CMS Manual System

Pub 100-19 Demonstrations

Transmittal 35

Department of Health & Human Services (DHHS)

Center for Medicare & Medicaid Services (CMS)

Date: DECEMBER 23, 2005

Change Request 4183

NOTE: Transmittal 31, dated November 2, 2005 is rescinded and replaced with Transmittal 35, dated December 23, 2005. There were changes made to the attachment. All other information remains the same.

SUBJECT: Physician's Voluntary Reporting Program (PVRP)

I. SUMMARY OF CHANGES: CMS will launch a Physician Voluntary Reporting Program (PVRP) to better analyze the quality of care provided to Medicare beneficiaries by using a set of quality G-codes established by Medicare. These G-codes are reportable on existing claims forms. These codes are for voluntary reporting purposes only. Physicians should not charge for these codes.

NEW/REVISED MATERIAL

EFFECTIVE DATE: January 01, 2006

IMPLEMENTATION DATE: January 03, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
N/A	

III. FUNDING:

No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

One-Time Notification

**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-19	Transmittal: 35	Date: December 23, 2005	Change Request 4183

NOTE: Transmittal 31, dated November 2, 2005 is rescinded and replaced with Transmittal 35, dated December 23, 2005. There were changes made to the attachment. All other information remains the same.

SUBJECT: *Physician's Voluntary Reporting Program* (PVRP)

I. GENERAL INFORMATION

A. Background: As part of its overall quality improvement efforts, CMS is launching the Physician Voluntary Reporting Program (PVRP). This new program builds on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered. Under the voluntary reporting program, physicians who choose to participate will help capture data about the quality of care provided to Medicare beneficiaries, in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care. Voluntary reporting of quality data through the PVRP will begin in January 2006.

B. Policy: As noted by CMS Administrator Mark B. McClellan, M.D., Ph.D. in his testimony before the House Ways and Means Subcommittee on Health on September 29, 2005, CMS believes that an important component of delivering high quality care is the ability to measure and evaluate quality. Accordingly, CMS is committed to the development of reporting and payment systems that will support and reward quality.

Providing quality health care to Medicare beneficiaries is a high priority for President Bush and the Department of Health and Human Services. CMS is also committed to assuring quality of care for all Americans. To that end, CMS has developed several quality initiatives that provide information on the quality of care across different settings, including hospitals, skilled nursing facilities, home health agencies, and dialysis facilities for end stage renal disease. The quality initiatives aim to empower providers and consumers with information that would support the overall delivery and coordination of care, and ultimately to support new payment systems that provide more financial resources to provide better care, rather than simply paying based on the volume of services.

The PVRP would initiate the process by which physicians who choose to participate would begin reporting quality data and be able to receive feedback on their performance, as well as to provide input on how quality reporting can be improved and made even less burdensome.

These steps are an important step in enabling CMS to provide better support for physicians' efforts to deliver high-quality care.

<u>Reporting Infrastructure</u>

CMS has developed the underlying infrastructure so that voluntary reporting of quality measures can begin by January 2006, using the existing administrative system for physician claims.

While the usual source of the clinical data for quality measures is retrospective chart abstraction, data collection through this process can be burdensome. Consequently, the voluntary reporting program will focus on ways to obtain valid quality measures as efficiently as possible.

Electronic health records (EHRs) will greatly facilitate clinical data reporting and performance improvement in the future but its adoption is not currently widespread. CMS is working with physicians to achieve the goal of adopting EHRs in their offices, building on reporting based on the pre-existing claims based system will be used for reporting data under the PVRP. The utilization of a pre-existing reporting system will minimize the burden on physicians.

Physicians can begin providing voluntary information for constructing evidence-based quality measures for the Medicare population through a defined set of HCPCS codes (called "G-codes"), which are reported on the pre-existing physician claim form. These new codes will supplement the usual claims data with clinical data that can be used to measure the quality of services rendered to beneficiaries.

The G-codes are an interim step until electronic submission of clinical data through EHRs replaces this process. Medicare expects to work with some physician groups that have already adopted EHRs to assist with this transition.

Medicare's contracted Quality Improvement Organizations (QIOs) are helping physicians move toward a more dynamic and evolving public reporting and pay-for-performance quality improvement environment. In specific, QIOs are providing assistance to help physicians create systems so that the measures can be more easily reported.

Development of Measures

Measuring and evaluating quality requires the development of clinically valid quality measures. Effective measures for performance measurement, quality improvement, disease prevention, and public reporting should be valid, reliable, evidence-based, and relevant for consumers, clinicians and purchasers. In addition, such measures must be developed through open and transparent processes and implemented in a realistic manner with minimal burden on physicians so as not to discourage appropriate care.

The PVRP will begin to phase in quality performance measures that are consistent with these requirements. These 36 evidence-based clinically valid measures have been part of the guidelines endorsed by physicians and the medical specialty societies and are the result of extensive input and feedback from physicians and other quality care experts. Physicians recognize the importance of these measures for the management of their patients' care, providing CMS with a strong starting point for the voluntary program.

Additional quality measures are under development now and could be phased-in for reporting later in 2006.

Quality Measures

The 36 quality measures are arranged in sets of measures, with multiple G-codes in each set. The physician will report the appropriate G-code that represents the clinical services furnished with regard to a specific measure set.

Each measure set has a defined numerator (the appropriate G-code) and a denominator (specifically defined according to the appropriate services or condition), which will be used to calculate performance.

The objective of the PVRP is to help physicians obtain information they can use to improve quality and avoid unnecessary costs. Thus, CMS will provide feedback to physicians on their level of performance based upon the data submitted through this voluntary effort. This feedback may begin as early as summer 2006.

Physician Use of G-codes – General Information

- G-codes, when applicable, should be reported in addition to CPT and ICD-9 codes required for appropriate claims coding.
- G-codes do NOT substitute for CPT and ICD-9 codes requirements for payment.
- G-codes are not associated with a separate fee, and will NOT be individually compensated. These codes are for voluntary reporting purposes only. Physicians should NOT charge for these codes.
- G-codes are not specialty specific. Therefore, a medical specialty may report G-codes classified under other specialties; however, CMS anticipates that the reporting of certain G-codes will be predominated by certain specialties.
- The failure to provide a G-code will NOT result in denial of a claim that would otherwise be approved, and thus submission of a G code is voluntary.

Although reporting is voluntary, physicians are encouraged to submit G-codes when applicable. The potential advantages to the physician include receiving feedback reports for calculated measures that will promote quality improvement for the physician practice and allows the physician the opportunity to improve the accuracy of data submission in a voluntary setting.

Physician Use of G-codes – When to report

G-codes are reportable when all of the following circumstances are met:

- The G-code reported on the claim relates to a covered diagnosis, covered treatment(s) or covered preventive service(s) that are applicable to the beneficiary.
- The G-code is directly relevant to the specific service(s) provided to the beneficiary by the practitioner reported on the claim.
- The G-code represents medically necessary and appropriate medical practice under the circumstances.
- The basis for the G-code is documented in the beneficiary medical record.

