis, esophageal;
- Cervical cancer, invasive;
- Coccidioidomycosis, disseminated or extrapulmonary;
- Cryptococcosis, extrapulmonary;
- Cryptosporidiosis, chronic intestinal (greater than 1 month's duration);
- Cytomegalovirus disease (other than liver, spleen, or nodes);
- Cytomegalovirus retinitis (with loss of vision);
- Encephalopathy, HIV-related;
- Herpes simplex: chronic ulcer(s) (greater than 1 month's duration);
- Bronchitis, pneumonitis, or esophagitis;
- Histoplasmosis, disseminated or extrapulmonary;
- Isosporiasis, chronic intestinal (greater than 1 month's duration);
- Kaposi's sarcoma;
- Lymphoma, Burkitt's (or equivalent term);
- Lymphoma, immunoblastic (or equivalent term);
- Lymphoma, primary, of brain;
- Mycobacterium avium complex or *M. kansasii*, disseminated or extrapulmonary;
- Mycobacterium tuberculosis, any site (pulmonary or extrapulmonary);
- Mycobacterium, other species or unidentified species, disseminated or extrapulmonary;
- Pneumocystis carinii pneumonia;
- Pneumonia, recurrent;
- Progressive multifocal leukoencephalopathy;
- Salmonella septicemia, recurrent;

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- Toxoplasmosis of brain;
- Wasting syndrome due to HIV. (NYSDOH, 2007)

Prescribed – May include prescription given to the patient for potent antiretroviral therapy at one or more visits in the 12-month period OR patient already taking potent antiretroviral therapy as documented in current medication list.

Numerator Options:

Potent antiretroviral therapy prescribed (4276F)

AND

History of nadir CD4+ cell count <350 cells/mm³ (3492F)

OR

History of AIDS-defining condition (3490F)

OR

No history of nadir CD4+ cell count <350 cells/mm³ AND no history of AIDS-defining condition (3493F)

OR

Potent antiretroviral therapy not prescribed, reason not specified (4276F *with* 8P)

AND

History of nadir CD4+ cell count < 350 cells/mm³ (3492F)

OR

History of AIDS-defining condition (3490F)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #162: HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who are receiving potent antiretroviral therapy, who have a viral load below limits of quantification after at least 6 months of potent antiretroviral therapy or patients whose viral load is not below limits of quantification after at least 6 months of potent antiretroviral therapy and have documentation of a plan of care

NUMERATOR:

Patients with viral load below limits of quantification or patients with viral load not below limits of quantification who have a documented plan of care

Numerator Instructions: Viral load below limits of quantification is determined using laboratory cutoff levels for reference laboratory used by clinic or provider

Definitions:

Potent Antiretroviral Therapy – Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials. For potent antiretroviral therapy recommendations, refer to current DHHS guidelines available for download at the following address as of 11/3/08 - <http://www.aids.gov>.

Plan of Care – May include altering the therapy regimen, reaffirming to the patient the importance of high adherence to the regimen, or reassessment of viral load at a specified future date

Numerator Options:

HIV RNA viral load below limits of quantification (3502F)

AND

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

HIV RNA viral load not below limits of quantification (3503F)

AND

HIV RNA control plan of care, documented (0575F)

AND

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

Patient receiving potent antiretroviral therapy for less than 6 months or not receiving potent antiretroviral therapy (4271F)

OR

Viral load not performed or documented, reason not specified (3502F *with* 8P)

AND

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

OR

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

Plan of care for viral load not below limits of quantification was not documented, reason not specified (0575F *with* 8P)

AND

HIV RNA viral load not below limits of quantification (3503F)

AND

Patient receiving potent antiretroviral therapy for 6 months or longer (4270F)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #205: HIV/AIDS: Sexually Transmitted Disease Screening for Chlamydia and Gonorrhea

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom chlamydia and gonorrhea screenings were performed at least once since the diagnosis of HIV infection

NUMERATOR:

Patients with chlamydia and gonorrhea screenings performed at least once since the diagnosis of HIV infection

Numerator Options:

Chlamydia and gonorrhea screenings documented as performed (3511F)

OR

Chlamydia and gonorrhea screenings not documented as performed, due to patient reason (3511F *with* 2P)

OR

Chlamydia and gonorrhea screenings not documented as performed, reason not specified (3511F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #206: HIV/AIDS: Screening for High Risk Sexual Behaviors

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for high risk sexual behaviors at least once within 12 months

NUMERATOR:

Patients who were screened for high risk sexual behaviors at least once within 12 months

Numerator Options:

Patient screened for high risk sexual behavior (4293F)

