

2011 AAOS PQRS WORKSHEET, No. 1
Detailed Version

Note: Refer to the 2011 PQRI Specifications Manuals at http://www.aaos.org/research/committee/evidence/pqri_addinfo.asp for additional information.

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

[Reporting Key: C-MG-R-GP: This measure is reportable via Claims, Perioperative Measures Group, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required).

INSTRUCTIONS: This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo surgical procedures with the indications for prophylactic parenteral antibiotics. There is no diagnosis associated with this measure.

NUMERATOR: Surgical patients who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral antibiotic is to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) OR documentation that prophylactic parenteral antibiotic has been given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

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

Numerator Coding:

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

<ul style="list-style-type: none"> • Ampicillin/sulbactam • Aztreonam • Cefazolin • Cefmetazole • Cefotetan • Cefoxitin 	<ul style="list-style-type: none"> • Cefuroxime • Ciprofloxacin • Clindamycin • Ertapenem • Erythromycin base • Gatifloxacin 	<ul style="list-style-type: none"> • Gentamicin • Levofloxacin • Metronidazole • Moxifloxacin • Neomycin • Vancomycin
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Documentation of Order for Prophylactic Parenteral Antibiotic (written order, verbal order, or standing order/protocol)

G8629: Documentation of order for prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required).

OR

Documentation that Prophylactic Parenteral Antibiotic has been Given within One Hour Prior to the Surgical Incision (or start of procedure when no incision is required)

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

OR

Order for Prophylactic Parenteral Antibiotic not Given for Documented Reasons

G8631: Clinician documented that patient was not an eligible candidate for ordering prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required).

OR

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

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

DENOMINATOR: All surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics.

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT): Listed below are surgical procedures for which prophylactic parenteral antibiotics are indicated.

SURGICAL PROCEDURE	CPT CODE
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737

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

[[Reporting Key: C-MG-R-GP: This measure is reportable via Claims, Perioperative Measures Group, Registry, or Group Practice Reporting Option II]]

DESCRIPTION: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis.

INSTRUCTIONS: This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo surgical procedures with the indications for a first or second generation cephalosporin prophylactic antibiotic. There is no diagnosis associated with this measure.

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

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

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

Numerator Coding:

Acceptable First and Second Generation Cephalosporin Prophylactic Antibiotics

First generation cephalosporin: cefazolin

Second generation cephalosporin: cefuroxime

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

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

OR

Order for First or Second Generation Cephalosporin not Ordered for Medical Reasons Append a modifier (1P) to CPT Category II code 4041F to report documented circumstances that appropriately exclude patients from the denominator.

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

OR

Order for First or Second Generation Cephalosporin not Ordered, Reason Not Specified Append a reporting modifier (8P) to CPT Category II code 4041F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

DENOMINATOR: All surgical patients aged 18 years and older undergoing procedures with the indications for a first or second generation cephalosporin prophylactic antibiotic.

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

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT): Listed below are surgical procedures with indications for first or second generation cephalosporin prophylactic antibiotic.

SURGICAL PROCEDURE	CPT CODE
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737

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

[Reporting Key: C-MG-R-GP: This measure is reportable via Claims, Perioperative Measures Group, Registry, or Group Practice Reporting Option II]

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

INSTRUCTIONS: This measure is to be reported each time a procedure is performed during the reporting period for patients who undergo non-cardiac surgical procedures with the indications for prophylactic parenteral antibiotics. There is no diagnosis associated with this measure.

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

Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) specifying that prophylactic parenteral antibiotic is to be discontinued within 24 hours of surgical end time OR specifying a course of antibiotic administration limited to that 24-hour period (e.g., “to be given every 8 hours for three doses” or for “one time” IV dose orders) OR documentation that prophylactic parenteral antibiotic was discontinued within 24 hours of surgical end time. **NUMERATOR NOTE:** The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The “correct combination” of codes may require the submission of multiple numerator codes.

Numerator Coding:

Documentation of Order for Discontinuation of Prophylactic Parenteral Antibiotics (written order, verbal order, or standing order/protocol) within 24 Hours of Surgical End Time
(Two CPT II codes [4049F & 4046F] are required on the claim form to submit this numerator option)

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

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

AND

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

OR

Prophylactic Parenteral Antibiotics not Discontinued for Medical Reasons

(Two CPT II codes [4049F-1P & 4046F] are required on the claim form to submit this numerator option). Append a modifier (1P) to CPT Category II code **4049F** to report documented circumstances that appropriately exclude patients from the denominator.