CMS Calculation of quality measures using G-codes

This document contains 36 sets of G-codes pertaining to identified healthcare quality measures for physician services. For each measure, a description is provided along with two or three G-codes. Each measure has a defined numerator and a denominator. The numerator will consist of the appropriate G-code. The denominator is specifically defined according to the appropriate services or condition. As part of this voluntary program, CMS will calculate the reporting rate for physicians. For those who participate in the voluntary program, CMS will provide feedback information to physicians in an effort to assist with improving their data accuracy and reporting rate. The reporting rate is calculated as a percentage for each of the 36 measures. See the appendix for the specific measures and G-codes.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4183.1	Contractors shall instruct providers, when applicable, to report G-codes in addition to CPT and ICD-9 codes required for appropriate claims coding.			X						
4183.2	Contractors shall instruct providers to not substitute G-codes for CPT and ICD-9 codes requirements for payment.			X						
4183.3	Contractors shall instruct providers to not associate G-codes with a separate fee, and therefore, will not be individually compensated.			X						
4183.4	Contractors shall instruct providers to, when applicable, report G-codes classified under other specialties; however, CMS anticipates that the reporting of certain G-codes will be predominated by certain specialties.			X						

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4183.5	Contractor shall instruct providers to submit G-codes on a voluntary basis.			X						
4183.6	Contractor shall instruct providers to report G-codes on the claim at it relates to a covered diagnosis, covered treatment(s) or covered preventive service(s) that are applicable to the beneficiary.			X						
4183.7	Contractor shall instruct providers to submit G-code that is directly relevant to the specific service(s) provided to the beneficiary reported on the claim.			X						
4183.8	Contractors shall instruct providers to use G-codes that represent medically necessary and appropriate medical practice under the circumstances.			X						
4183.9	Contractor shall instruct provider to document the basis for the G-code in the beneficiary medical record.			X						

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)					
		FI	RHH	Car	DME	Shared System Maintainers	Other

						FISS	MCS	VMS	CWF	
4183.10	A provider education article related to this instruction will be available at www.cms.hhs.gov/medlearn/matters shortly after the CR is released. You will receive notification of the article release via the established "medlearn matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin and incorporated into any educational events on this topic. Contractors are free to supplement Medlearn Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.			X						

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: January 1, 2006 **Implementation Date:** January 3, 2006 **Pre-Implementation Contact(s):** John M. Young (410) 786-0505 or John.Young@cms.hhs.gov. **Post-Implementation Contact(s):** John M. Young (410) 786-0505 or John.Young@cms.hhs.gov.	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Attachment

G-Code Specifications and Instruction for Clinical Measures
Physician Voluntary Reporting Program (PVRP)
As of: December 27, 2005

Measure: Aspirin at arrival for acute myocardial infarction

Numerator:
G8006: Acute myocardial infarction: patient documented to have received aspirin at arrival

G8007: Acute myocardial infarction: patient not documented to have received aspirin at arrival

G8008: Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival measure

Denominator:
*Patients with a*cute myocardial infarction *who present to hospital emergency department or are hospitalized as listed:*

Patients with acute myocardial infarction:
ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91
And
ED E&M: 99281-99285; initial hospital care E&M: 99221-99223; observation: 99218-99220, 99234-99236; critical care services: 99291- 99292

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with acute myocardial infarction. It is anticipated that the patient would receive aspirin therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period before presentation and the 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction who present to the emergency department or the hospital setting.

Measure: Beta blocker at time of arrival for acute myocardial infarction

Numerator:
G8009: Acute myocardial infarction: patient documented to have received beta-blocker at arrival

G8010: Acute myocardial infarction: patient not documented to have received beta-blocker at arrival

G8011: Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure

Denominator:

Patients with acute myocardial infarction *who present to hospital emergency department or are hospitalized as listed:*

Patients with acute myocardial infarction:
ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91
And
ED E&M: 99281-99285; initial hospital care E&M: 99221-99223; observation: 99218-99220, 99234-99236; critical care services: 99291- 99292

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with acute myocardial infarction who presents to the hospital emergency department or other hospital setting. It is anticipated that the patient would receive beta-blocker therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction in the emergency department or hospital setting.

Measure: Antibiotic administration timing for patient hospitalized for pneumonia

Numerator:
G8012: Pneumonia: patient documented to have received antibiotic within 4 hours of presentation

G8013: Pneumonia: patient not documented to have received antibiotic within 4 hours of presentation

G8014: Clinician documented that pneumonia patient was not an eligible candidate for antibiotic within 4 hours of presentation measure

Denominator:
Patients with pneumonia as listed:

ICD-9CM codes: 480.1, 480.2, 480.3, 480.8, 480.9, 481 (S. pneumo), 482.0 (Klebsiella), 482.1 (Pseudomonas), 482.2 (H. flu), 482.30 (unspec. Strep), 482.31 (Strep A), 482.32 (Strep B), 482.39 (other Strep), 482.40 (unspec. Staph), 482.41(S. aureus), 482.49 (other Staph), 482.81 (Anaerobes), 482.82 (E. coli), 482.83 (other gram neg), 482.84 (Legionnaires), 482.89 (other spec. bacteria), 482.9 (unspec. bacteria), 483.0 (M. pneumoniae), 483.1 (Chlamydia), 483.8 (other spec. organism), 485 (Bronchopneumonia, unspec. organism), 486 (unspec organism), 487.0 (influenza with pneumonia)
And
ED E&M: 99281-99285; initial hospital care E&M: 99221-99223, 99218-99220; critical care codes 99291-99292

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 is used with the listed CPT services for a patient with pneumonia. This measure should reflect the quality of services for the initial management of a patient with pneumonia presenting to the emergency department

and admitted to hospital or a hospital setting. Patients transferred to an emergency department should not be considered an eligible candidate and the clinician should use the appropriate quality G-code indicator to indicate that such a patient is not a candidate for this measure.

Priority Measure: Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus

Numerator:

G8016: Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as less than or equal to 9%

G8015: Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as greater than 9%

G8017: Clinician documented that diabetic patient was not eligible candidate for hemoglobin A1c measure

G8018: Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (6 months)

Denominator:

Patients with diabetes:

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus. It is not anticipated that clinicians would use this indicator if the clinician is not providing services for the primary management of diabetes mellitus.

Measure: Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus

Numerator:

G8020: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl

G8019: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl

G8021: Clinician documented that diabetic patient was not eligible candidate for low-density lipoprotein measure

G8022: Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)

Denominator:
Patients with diabetes:

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus. It is not anticipated that clinicians would use this indicator if the clinician is not providing services for the primary management of diabetes mellitus.

Measure: High blood pressure control in patient with Type I or Type II diabetes mellitus

Numerator:
G8024: Diabetic patient with most recent blood pressure (within the last 6 months) documented less than 140 systolic and less than 80 diastolic

G8023: Diabetic patient with most recent blood pressure (within the last 6 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 mmHg diastolic

G8025: Clinician documented that the diabetic patient was not eligible candidate for blood pressure measure

G8026: Clinician has not provided care for the diabetic patient for the required time for blood measure (within the last 6 months)

Denominator:
Patients with diabetes:

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus.

Measure: Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction

Numerator:

G8027: Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

G8028: Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

G8029: Clinician documented that heart failure patient was not an eligible candidate for either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy measure

Denominator:

Heart failure patients with LVEF < 40% or with moderately or severely depressed left ventricular systolic function:

Patients with heart failure:
Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9
And
Patients who had documentation of an ejection fraction < 40% (use most recent value) or moderately or severely depressed left ventricular systolic function
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services visit are provided to patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment would be an echocardiogram that provides a numerical value of left ventricular systolic dysfunction or that uses descriptive terms such moderate or severely depressed left ventricular dysfunction. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure.

Measure: Beta-blocker therapy for left ventricular systolic dysfunction

Numerator:

G8030: Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on beta-blocker therapy

G8031: Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on beta-blocker therapy

G8032: Clinician documented that heart failure patient was not eligible candidate for beta-blocker therapy measure

Denominator:
Heart failure patients with left ventricular ejection fraction (LVEF) < 40% or with moderately or severely depressed left ventricular systolic function

Patients with heart failure:
Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
And
Patient who has documentation of an LVEF < 40% (use most recent value) or moderately or severely depressed left ventricular systolic function
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and E&M services are provided for a patient with documented left ventricular systolic dysfunction. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure.