OR

Patient not screened for high risk sexual behaviors, reason not specified (4293F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #207: HIV/AIDS: Screening for Injection Drug Use

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for injection drug use at least once within 12 months

NUMERATOR:

Patients who were screened for injection drug use at least once within 12 months

Numerator Options:

Patient screened for injection drug use (4290F)

OR

Patient not screened for injection drug use, reason not specified (4290F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #208: HIV/AIDS: Sexually Transmitted Disease Screening for Syphilis

DESCRIPTION:

Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for syphilis at least once within 12 months

NUMERATOR:

Patients who were screened for syphilis at least once within 12 months

Numerator Options:

Syphilis screening documented as performed (3512F)

OR

Syphilis screening not documented as performed, due to patient reason (3512F *with* 2P)

OR

Syphilis screening not documented as performed, reason not specified (3512F *with* 8P)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

COMMUNITY-ACQUIRED PNEUMONIA (CAP) MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN COMMUNITY-ACQUIRED PNEUMONIA (CAP) MEASURES GROUP:

- #56. Community-Acquired Pneumonia (CAP): Vital Signs
- #57. Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation
- #58. Community-Acquired Pneumonia (CAP): Assessment of Mental Status
- #59. Community-Acquired Pneumonia (CAP): Empiric Antibiotic

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the CAP Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8546: I intend to report the Community-Acquired Pneumonia (CAP) Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) episodes (patients) meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
- Patient sample criteria for the CAP Measures Group are patients aged 18 years and older with a specific diagnosis of CAP accompanied by a specific patient encounter:

The following diagnosis codes indicating CAP: 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0

Accompanied by

One of the following patient encounter codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

**Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.*

- Report quality-data codes on **all** measures within the CAP Measures Group for each episode (patient) within the eligible professional's patient sample.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

- Instructions for quality-data code reporting for each of the measures within the CAP Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G code G8550: All quality actions for the applicable measures in the Community-Acquired Pneumonia (CAP) Measures Group have been performed for this patient

- To report satisfactorily for the CAP Measures Group it requires all measures for each patient within the eligible professional's patient sample to be reported once during each occurrence of CAP. Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.
- When using the 30 Patient Sample Method, report all measures for the 30 Medicare episodes of CAP (patients seen). When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8546 (and G8550 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

***Measure #56: Community-Acquired Pneumonia (CAP): Vital Signs**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed

NUMERATOR:

Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

Definitions:

Vital Signs – Are defined as temperature, pulse, respiratory rate, and blood pressure

Documented and Reviewed – May include one of the following: Clinician documentation 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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Vital Signs Documented and Reviewed

CPT II 2010F: Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

OR

Vital Signs not Documented and Reviewed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2010F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2010F with 8P: Vital signs (temperature, pulse, respiratory rate, and blood pressure) not documented and reviewed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

***Measure #57: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed

NUMERATOR:

Patients with oxygen saturation documented and reviewed

Definitions:

Oxygen Saturation – Includes assessment through pulse oximetry or arterial blood gas measurement

Documented and Reviewed – May include one of the following: Clinician documentation 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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Oxygen Saturation Documented and Reviewed

CPT II 3028F: Oxygen saturation results documented and reviewed (includes assessment through pulse oximetry or arterial blood gas measurement)

OR

Oxygen Saturation not Documented and Reviewed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P** or **3P**) to CPT Category II code **3028F** to report documented circumstances that appropriately exclude patients from the denominator.

3028F with 1P: Documentation of medical reason(s) for not documenting and reviewing oxygen saturation

3028F with 2P: Documentation of patient reason(s) for not documenting and reviewing oxygen saturation

3028F with 3P: Documentation of system reason(s) for not documenting and reviewing oxygen saturation

OR

Oxygen Saturation not Documented and Reviewed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3028F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3028F with 8P: Oxygen saturation results not documented and reviewed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

***Measure #58: Community-Acquired Pneumonia (CAP): Assessment of Mental Status**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed

NUMERATOR:

Patients for whom mental status was assessed

Definition:

Assessed – May include: Documentation by clinician that patient’s mental status was noted (e.g., patient is oriented or disoriented).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Mental Status Assessed

CPT II 2014F: Mental status assessed

OR

Mental Status not Assessed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **2014F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

2014F with 8P: Mental status not assessed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures’ full specifications in the document “2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures” available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

***Measure #59: Community-Acquired Pneumonia (CAP): Empiric Antibiotic**

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed

NUMERATOR:

Patients with appropriate empiric antibiotic prescribed

Definitions:

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.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Appropriate Empiric Antibiotic Prescribed

CPT II 4045F: Appropriate empiric antibiotic prescribed

OR

Appropriate Empiric Antibiotic not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P** or **3P**) to CPT Category II code **4045F** to report documented circumstances that appropriately exclude patients from the denominator.