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

AND

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

OR

If patient is not eligible for this measure because patient did not receive prophylactic parenteral antibiotics within specified timeframe, report:

(One CPT II code [4042F] is required on the claim form to submit this numerator option)

CPT II 4042F: Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively.

OR

Prophylactic Parenteral Antibiotics not Discontinued, Reason Not Specified (Two CPT II codes [4049F-8P & 4046F] are required on the claim form to submit this numerator option). Append a reporting modifier (8P) to CPT Category II code **4049F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4049F with 8P: Order was not given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure, reason not otherwise specified.

AND

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

DENOMINATOR: All non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic.

Denominator Instructions: CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population. Both surgeons participating in the Physician Quality Reporting System will be fully accountable for the clinical action described in the measure. For the purpose of this measure of antibiotic discontinuation, patients may be counted as having “received a prophylactic parenteral antibiotic” if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively.

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter.

AND

Patient encounter during the reporting period (CPT): Listed below are non-cardiac surgical procedures for which prophylactic parenteral antibiotics are indicated.

SURGICAL PROCEDURE	CPT CODE
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (Fractures)	27235, 27236, 27244, 27245, 27758, 27759, 27766, 27792, 27814
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Neurological Surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Foot & Ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737

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

[Reporting Key: C-MG-R-GP: This measure is reportable via Claims, Perioperative Measures Group, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

INSTRUCTIONS: This measure is to be reported each time a procedure is performed during the reporting period for all patients who undergo surgical procedures for which VTE prophylaxis is indicated. There is no diagnosis associated with this measure.

NUMERATOR: Surgical patients who had an order for LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time
Numerator Instructions: There must be documentation of order (written order, verbal order, or standing order/protocol) for VTE prophylaxis OR documentation that VTE prophylaxis was given.
Definition: Mechanical Prophylaxis – Does not include TED hose.

Numerator Coding:

Appropriate VTE Prophylaxis Ordered

CPT II 4044F: Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hours prior to incision time or 24 hours after surgery end time *Note: A single CPT Category II code is provided for VTE prophylaxis is ordered or VTE prophylaxis is given. If VTE prophylaxis is given, report 4044F.*
OR

VTE Prophylaxis not Ordered for Medical Reasons

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

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

OR

VTE Prophylaxis not Ordered, Reason Not Specified

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

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

DENOMINATOR: All surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients.

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

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT): Listed below are surgical procedures for which VTE prophylaxis is indicated.

SURGICAL PROCEDURE	CPT CODE
Spine	22558, 22600, 22612, 22630, 63015, 63020, 63047, 63056, 63081, 63267, 63276
Neurological Surgery	22558, 22600, 22612, 22630, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276
Hip Reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Knee Reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Hip Fracture Surgery	27235, 27236, 27244, 27245, 27269

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***Measure #24: Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older**

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patients aged 50 years and older treated for a hip, spine, or distal radial fracture with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

INSTRUCTIONS: This measure is to be reported after each occurrence of a fracture during the reporting period. It is anticipated that clinicians who treat the hip, spine, or distal radial fracture will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT procedure code for surgical treatment of a fracture.

Patients with a fracture of the hip, spine, or distal radius should have documentation in the medical record of communication from the clinician treating the fracture to the clinician managing the patient's on-going care that the fracture occurred and that the patient was or should be tested or treated for osteoporosis. If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted. Claims data will be analyzed to determine unique occurrences. Documentation must indicate that communication to the clinician managing the on-going care of the patient occurred within three months of treatment for the fracture. The CPT Category II code should be reported during the episode of care (e.g., treatment of the fracture). The reporting of the code and documentation of communication do not need to occur simultaneously.

NUMERATOR: Patients with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.

Numerator Coding:

Post-Fracture Care Communication Documented

CPT II 5015F: Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis.

OR

Post-Fracture Care not Communicated for Medical or Patient Reasons

Append a modifier (**1P** or **2P**) to CPT Category II code **5015F** to report documented circumstances that appropriately exclude patients from the denominator.

- **5015F with 1P:** Documentation of medical reason(s) for not communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
- **5015F with 2P:** Documentation of patient reason(s) for not communicating that a fracture occurred and that the patient was or should be tested or treated for osteoporosis with physician managing ongoing care of patient.

OR

Post-Fracture Care not Communicated, Reason Not Specified

Append a reporting modifier (**8P**) to CPT Category II code **5015F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **5015F with 8P:** No documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason not otherwise specified.