Measure: Beta-blocker therapy for patient with prior myocardial infarction

Numerator:
G8033: Prior myocardial infarction - coronary artery disease patient documented to be on beta-blocker therapy

G8034: Prior myocardial infarction - coronary artery disease patient not documented to be on beta -blocker therapy

G8035: Clinician documented that prior myocardial infarction - coronary artery disease patient was not eligible candidate for beta - blocker therapy measure

Denominator:
Patients with coronary artery disease who also have prior MI at any time as listed:

Patients with Coronary artery disease:
414.00-414.07, 414.8, 414.9, 410.00-410.92 (Acute myocardial infarction), 412 (old MI), 411.0-411.89, 413.0-413.9 (angina), V45.81 (Aortocoronary bypass status), V45.82 (PTCA status)
And

E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)
And
Patients with prior MI:
410.00-410.92, 412

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients with documented coronary artery disease and prior myocardial infarction. This measure is intended to reflect the quality of services provided for the primary management of patients with coronary artery disease.

Measure: Antiplatelet therapy for patient with coronary artery disease

Numerator:
G8036: Coronary artery disease patient documented to be on antiplatelet therapy

G8037: Coronary artery disease patient not documented to be on antiplatelet therapy

G8038: Clinician documented that coronary artery disease patient was not eligible candidate for antiplatelet therapy measure

Denominator:
Patients with coronary artery disease:
ICD-9-CM codes for Coronary artery disease: 414.00-414.07, 414.8, 414.9, 410.00-410.92 (Acute myocardial infarction); 412 (old MI), 411.0-411.89, 413.0-413.9 (angina), V45.81 (Aortocoronary bypass status), V45.82 (PTCA status)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used with the listed E&M services provided for a patient with coronary artery disease. This measure is intended to reflect the quality of services provided for the management of patients with coronary artery disease. Antiplatelet therapy consists of aspirin, clopidogrel, or combination of aspirin and dypyridamole.

Measure: Low-density lipoprotein control in patient with coronary artery disease

Numerator:
G8040: Coronary artery disease – patient with low-density lipoprotein documented to be less than or equal to 100mg/dl

G8039: Coronary artery disease – patient with low-density lipoprotein documented to be greater than 100mg/dl

G8041: Clinician documented that coronary artery disease patient was not eligible candidate for low-density lipoprotein measure

G8182: Clinician has not provided care for the cardiac patient for the required time for low-density lipoprotein measure (6 months)

Denominator:
Patients with coronary artery disease:

ICD-9-CM codes for coronary artery disease: 414.00-414.07, 414.8, 414.9, 410.00-410.92 (Acute myocardial infarction), 412 (old MI), 411.0-411.89, 413.0-413.9 (angina), V45.81 (aortocoronary bypass status), V45.82 (PTCA status);
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the CPT services are provided for a patient with coronary artery disease. This measure is intended to reflect the quality of services provided for the management of patients with coronary artery disease.

Measure: Osteoporosis assessment in elderly female patient

Numerator:
G8051: Patient (female) documented to have been assessed for osteoporosis

G8052: Patient (female) not documented to have been assessed for osteoporosis

G8053: Clinician documented that (female) patient was not an eligible candidate for osteoporosis assessment measure

Denominator:
Female patients 75 years of age or older:

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99341-99350 (home visit)
And
Female patients 75 years of age or older

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include counseling the patient about the risk of osteoporosis and the potential need for preventive therapy.

Measure: Assessment of elderly patients for falls

Numerator:
G8055: Patient documented for the assessment for falls within last 12 months

G8054: Patient not documented for the assessment for falls within last 12 months

G8056: Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months

Denominator:
Patients 75 years of age or older:

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); G0344
And
Patients 75 years of age or older

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include annual review of the patient's fall history as part of a medically necessary visit.

Measure: Assessment of hearing acuity in elderly patient

Numerator:
G8057: Patient documented to have received hearing assessment

G8058: Patient not documented to have received hearing assessment

G8059: Clinician documented that patient was not an eligible candidate for hearing assessment measure

Denominator:
Patients 75 years of age or older:

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99341-99350 (home visit); G0344
And
Patients 75 years of age or older

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include an annual clinical examination and history of hearing capacity as part of a medically necessary visit.

Measure: Assessment for urinary incontinence in elderly patients

Numerator:
G8060: Patient documented for the assessment of urinary incontinence

G8061: Patient not documented for the assessment of urinary incontinence

G8062: Clinician documented that patient was not an eligible candidate for urinary incontinence assessment measure

Denominator:
Patients 75 years of age or older:

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99341-99350 (home visit); G0344
And
Patients 75 years of age or older

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include annual history of patient's absence or presence of urinary incontinence.

Measure: Dialysis dose in end stage renal disease patient

Numerator:
G8075: End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)

G8076: End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)

G8077: Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure

Denominator:
Patients with end-stage renal disease *on hemodialysis as listed:*

CPT: G0308-G0327, 90945, 90947
Or
585.6 (End-stage renal disease)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services or ICD-9 are provided and the listed hemodialysis CPT services are provided to patients with end stage

renal disease. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease.

Measure: Hematocrit level in end stage renal disease patient

Numerator:
G8078: End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)

G8079: End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)

G8080: Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure

Denominator:
Patients with end-stage renal disease *as listed:*

CPT: G0308-G0327, 90945, 90947
Or
585.6 (End-stage renal disease)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 is used or the listed CPT services or ICD-9 are provided to patients with end stage renal disease on hemodialysis. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease.

Measure: Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis

Numerator:
G8081: End-stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula

G8082: End-stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula

Denominator:
Patients with end-stage renal disease *on hemodialysis as listed:*

CPT: 36800, 36810, 36815, 36818-36821, 36825, 36830
And

585.6 (End-stage renal disease)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are used and the listed CPT services are provided to patients with end stage renal disease on hemodialysis. It is anticipated that the clinician providing vascular access for the patient's hemodialysis would submit this measure for their patients. It is anticipated that clinicians will still make clinical determinations at the individual level regarding whether a patient is an appropriate candidate for arteriovenous fistula placement.

Measure: Warfarin therapy in heart failure patient with atrial fibrillation

Numerator:
G8183: Patient with heart failure and atrial fibrillation documented to be on warfarin therapy

G8184: Clinician documented that patient with heart failure and atrial fibrillation was not an eligible candidate for warfarin therapy measure

Denominator:
Patients with heart failure:
Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9
And
E&M visit: 99201-99205, 99211-99215, 99241-99245 (office consultation); 99341-99350 (home visit); 99218-99220 (observation); 99234-99236 (observation or inpatient); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337(domiciliary); 99221-99223
And
Atrial fibrillation 427.31

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes for heart failure and atrial fibrillation are used with the listed CPT services. This measure should reflect the quality of the services for the management of atrial fibrillation for a patient with heart failure.

Measure: Smoking cessation intervention in newly diagnosed chronic obstructive pulmonary disease

Numerator:
G8093: Newly diagnosed chronic obstructive pulmonary disease (COPD) patient documented to have received smoking cessation intervention, within 3 months of diagnosis,

G8094: Newly diagnosed chronic obstructive pulmonary disease (COPD) patient not documented to have received smoking cessation intervention, within 3 months of diagnosis

Denominator:
Patients with COPD:

ICD-9: 491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9 (Chronic bronchitis); 492.0, 492.8 (Emphysema); 494.0, 494.1 (Bronchiectasis); 496 (COPD); 493.20 – 493.22 (COPD with chronic obstructive asthma)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99324-99328, 99334-99337 (domiciliary); 99304-99306, 99307-99310 (nursing facility); G0375; G0376

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are used and the listed E&M services are provided to patients with documented COPD.

Measure: Prescription of calcium and vitamin D supplements in osteoporosis

Numerator:
G8099: Osteoporosis patient documented to have been prescribed calcium and vitamin D supplements

G8100: Clinician documented that osteoporosis patient was not an eligible candidate for calcium and vitamin D supplement measure

Denominator:
Patients with Osteoporosis as listed:

ICD-9: 733.00, 733.01, 733.02, 733.03, 733.09
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337(domiciliary); 99341-99350 (home visit)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided for a patient with osteoporosis. It is anticipated that this measures reflects the services provided for the primary management of osteoporosis.