4045F with 1P: Documentation of medical reason(s) for not prescribing appropriate empiric antibiotic

4045F with 2P: Documentation of patient reason(s) for not prescribing appropriate empiric antibiotic

4045F with 3P: Documentation of system reason(s) for not prescribing appropriate empiric antibiotic

OR

Appropriate Empiric Antibiotic not Prescribed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4045F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4045F with 8P: Appropriate empiric antibiotic not prescribed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

ASTHMA MEASURES GROUP OVERVIEW

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR MEASURES GROUPS: CLAIMS, REGISTRY

2011 PHYSICIAN QUALITY REPORTING MEASURES IN ASTHMA MEASURES GROUP:

- #53. Asthma: Pharmacologic Therapy
- #64. Asthma: Asthma Assessment
- #231. Asthma: Tobacco Use: Screening - Ambulatory Care Setting
- #232. Asthma: Tobacco Use: Intervention - Ambulatory Care Setting

INSTRUCTIONS FOR REPORTING: (These instructions apply to both Claims and Registry reporting, unless otherwise specified.)

- Indicate your intention to report the Asthma Measures Group by submitting the measures group-specific intent G-code at least once during the reporting period when billing a patient claim for both the 30 Patient Sample and the 50% Patient Sample Methods. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions.

G8645: I intend to report the Asthma Measures Group

- Select patient sample method:
30 Patient Sample Method: 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group.
OR
50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry: All patients meeting patient sample criteria for the measure group during the entire reporting period (January 1 through December 31, 2011 **OR** July 1 through December 31, 2011). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.

- Patient sample criteria for the Asthma Measures Group are patients aged 5 through 50 years with a specific diagnosis of Asthma accompanied by a specific patient encounter:

The following diagnosis codes indicating Asthma: 493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.82, 493.90, 493.92

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 Asthma Measures Group for each patient within the eligible professional's patient sample.
- Instructions for quality-data code reporting for each of the measures within the Asthma Measures Group are displayed on the next several pages. If all quality actions for the patient have been performed for all measures within the group, the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the

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group. It is not necessary to submit the following composite G-code for registry-based submissions.

Composite G code G8646: All quality actions for the applicable measures in the Asthma Measures Group have been performed for this patient

- To report satisfactorily for the Asthma Measures Group it requires **all** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.
- When using the 30 Patient Sample Method, report all measures for the 30 Medicare Part B FFS patients seen. When using the 50% Patient Sample Method via Claims, report all measures on at least 50% of the patient sample for the eligible professional for the 12-month or 6-month reporting period. When using the 80% Patient Sample Method via Registry, report all measures on at least 80% of the patient sample for the eligible professional for the 12-month or 6-month reporting period.
- For claims-based submissions, the Carrier/MAC remittance advice notice sent to the practice will show a denial remark code (N365) for the line item on the claim containing G8546 (and G8550 if reported) as well as all other line items containing QDCs. 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 intent G-code or other QDCs. The N365 remark code does NOT indicate whether the QDC is accurate for that claim or for the measure the eligible professional is attempting to report, but does indicate that the QDC was processed and transmitted to the NCH.

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

▲ Measure #53: Asthma: Pharmacologic Therapy

DESCRIPTION:

Percentage of patients aged 5 through 50 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

NUMERATOR:

Patients who were prescribed *either* the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta₂-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines)

Numerator Instructions: Documentation of persistent asthma must be present. One method of identifying persistent asthma is at least daily use of short-acting bronchodilators.

Definition:

Prescribed – May include prescription given to the patient for long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta₂-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines) at one or more visits in the 12-month period or patient already taking long-term control medication or an acceptable alternative treatment as documented in current medication list.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Preferred Long-Term Control Medication or Acceptable Alternative Treatment Prescribed

(Two CPT II codes [4015F & 1038F] are required on the claim form to submit this numerator option)

CPT II 4015F: Persistent asthma, preferred long term control medication or acceptable alternative treatment prescribed

AND

CPT II 1038F: Persistent asthma (mild, moderate or severe)

OR

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Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed for Patient Reasons

(Two CPT II codes [4015F-2P & 1038F] are required on the claim form to submit this numerator option)

Append a modifier (2P) to CPT Category II code 4015F to report documented circumstances that appropriately exclude patients from the denominator.