Measure: Antiresorptive therapy and/or parathyroid hormone treatment in newly diagnosed osteoporosis

Numerator:
G8103: Newly diagnosed osteoporosis patients documented to have been treated with antiresorptive therapy and/or parathyroid hormone treatment within 3 months of diagnosis

G8104: Clinician documented that newly diagnosed osteoporosis patient was not an eligible candidate for antiresorptive therapy and/or parathyroid hormone treatment measure within 3 months of diagnosis

Denominator:
Patients with Osteoporosis:

ICD-9: 733.00 733.01 733.02 733.03 733.09
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350 (home visit)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided for a patient with osteoporosis. It is anticipated that this measure reflects the services provided for the primary management of osteoporosis.

Measure: Bone mineral density testing and osteoporosis treatment and prevention following osteoporosis associated nontraumatic fracture

Numerator:
G8106: Within 6 months of suffering a nontraumatic fracture, female patient 65 years of age or older documented to have undergone bone mineral density testing or to have been prescribed a drug to treat or prevent osteoporosis

G8107: Clinician documented that female patient 65 years of age or older who suffered a nontraumatic fracture within the last 6 months was not an eligible candidate for measure to test bone mineral density or drug to treat or prevent osteoporosis

Denominator:
Female patients 65 and older with osteoporosis:

ICD-9: 733.00 733.01 733.02 733.03 733.09
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350 (home visit)
And
Female patients 65 and older with osteoporosis

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for an elderly female patient with nontraumatic fracture. This measure should reflect quality of services for the detection of osteoporosis related complications in the elderly female population. It is anticipated that the clinician who provides primary management of the patient would submit this measure.

Measure: Annual assessment of function and pain in symptomatic osteoarthritis

Numerator:
G8185: Patients diagnosed with symptomatic osteoarthritis with documented annual assessment of function and pain

G8186: Clinician documented that symptomatic osteoarthritis patient was not an eligible candidate for annual assessment of function and pain measure

Denominator:
Visits for patients with Osteoarthritis as listed:

ICD-9: 715.00-715.98 (OA)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350 (home visit)

Instructions:
This measure is reported whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with symptomatic osteoarthritis. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. This measure should reflect quality of services for the primary management of osteoarthritis.

Measure: Influenza vaccination

Numerator:
G8108: Patient documented to have received influenza vaccination during influenza season

G8109: Patient not documented to have received influenza vaccination during influenza season

G8110: Clinician documented that patient was not an eligible candidate for influenza vaccination measure

Denominator:
Patients 50 years of age or older:

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350; G0008
And
Patients 50 years of age or older

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients for the purpose of providing preventive services. This indicator should be provided only on an annual basis.

Measure: Mammography

Numerator:
G8111: Patient (female) documented to have received a mammogram during the measurement year or prior year to the measurement year

G8112: Patient (female) not documented to have received a mammogram during the measurement year or prior year to the measurement year

G8113: Clinician documented that female patient was not an eligible candidate for mammography measure

G8114: Clinician did not provide care to patient for the required time of mammography measure (i.e., measurement year or prior year)

Denominator:
Women age 40 or over:

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350 (home visit); G0344
And
Female patients age 40 or over

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients for the purpose of providing preventive services. This indicator should be provided only on an annual basis.

Measure: Pneumococcal vaccination

Numerator:
G8115: Patient documented to have received pneumococcal vaccination

G8116: Patient not documented to have received pneumococcal vaccination

G8117: Clinician documented that patient was not an eligible candidate for pneumococcal vaccination measure

Denominator:
Patients 65 years of age or older:

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); 99341-99350; G0009, G0344
And
Patients 65 years of age or older

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients for the purpose of providing preventive services. This indicator shall not be reported more than once a year.

Measure: Antidepressant medication during acute phase for patient diagnosed with new episode of major depression

Numerator:
G8126: Patient documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

G8127: Patient not documented as being treated with antidepressant medication during the entire 12 weeks acute treatment phase

G8128: Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week acute treatment phase measure

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

E&M Visit: 99201-99205, 99211-99215; psychiatry: 90801, 90804-90809
And
ICD-9 296.2, 296.3, 300.4, 309.1, 311 (major depression)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the patient is placed on prescription therapy for the treatment of a new episode of major depression disorder. It is anticipated that the clinician that provides the primary management of depression for the patient would submit this measure.

Measure: Antidepressant medication duration for patient diagnosed with new episode of major depression

Numerator:
G8129: Patient documented as being treated with antidepressant medication for at least 6 months continuous treatment phase

G8130: Patient not documented as being treated with antidepressant medication for at least 6 months continuous treatment phase

G8131: Clinician documented that patient was not an eligible candidate for antidepressant medication for continuous treatment phase

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

E&M Visit: 99201-99205, 99211-99215; psychiatry: 90801, 90804-90809
And
ICD-9 296.2, 296.3, 300.4, 309.1, 311 (major depression)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the patient is placed on prescription therapy for the treatment of a new episode of major depression disorder. This measure is anticipated to reflect that the primary management of the acute treatment for depression including continuous treatment (beyond 12 weeks) where clinically appropriate.

Measure: Antibiotic prophylaxis in surgical patient

Numerator:
G8152: Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)

G8153: Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)

G8154: Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure

Denominator:
Patients with selected surgical procedures as listed:

Musculoskeletal: 27130, 27125, 27138, 27437, 27445, 27446

Cardiovascular System: 33300 33305 33400 33401 33403 33404 33405 33406 33410 33411 33412 33413 33414 33415 33416 33417 33420 33422 33425 33426 33427 33430 33460 33463 33464 33465 33468 33470 33471 33472 33474 33475 33476 33478 33496 33510 33511 33512 33513 33514 33516 33517 33518 33519 33521 33522 33523 33530 33533 33534 33535 33536 33545 33560 33600 33602 33608 33610 33611 33612 33615 33617 33619 33641 33645 33647 33660 33665 33670 33681 33684 33688 33692 33694 33697 33702 33710 33720 33722 33730 33732 33735 33736 33737 33770 33771 33774 33775 33776 33777 33778 33779 33780 33781 33786 33813 33814 33875 33877 33918 33919 33920 33924 33999 34520 34830 34831 34832 35081 35082 35091 35092 35102 35103 35111 35112 35121 35122 35131 35132 35141 35142 35151 35152 35256 35286 35331 35341 35351 35355 35361 35363 35371 35372 35381 35516 35518 35521 35522 35525 35531 35533 35536 35541 35546 35548 35549 35551 35556 35558 35563 35565 35566 35571 35583 35585 35587 35600 35616 35621 35623 35631 35636 35641 35646 35647 35650 35651 35654 35656 35661 35665 35666 35671 35686 35879 35881 35903 35907 37500 37700 37720 37730 37735 37760 37765 37766 37780 37785 37788 37791 92992 92993 93580 93581

Hemic and Lymphatic Systems: 38082 38103

Digestive System: 44025 44110 44111 44120 44121 44125 44130 44139 44140 44141 44143 44144 44145 44146 44147 44150 44151 44152 44153 44155 44156 44160 44204 44205 44206 44207 44208 44210 44211 44212 44300 44320 44322 44604 44605 44615 44625 44626 44660 44661 44799 45110 45111 45112 45113 45114 45116 45119 45120 45121 45123 45126 45130 45135 45550 45562 45563 45800 45805 45820 45825 45999

Urinary System: 51597 51925

Female Genital System: 57307 58150 58152 58180 58200 58210 58240 58260 58262 58263 58285 58550 58552 58553 58554 58951 58953 59135 59136 59140 59525

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing surgery that typically requires the administration of prophylactic antibiotics. It is anticipated that this measure should reflect the management of the surgical patient to reduce complications from infections. Thus, it is anticipated that it may be appropriate for both the clinician performing the surgery and the clinician providing anesthesia services may submit this measure for a patient.

Measure: Thromboembolism prophylaxis in surgical patient

Numerator:
G8155: Patient with documented receipt of thromboemoblism prophylaxis

G8156: Patient without documented receipt of thromboemoblism prophylaxis

G8157: Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Denominator:
Patients with selected surgical procedures as listed:

Integumentary System: 13160

Musculoskeletal System: 20102 22554 22556 22558 22585 22590 22600 22612 22614 22800 22802 22804 22808 22810 22812 22840 22851 27120 27125 27130 27132 27134 27137 27138 27236 27437 27445 27446 27447 27486 27487
Respiratory System: 32140 32141 32220 32225 32310 32320 32440 32442 32445 32480 32482 32484 32486 32488 32520 32522 32525 32651 32652 32655 32656 32663 32800 32850

Cardiovascular System: 33930 35840 35870 37799

Hemic and Lymphatic Systems: 38100 38101 38102 38120

Mediastinum and Diaphragm: 39501 39502 39503 39520 39530 39531 39540 39541 39545 39560 39561 39599

Digestive System: 42953 43020 43045 43107 43108 43112 43113 43116 43117 43118 43121 43122 43123 43124 43228 43240 43250 43251 43258 43267 43268 43269 43271 43272 43280 43289 43300 43305 43310 43312 43313 43314 43316 43320 43324 43325 43326 43340 43341 43350 43351 43352 43360 43361 43401 43405 43410 43415 43420 43425 43496 43499 43500 43501 43502 43510 43620

43621 43622 43631 43632 43633 43634 43635 43638 43639 43640 43641 43652 43761 43800 43810 43820 43825 43840 43842 43843 43845 43846 43847 43848 43850 43855 43860 43865 43870 43880 43999 44005 44010 44015 44020 44021 44025 44050 44055 44110 44111 44120 44121 44125 44126 44127 44128 44130 44132 44133 44139 44140 44141 44143 44144 44145 44146 44147 44150 44151 44152 44153 44155 44156 44160 44201 44202 44203 44204 44205 44206 44207 44208 44210 44211 44212 44300 44310 44316 44320 44322 44340 44345 44346 44351 44370 44379 44383 44397 44602 44603 44604 44605 44615 44620 44625 44626 44640 44650 44660 44661 44680 44700 44799 44800 44820 44850 45000 45005 45020 45110 45111 45112 45113 45114 45116 45119 45120 45121 45123 45126 45130 45135 45136 45160 45170 45321 45327 45345 45387 45500 45505 45540 45541 45550 45562 45563 45800 45805 45820 45825 45999 46730 46735 46744 46746 46748 47010 47011 47120 47122 47125 47130 47133 47300 47315 47350 47360 47361 47362 47370 47371 47380 47381 47382 47399 47400 47420 47425 47460 47510 47511 47564 47570 47579 47610 47612 47620 47716 47720 47721 47740 47741 47760 47765 47780 47785 47800 47802 47900 47999 48000 48001 48005 48020 48120 48140 48145 48146 48148 48150 48151 48152 48153 48154 48155 48160 48180 48500 48510 48511 48520 48540 48545 48547 48550 48554 48556 48662 48999 49002 49020 49021 49040 49041 49060 49061 49080 49081 49085 49201 49210 49215 49220 49255 49420 49421 49425 49426 49605 49606 49610 49611 49900 49904 49906 49999 96445

Urinary System:
50020 50021 50220 50223 50225 50230 50234 50236 50240 50300 50320 50340 50360 50365 50370 50380 50543 50545 50546 50547 50548 50562 50715 50722 50725 50727 50728 50760 50770 50780 50782 50783 50785 50800 50810 50815 50820 50947 50948 51314 51550 51555 51565 51570 51575 51580 51585 51590 51595 51596 51597 51800 51820 51860 51865 51880 51900 51920 51925 51940 51960 52355 53899

Male Genital System: 54380 54385 54390 54595 55810 55812 55815 55821 55831 55840 55842 55845 55866

Female Genital System: 57307 57330 57531 58150 58152 58180 58200 58210 58240 58260 58262 58263 58285 58291 58292 58550 58552 58553 58554 58661 58662 58679 58700 58720 58823 58920 58925 58940 58943 58950 58951 58952 58953 58954 58960 58999
59120 59121 59135 59136 59140 59150 59151 59154 59525

Endocrine System: 60540 60545

Nervous System: 61105 61107 61108 61120 61150 61151 61154 61156 61210 61250 61253 61304 61305 61312 61313 61314 61315 61320 61321 61322 61323 61330 61332 61333 61340 61345 61437 61440 61470 61480 61490 61510 61512 61514 61516 61518 61519 61520 61521 61522 61524 61526 61530 61534 61536 61537 61538 61539 61540 61541 61542 61543 61545 61556 61557 61570 61571 61575 61576 61580 61581 61582 61583 61584 61585 61586 61590 61591 61592 61595 61598 61600 61601 61605 61606 61607 61608 61615 61616 61720 61735 61770 61800 62000 62005 62010 62161 62162 62163 62164 64752 64755 64760 64999

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services codes are provided to a surgical patient. This measure should reflect the quality of the services provided

for surgical patients to prevent the complications of thromboembolism. It is anticipated that the clinician providing primary management of the surgical patient would submit this measure. It is anticipated that thromboembolism prophylaxis includes low-dose unfractionated heparin, low molecular weight heparin, graduated compression stockings, intermittent pneumatic compression devices, factor Xa inhibitor and warfarin. The appropriate use of thromboembolism prophylaxis will vary according to the surgical procedure.

Measure: Use of internal mammary artery in coronary artery bypass graft surgery

Numerator:
G8158: Patient documented to have received coronary artery bypass graft with use of internal mammary artery

G8159: Patient documented to have received coronary artery bypass graft without use of internal mammary artery

G8160: Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure

Denominator:
Patients with coronary artery bypass graft using internal mammary artery:

CPT: 33510, 33511, 33512, 33533, 33534, 33535

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure is intended to reflect the quality of the surgical services provided for CABG patients.

Measure: Pre-operative beta-blocker for patient with isolated coronary artery bypass graft

Numerator:
G8161: Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade

G8162: Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade

G8163: Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure

Denominator:
Patients with Coronary artery bypass graft *as listed:*

CPT: 33510, 33511, 33512, 33533, 33534, 33535

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure should reflect the primary management of the surgical patient undergoing isolated coronary artery bypass surgery.

Measure: Prolonged intubation in isolated coronary artery bypass graft surgery

Numerator:
G8164: Patient with isolated coronary artery bypass graft documented to have prolonged intubation

G8165: Patient with isolated coronary artery bypass graft not documented to have prolonged intubation

Denominator:
Patients with coronary artery bypass graft *as listed:*

CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing isolated coronary artery bypass graft surgery. This measure should reflect the management of the surgical patient undergoing coronary artery bypass graft surgery. This measure is not intended to encourage the inappropriate early extubation of patients. The treating clinician should continue to make the appropriate clinical determination regarding the necessity for intubation.

Measure: Surgical re-exploration in coronary artery bypass graft surgery

Numerator:
G8166: Patient with isolated coronary artery bypass graft documented to have required surgical re-exploration

G8167: Patient with isolated coronary artery bypass graft did not require surgical re-exploration

Denominator:
Patients with coronary artery bypass graft *as listed:*

CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. It is anticipated that there may be clinical reasons for a patient to undergo re-exploration. This measure is not anticipated to discourage the treating physician from making the appropriate clinical decision for surgical re-exploration.

Measure: Aspirin or clopidogrel on discharge for patient undergoing isolated coronary artery bypass graft

Numerator:
G8170: Patient with isolated coronary artery bypass graft documented to have been discharged on aspirin or clopidogrel

G8171: Patient with isolated coronary artery bypass graft not documented to have been discharged on aspirin or clopidogrel

G8172: Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for antiplatelet therapy at discharge measure

Denominator:
Patients with coronary artery bypass graft*:*

CPT: 33510, 33511, 33512, 33513, 33514, 33516, 33533, 33534, 33535, 33536

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure should reflect the primary management of the surgical patient undergoing isolated coronary artery bypass surgery.