4015F with 2P: Documentation of patient reason(s) for not prescribing either the preferred long-term control medication (inhaled corticosteroid or inhaled corticosteroid with long-acting inhaled beta2-agonist) or an acceptable alternative treatment (leukotriene modifiers, cromolyn sodium, nedocromil sodium, or sustained-released methylxanthines)

AND

CPT II 1038F: Persistent asthma (mild, moderate or severe)

OR

If patient is not eligible for this measure because patient does not have persistent asthma, report:

(One CPT II code [1039F] is required on the claim form to submit this numerator option)

CPT II 1039F: Intermittent asthma

OR

Preferred Long-Term Control Medication or Acceptable Alternative Treatment not Prescribed, Reason not Specified

(Two CPT II codes [4015F-8P & 1038F] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 4015F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4015F with 8P: Persistent asthma, preferred long term control medication or acceptable alternative treatment not prescribed, reason not otherwise specified

AND

CPT II 1038F: Persistent asthma (mild, moderate or severe)

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

▲ Measure #64: Asthma: Asthma Assessment

DESCRIPTION:

Percentage of patients aged 5 through 50 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

NUMERATOR:

Patients who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Numerator Instructions: To be counted in calculation 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.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Asthma Symptom Frequency Evaluated

CPT II 1005F: Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)

OR

Asthma Symptom Frequency not Evaluated, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1005F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1005F with 8P: *Asthma symptoms not evaluated, reason not otherwise specified*

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #231: Asthma: Tobacco Use: Screening - Ambulatory Care Setting

DESCRIPTION:

Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months

NUMERATOR:

Patients who were queried about tobacco use and exposure to second hand smoke in their home environment at least once within 12 months

Numerator Instructions: Information regarding tobacco exposure for patients under 18 obtained from a parent or guardian is valid for reporting the numerator. In order to meet the measure, there must be a note in the medical record documenting that the patient was queried about both smoking status AND exposure to environmental smoke in the home environment.

NUMERATOR NOTE: For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including non-smoker tobacco users e.g. chew, snuff).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Tobacco Use Assessed, Including Exposure to Secondhand Smoke

Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

G8686: Currently a Tobacco Smoker OR Current Exposure to Secondhand Smoke

OR

Current Tobacco Non-User AND No Exposure to Secondhand Smoke

G8687: Currently a Tobacco Non-User AND No Exposure to Secondhand Smoke

OR

Tobacco Use not Assessed, Reason Not Specified

G8689: Tobacco Use not assessed, reason not otherwise specified

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

SPECIFICATION FOR MEASURES GROUP REPORTING ONLY

□ Measure #232: Asthma: Tobacco Use: Intervention - Ambulatory Care Setting

DESCRIPTION:

Percentage of patients aged 5 through 50 years with a diagnosis of asthma who were identified as tobacco users (patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment) who received tobacco cessation intervention within 12 months

NUMERATOR:

Patients who received tobacco use cessation intervention

Numerator Instructions: Practitioners providing tobacco cessation interventions to a pediatric patient's primary caregiver are still numerator complaint even if the primary caregiver is not the source of second hand smoke in the home.

Definitions:

Tobacco Users – Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.

Tobacco Use Cessation Intervention – May include brief counseling (3 minutes or less) and/or pharmacotherapy.

NUMERATOR NOTE: For the purpose of this measure, "tobacco user" refers to tobacco smokers and "tobacco non-user" refers to non-smokers (including non-smoker tobacco users e.g. chew, snuff).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patients who Received Tobacco Use Cessation Intervention

CPT II 4000F: Tobacco Use Cessation Intervention, Counseling

OR

CPT II 4001F: Tobacco Use Cessation Intervention, Pharmacologic Therapy

AND

Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

G8690: Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

OR

If patient is not eligible for this measure because patient is a non tobacco user AND Has No Exposure to Secondhand Smoke, report:

G8691: Current Tobacco Non-User AND No Exposure to Secondhand Smoke

OR

Tobacco Use not Assessed, Reason Not Specified

G8693: Tobacco Use not assessed, reason not specified

OR

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Tobacco Use Cessation Intervention not Performed, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4000F OR 4001F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4000F with 8P: Tobacco Use Cessation Intervention, Counseling, not performed, reason not otherwise specified

OR

4001F with 8P: Tobacco Use Cessation Intervention, Pharmacologic Therapy, not performed, reason not otherwise specified

AND

Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

G8690: Current Tobacco Smoker OR Current Exposure to Secondhand Smoke

NOTE: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures groups option. For all other claims-based or registry-based reporting options, please see the measures' full specifications in the document "2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting for Individual Measures" available for download from the CMS Physician Quality Reporting website.

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