PVRP Core Starter Set
Background and General Information
As of: December 27, 2005

On October 28, 2005, CMS announced the Physician Voluntary Reporting Program (PVRP) to begin on January 3, 2006. The primary purpose of the PVRP is to provide a means for physicians to report clinical data using the claim process. This clinical and other claims data can be used to calculate quality measures. Physicians who participate will receive confidential feedback, if requested, on their reporting and performance rates.

The PVRP's 36 sets of G codes were selected after extensive interaction with physician organizations to cover as broad a range of physician specialties as feasible, consistent with the availability of consensus based quality measures. Continued interaction with physicians after the announcement of PVRP has indicated significant interest in participation among physician practices. However, suggestions have also been made by several physician organizations to identify a starter set in order to lessen the potential reporting burden for physicians and better align the PVRP with other quality measurement activities affecting physicians.

CMS has decided to adopt the suggestion of a smaller core starter set of PVRP measures. The core set consists of 16 measures which will significantly reduce the number of measures applicable to any individual physician practice specialty. Additionally, we have selected primary care measures that are based on measures that are National Quality Forum (NQF) endorsed, part of the Ambulatory Care Quality Alliance (AQA) starter set, and that will be used by the Quality Improvement Organization (QIO) programs for physician quality improvement in its eighth Scope of Work (8th SOW). Despite the smaller starter set of 16 measures the PVRP maintains its same scope of coverage for physician specialties.

Confidential reports available to physicians will be limited to the 16 core starter set. In this way, CMS believes that physicians will be encouraged to report clinical data on a high percentage of patients for whom measures are applicable. Physicians may report clinical data on the remaining 20 measures, but will not receive summarizing reports.

CMS intends to pursue further development and refinement of the remaining 20 measures within the 36 measure PVRP set, as well as other measures suggested by physician groups. It is anticipated that the PVRP will be expanded as consensus measures become available.

The 16 PVRP core starter set are:
- Aspirin at arrival for acute myocardial infarction
- Beta blocker at time of arrival for acute myocardial infarction
- Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus
- Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus
- High blood pressure control in patient with Type I or Type II diabetes mellitus
- Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction
- Beta-blocker therapy for patient with prior myocardial infarction
- Assessment of elderly patients for falls
- Dialysis dose in end stage renal disease patient

●Hematocrit level in end stage renal disease patient
●Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis
●Antidepressant medication during acute phase for patient diagnosed with new episode of major depression
●Antibiotic prophylaxis in surgical patient
●Thromboembolism prophylaxis in surgical patient
● Use of internal mammary artery in coronary artery bypass graft surgery
●Pre-operative beta-blocker for patient with isolated coronary artery bypass graft

Note The following measures have been revised since the initial November posting:
● Denominator specifications and instructions
    Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis
● Denominator specifications only
    Use of internal mammary artery in coronary artery bypass graft surgery
    Pre-operative beta-blocker for patient with isolated coronary artery bypass graft

Additional details regarding the program can be found at
http://www.cms.hhs.gov/PhysicianFocusedQualInits/01_Overview.asp

Questions regarding the PVRP can be addressed to: PVRP@cms.hhs.gov

Physician Voluntary Reporting Program (PVRP) Core Starter Set G-Code Specifications and Instruction
Note: These measures have been excerpted from the full 36 measure set
As of: December 27, 2005

Measure: Aspirin at arrival for acute myocardial infarction

Numerator:
G8006: Acute myocardial infarction: patient documented to have received aspirin at arrival

G8007: Acute myocardial infarction: patient not documented to have received aspirin at arrival

G8008: Clinician documented that acute myocardial infarction patient was not an eligible candidate to receive aspirin at arrival measure

Denominator:
*Patients with a*cute myocardial infarction *who present to hospital emergency department or are hospitalized as listed:*

Patients with acute myocardial infarction:
ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91
And
ED E&M: 99281-99285; initial hospital care E&M: 99221-99223; observation: 99218-99220, 99234-99236; critical care services: 99291- 99292

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with acute myocardial infarction. It is anticipated that the patient would receive aspirin therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period before presentation and the 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction who present to the emergency department or the hospital setting.

Measure: Beta blocker at time of arrival for acute myocardial infarction

Numerator:
G8009: Acute myocardial infarction: patient documented to have received beta-blocker at arrival

G8010: Acute myocardial infarction: patient not documented to have received beta-blocker at arrival

G8011: Clinician documented that acute myocardial infarction patient was not an eligible candidate for beta-blocker at arrival measure

Denominator:
*Patients with a*cute myocardial infarction *who present to hospital emergency department or are hospitalized as listed:*

Patients with acute myocardial infarction:
ICD-9: 410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91
And
ED E&M: 99281-99285; initial hospital care E&M: 99221-99223; observation: 99218-99220, 99234-99236; critical care services: 99291- 99292

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed CPT services are provided for a patient with acute myocardial infarction who presents to the hospital emergency department or other hospital setting. It is anticipated that the patient would receive beta-blocker therapy upon initial arrival if clinically appropriate. However, the timeframe for this measure includes the entire 24 hour period from the time of presentation. This construct is consistent with the hospital performance measure. This measure is intended to reflect the quality of services provided for the initial, primary management of patients with acute myocardial infarction in the emergency department or hospital setting.

Measure: Hemoglobin A1c control in patient with Type I or Type II diabetes mellitus

Numerator:
G8016: Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as less than or equal to 9%

G8015: Diabetic patient with most recent hemoglobin A1c level (within the last 6 months) documented as greater than 9%

G8017: Clinician documented that diabetic patient was not eligible candidate for hemoglobin A1c measure

G8018: Clinician has not provided care for the diabetic patient for the required time for hemoglobin A1c measure (6 months)

Denominator:
Patients with diabetes:

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary

management of diabetes mellitus. It is not anticipated that clinicians would use this indicator if the clinician is not providing services for the primary management of diabetes mellitus.

Measure: Low-density lipoprotein control in patient with Type I or Type II diabetes mellitus

Numerator:
G8020: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as less than 100 mg/dl

G8019: Diabetic patient with most recent low-density lipoprotein (within the last 12 months) documented as greater than or equal to 100 mg/dl

G8021: Clinician documented that diabetic patient was not eligible candidate for low-density lipoprotein measure

G8022: Clinician has not provided care for the diabetic patient for the required time for low-density lipoprotein measure (12 months)

Denominator:
Patients with diabetes:

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus. It is not anticipated that clinicians would use this indicator if the clinician is not providing services for the primary management of diabetes mellitus.

Measure: High blood pressure control in patient with Type I or Type II diabetes mellitus

Numerator:
G8024: Diabetic patient with most recent blood pressure (within the last 6 months) documented less than 140 systolic and less than 80 diastolic

G8023: Diabetic patient with most recent blood pressure (within the last 6 months) documented as equal to or greater than 140 systolic or equal to or greater than 80 mmHg diastolic

G8025: Clinician documented that the diabetic patient was not eligible candidate for blood pressure measure

G8026: Clinician has not provided care for the diabetic patient for the required time for blood measure (within the last 6 months)

Denominator:
Patients with diabetes:

ICD-9-CM codes 250.0-250.9 (DM), 357.2 (polyneuropathy in DM), 362.0 (DM retinopathy), 366.41 (DM cataract), 648.0 (DM in pregnancy, not gestational)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services are provided to patients with diabetes mellitus for the primary management of diabetes mellitus.

Measure: Angiotensin-converting enzyme inhibitor or angiotensin-receptor blocker therapy for left ventricular systolic dysfunction

Numerator:
G8027: Heart failure patient with left ventricular systolic dysfunction (LVSD) documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

G8028: Heart failure patient with left ventricular systolic dysfunction (LVSD) not documented to be on either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy

G8029: Clinician documented that heart failure patient was not an eligible candidate for either angiotensin-converting enzyme-inhibitor or angiotensin-receptor blocker (ACE-I or ARB) therapy measure

Denominator:
Heart failure patients with LVEF < 40% or with moderately or severely depressed left ventricular systolic function:

Patients with heart failure:
Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91; Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93; Heart Failure codes: 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9
And
Patients who had documentation of an ejection fraction < 40% (use most recent value) or moderately or severely depressed left ventricular systolic function
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)

Instructions:

This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the listed E&M services visit are provided to patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment. Examples of a quantitative or qualitative assessment would be an echocardiogram that provides a numerical value of left ventricular systolic dysfunction or that uses descriptive terms such moderate or severely depressed left ventricular dysfunction. This measure is intended to reflect the quality of services provided for the primary management of patients with heart failure.

Measure: Beta-blocker therapy for patient with prior myocardial infarction

Numerator:
G8033: Prior myocardial infarction - coronary artery disease patient documented to be on beta-blocker therapy

G8034: Prior myocardial infarction - coronary artery disease patient not documented to be on beta -blocker therapy

G8035: Clinician documented that prior myocardial infarction - coronary artery disease patient was not eligible candidate for beta - blocker therapy measure

Denominator:
Patients with coronary artery disease who also have prior MI at any time as listed:

Patients with Coronary artery disease:
414.00-414.07, 414.8, 414.9, 410.00-410.92 (Acute myocardial infarction), 412 (old MI), 411.0-411.89, 413.0-413.9 (angina), V45.81 (Aortocoronary bypass status), V45.82 (PTCA status)
And
E&M visit: 99201-99205, 99211-99215 (E&M); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary)
And
Patients with prior MI:
410.00-410.92, 412

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to patients with documented coronary artery disease and prior myocardial infarction. This measure is intended to reflect the quality of services provided for the primary management of patients with coronary artery disease.

Measure: Assessment of elderly patients for falls

Numerator:
G8055: Patient documented for the assessment for falls within last 12 months

G8054: Patient not documented for the assessment for falls within last 12 months

G8056: Clinician documented that patient was not an eligible candidate for the falls assessment measure within the last 12 months

Denominator:
Patients 75 years of age or older:

E&M visit: 99201-99205, 99211-99215 (E&M); 99241-99245 (office consult); 99341-99350 (home visit); 99304-99306, 99307-99310 (nursing facility); G0344
And
Patients 75 years of age or older

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided to geriatric patients. This indicator, as well as other indicators related to assessments, should be provided only on an annual basis. It is anticipated that the clinical assessment would include annual review of the patient's fall history as part of a medically necessary visit.

Measure: Dialysis dose in end stage renal disease patient

Numerator:
G8075: End-stage renal disease patient with documented dialysis dose of URR greater than or equal to 65% (or Kt/V greater than or equal to 1.2)

G8076: End-stage renal disease patient with documented dialysis dose of URR less than 65% (or Kt/V less than 1.2)

G8077: Clinician documented that end-stage renal disease patient was not an eligible candidate for URR or Kt/V measure

Denominator:
Patients with end-stage renal disease *on hemodialysis as listed:*

CPT: G0308-G0327, 90945, 90947
Or
585.6 (End-stage renal disease)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services or ICD-9 are provided and the listed hemodialysis CPT services are provided to patients with end stage renal disease. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease.

Measure: Hematocrit level in end stage renal disease patient

Numerator:
G8078: End-stage renal disease patient with documented hematocrit greater than or equal to 33 (or hemoglobin greater than or equal to 11)

G8079: End-stage renal disease patient with documented hematocrit less than 33 (or hemoglobin less than 11)

G8080: Clinician documented that end-stage renal disease patient was not an eligible candidate for hematocrit (hemoglobin) measure

Denominator:
Patients with end-stage renal disease *as listed:*

CPT: G0308-G0327, 90945, 90947
Or
585.6 (End-stage renal disease)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 is used or the listed CPT services or ICD-9 are provided to patients with end stage renal disease on hemodialysis. This measure is anticipated to reflect the services provided for the primary management of end stage renal disease. It is not anticipated that this measure would be applicable for services not related to the primary management of end stage renal disease.

Measure: Receipt of autogenous arteriovenous fistula in end-stage renal disease patient requiring hemodialysis

Numerator:
G8081: End-stage renal disease patient requiring hemodialysis vascular access documented to have received autogenous AV fistula

G8082: End-stage renal disease patient requiring hemodialysis documented to have received vascular access other than autogenous AV fistula

Denominator:
Patients with end-stage renal disease *on hemodialysis as listed:*

CPT: 36800, 36810, 36815, 36818-36821, 36825, 36830
AND
585.6 (End-stage renal disease)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are used and the listed CPT services are provided to patients with end stage renal disease on hemodialysis. It is anticipated that the clinician providing vascular access for the patient's hemodialysis would submit this measure for their patients. It is anticipated that clinicians will still make clinical determinations at the individual level regarding whether a patient is an appropriate candidate for arteriovenous fistula placement.

Measure: Antidepressant medication during acute phase for patient diagnosed with new episode of major depression

Numerator:
G8126: Patient documented as being treated with antidepressant medication during the entire 12 week acute treatment phase

G8127: Patient not documented as being treated with antidepressant medication during the entire 12 weeks acute treatment phase

G8128: Clinician documented that patient was not an eligible candidate for antidepressant medication during the entire 12 week acute treatment phase measure

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

E&M Visit: 99201-99205, 99211-99215; psychiatry: 90801, 90804-90809
And
ICD-9 296.2, 296.3, 300.4, 309.1, 311 (major depression)

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed ICD-9 codes are used and the patient is placed on prescription therapy for the treatment of a new episode of major depression disorder. It is anticipated that the clinician that provides the primary management of depression for the patient would submit this measure.

Measure: Antibiotic prophylaxis in surgical patient

Numerator:
G8152: Patient documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)

G8153: Patient not documented to have received antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin)

G8154: Clinician documented that patient was not an eligible candidate for antibiotic prophylaxis one hour prior to incision time (two hours for vancomycin) measure

Denominator:
Patients with selected surgical procedures as listed:

Musculoskeletal: 27130, 27125, 27138, 27437, 27445, 27446

Cardiovascular System: 33300 33305 33400 33401 33403 33404 33405 33406 33410 33411 33412 33413 33414 33415 33416 33417 33420 33422 33425 33426 33427 33430 33460 33463 33464 33465 33468 33470 33471 33472 33474 33475 33476 33478 33496 33510 33511 33512 33513 33514 33516 33517 33518 33519 33521 33522 33523 33530 33533 33534 33535 33536 33545 33560 33600 33602 33608 33610 33611 33612 33615 33617 33619 33641 33645 33647 33660 33665 33670 33681 33684 33688 33692 33694 33697 33702 33710 33720 33722 33730 33732 33735 33736 33737 33770 33771 33774 33775 33776 33777 33778 33779 33780 33781 33786 33813 33814 33875 33877 33918 33919 33920 33924 33999 34520 34830 34831 34832 35081 35082 35091 35092 35102 35103 35111 35112 35121 35122 35131 35132 35141 35142 35151 35152 35256 35286 35331 35341 35351 35355 35361 35363 35371 35372 35381 35516 35518 35521 35522 35525 35531 35533 35536 35541 35546 35548 35549 35551 35556 35558 35563 35565 35566 35571 35583 35585 35587 35600 35616 35621 35623 35631 35636 35641 35646 35647 35650 35651 35654 35656 35661 35665 35666 35671 35686 35879 35881 35903 35907 37500 37700 37720 37730 37735 37760 37765 37766 37780 37785 37788 37791 92992 92993 93580 93581

Hemic and Lymphatic Systems: 38082 38103

Digestive System: 44025 44110 44111 44120 44121 44125 44130 44139 44140 44141 44143 44144 44145 44146 44147 44150 44151 44152 44153 44155 44156 44160 44204 44205 44206 44207 44208 44210 44211 44212 44300 44320 44322 44604 44605 44615 44625 44626 44660 44661 44799 45110 45111 45112 45113 45114 45116 45119 45120 45121 45123 45126 45130 45135 45550 45562 45563 45800 45805 45820 45825 45999

Urinary System: 51597 51925

Female Genital System: 57307 58150 58152 58180 58200 58210 58240 58260 58262 58263 58285 58550 58552 58553 58554 58951 58953 59135 59136 59140 59525

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing surgery that typically requires the administration of prophylactic antibiotics. It is anticipated that this measure should reflect the management of the surgical patient to reduce complications from infections. Thus, it is anticipated that it may be appropriate for both the clinician performing the surgery and the clinician providing anesthesia services may submit this measure for a patient.

Measure: Thromboembolism prophylaxis in surgical patient

Numerator:
G8155: Patient with documented receipt of thromboemoblism prophylaxis

G8156: Patient without documented receipt of thromboemoblism prophylaxis

G8157: Clinician documented that patient was not an eligible candidate for thromboembolism prophylaxis measure

Denominator:
Patients with selected surgical procedures as listed:

Integumentary System: 13160

Musculoskeletal System: 20102 22554 22556 22558 22585 22590 22600 22612 22614 22800 22802 22804 22808 22810 22812 22840 22851 27120 27125 27130 27132 27134 27137 27138 27236 27437 27445 27446 27447 27486 27487
Respiratory System: 32140 32141 32220 32225 32310 32320 32440 32442 32445 32480 32482 32484 32486 32488 32520 32522 32525 32651 32652 32655 32656 32663 32800 32850

Cardiovascular System: 33930 35840 35870 37799

Hemic and Lymphatic Systems: 38100 38101 38102 38120

Mediastinum and Diaphragm: 39501 39502 39503 39520 39530 39531 39540 39541 39545 39560 39561 39599

Digestive System: 42953 43020 43045 43107 43108 43112 43113 43116 43117 43118 43121 43122 43123 43124 43228 43240 43250 43251 43258 43267 43268 43269 43271 43272 43280 43289 43300 43305 43310 43312 43313 43314 43316 43320 43324 43325 43326 43340 43341 43350 43351 43352 43360 43361 43401 43405 43410 43415 43420 43425 43496 43499 43500 43501 43502 43510 43620 43621 43622 43631 43632 43633 43634 43635 43638 43639 43640 43641 43652 43761 43800 43810 43820 43825 43840 43842 43843 43845 43846 43847 43848 43850 43855 43860 43865 43870 43880 43999 44005 44010 44015 44020 44021 44025 44050 44055 44110 44111 44120 44121 44125 44126 44127 44128 44130 44132 44133 44139 44140 44141 44143 44144 44145 44146 44147 44150 44151 44152 44153 44155 44156 44160 44201 44202 44203 44204 44205 44206 44207 44208 44210 44211 44212 44300 44310 44316 44320 44322 44340 44345 44346 44351 44370 44379 44383 44397 44602 44603 44604 44605 44615 44620 44625 44626 44640 44650 44660 44661 44680 44700 44799 44800 44820 44850 45000 45005 45020 45110 45111 45112 45113 45114 45116 45119 45120 45121 45123 45126 45130 45135 45136 45160 45170 45321 45327 45345 45387 45500 45505 45540 45541 45550 45562 45563 45800 45805 45820 45825 45999 46730 46735 46744 46746 46748 47010 47011 47120 47122 47125 47130 47133 47300 47315 47350 47360 47361 47362 47370 47371 47380 47381 47382 47399 47400 47420 47425 47460 47510 47511 47564 47570 47579 47610 47612 47620 47716 47720 47721 47740 47741 47760 47765 47780 47785 47800 47802 47900 47999 48000 48001 48005 48020 48120 48140 48145 48146 48148 48150 48151 48152 48153 48154 48155 48160 48180 48500 48510 48511 48520 48540 48545 48547 48550 48554 48556 48662 48999 49002 49020 49021 49040 49041 49060 49061 49080 49081 49085 49201 49210 49215 49220 49255 49420 49421 49425 49426 49605 49606 49610 49611 49900 49904 49906 49999 96445

Urinary System:
50020 50021 50220 50223 50225 50230 50234 50236 50240 50300 50320 50340 50360 50365 50370 50380 50543 50545 50546 50547 50548 50562 50715 50722 50725 50727 50728 50760 50770 50780 50782 50783 50785 50800 50810 50815 50820 50947 50948 51314 51550 51555 51565 51570 51575 51580 51585 51590 51595 51596 51597 51800 51820 51860 51865 51880 51900 51920 51925 51940 51960 52355 53899

Male Genital System: 54380 54385 54390 54595 55810 55812 55815 55821 55831 55840 55842 55845 55866

Female Genital System: 57307 57330 57531 58150 58152 58180 58200 58210 58240 58260 58262 58263 58285 58291 58292 58550 58552 58553 58554 58661 58662 58679 58700 58720 58823 58920 58925 58940 58943 58950 58951 58952 58953 58954 58960 58999
59120 59121 59135 59136 59140 59150 59151 59154 59525

Endocrine System: 60540 60545

Nervous System: 61105 61107 61108 61120 61150 61151 61154 61156 61210 61250 61253 61304 61305 61312 61313 61314 61315 61320 61321 61322 61323 61330 61332 61333 61340 61345 61437 61440 61470 61480 61490 61510 61512 61514 61516 61518 61519 61520 61521 61522 61524 61526 61530 61534 61536 61537 61538 61539 61540 61541 61542 61543 61545 61556 61557 61570 61571 61575 61576 61580 61581 61582 61583 61584 61585 61586 61590 61591 61592 61595 61598 61600 61601 61605 61606 61607 61608 61615 61616 61720 61735 61770 61800 62000 62005 62010 62161 62162 62163 62164 64752 64755 64760 64999

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services codes are provided to a surgical patient. This measure should reflect the quality of the services provided for surgical patients to prevent the complications of thromboembolism. It is anticipated that the clinician providing primary management of the surgical patient would submit this measure. It is anticipated that thromboembolism prophylaxis includes low-dose unfractionated heparin, low molecular weight heparin, graduated compression stockings, intermittent pneumatic compression devices, factor Xa inhibitor and warfarin. The appropriate use of thromboembolism prophylaxis will vary according to the surgical procedure.

Measure: Use of internal mammary artery in coronary artery bypass graft surgery

Numerator:
G8158: Patient documented to have received coronary artery bypass graft with use of internal mammary artery

G8159: Patient documented to have received coronary artery bypass graft without use of internal mammary artery

G8160: Clinician documented that patient was not an eligible candidate for coronary artery bypass graft with use of internal mammary artery measure

Denominator:
Patients with coronary artery bypass graft using internal mammary artery:

CPT: 33510, 33511, 33512, 33533, 33534, 33535,

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure is intended to reflect the quality of the surgical services provided for CABG patients.

Measure: Pre-operative beta-blocker for patient with isolated coronary artery bypass graft

Numerator:
G8161: Patient with isolated coronary artery bypass graft documented to have received pre-operative beta-blockade

G8162: Patient with isolated coronary artery bypass graft not documented to have received pre-operative beta-blockade

G8163: Clinician documented that patient with isolated coronary artery bypass graft was not an eligible candidate for pre-operative beta-blockade measure

Denominator:
Patients with Coronary artery bypass graft *as listed:*

CPT: 33510, 33511, 33512, 33533, 33534, 33535,

Instructions:
This measure is reported using the appropriate quality G-code indicator whenever the listed CPT services are provided for a patient undergoing coronary artery bypass graft surgery. This measure should reflect the primary management of the surgical patient undergoing isolated coronary artery bypass surgery.