DENOMINATOR: All patients aged 50 years and older treated for hip, spine or distal radial fracture

Denominator Coding:

An ICD-9 diagnosis code and either a CPT E/M service code or a CPT procedure code to identify patients with a recent fracture of the hip, spine or distal radius are required for denominator inclusion. Eligible cases are determined, and must be reported, if either of the following conditions are met:

Option 1 - Denominator Criteria (Eligible Cases):

Patients aged \geq 50 years on date of encounter

AND

Diagnosis for hip, spine or distal radial fracture (ICD-9-CM): 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8

AND

Patient encounter during the reporting period (CPT) – Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

Option 2 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on the date of encounter

AND

Diagnosis for hip, spine or distal radial fracture (ICD-9-CM): 733.00, 733.01, 733.02, 733.03, 733.09 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8

AND

Patient encounter during the reporting period (CPT) – Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

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

[Reporting Key: C-R-E-MG-GP: This measure is reportable via Claims, Registry, Electronic Health Record, Preventive Care Measures Group, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

INSTRUCTIONS: This measure is to be reported a minimum of once during the reporting period for patients seen during the reporting period. Female patients aged 65 years and older should have a central DXA measurement ordered or performed at least once since the time they turned 60 years or have pharmacologic therapy prescribed to prevent or treat osteoporosis. It is anticipated that clinicians who provide primary care or care for treatment of fracture or osteoporosis will submit this measure.

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

Definition: Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

Numerator Coding:

Central DXA Measurement Ordered or Performed or Pharmacologic Therapy Prescribed

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

OR

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

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

OR

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

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

DENOMINATOR: All female patients aged 65 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 65 years on date of encounter

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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***Measure #40: Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older**

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patients aged 50 years and older with fracture of the hip, spine, or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed.

INSTRUCTIONS: This measure is to be reported after each occurrence of a fracture during the reporting period. It is anticipated that clinicians who treat hip, spine or distal radial fractures will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM diagnosis code for fracture or osteoporosis and a CPT service code **OR** an ICD-9-CM diagnosis code for a fracture or osteoporosis and a CPT procedure code for surgical treatment of fractures.

Patients with a fracture of the hip, spine, or distal radius should have a central DXA measurement ordered or performed or pharmacologic therapy prescribed. The management (DXA ordered or performed or pharmacologic therapy prescribed) should occur within three months of the initial visit with the reporting clinician following the fracture. If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted. Claims data will be analyzed to determine unique occurrences. Patients with documentation of prior central DXA measurement or already receiving pharmacologic therapy would automatically meet the intent of this measure.

NUMERATOR: Patients who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed.

Numerator Instructions: Modifiers may be appended to any of the CPT Category II codes for medical reasons, patient reasons, system reasons, or reasons not otherwise specified.

Definition: Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

Numerator Coding:

Central DXA Measurement Ordered or Results Documented or Pharmacologic Therapy Prescribed

CPT II 3096F: Central Dual-energy X-Ray Absorptiometry (DXA) ordered

OR

CPT II 3095F: Central Dual-energy X-Ray Absorptiometry (DXA) results documented

OR

G8633: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

OR

Central DXA Measurement not Ordered or Results not Documented or Pharmacologic Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P** or **3P**) to CPT Category II codes **3096F** or **3095F** to report documented circumstances that appropriately exclude patients from the denominator.

3096F or 3095F with 1P: Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

3096F or 3095F with 2P: Documentation of patient reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

3096F or 3095F with 3P: Documentation of system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement

OR

Pharmacologic Therapy not Prescribed for Documented Reasons

G8634: Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis

OR

Central DXA Measurement not Ordered or Results not Documented, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3096F** or **3095F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3096F or **3095F** *with* **8P**: Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed, reason not otherwise specified

OR

Pharmacologic Therapy not Prescribed, Reason not Specified

G8635: Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

DENOMINATOR: All patients aged 50 years and older with a fracture of the hip, spine, or distal radius
Eligible cases are determined, and must be reported, if either of the following conditions are met:

Option 1 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter

AND

Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM): 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8

AND

Patient encounter during the reporting period (CPT) - Service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

Option 2 - Denominator Criteria (Eligible Cases):

Patients aged ≥ 50 years on date of encounter

AND

Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM): 733.00, 733.01, 733.02, 733.03, 733.09, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.4, 805.6, 805.8, 813.40, 813.41, 813.42, 813.44, 813.45, 813.47, 813.50, 813.51, 813.52, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8

AND

Patient encounter during the reporting period (CPT) - Procedure codes: 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

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***Measure #41: Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older**

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months.

INSTRUCTIONS: This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. Patients with a diagnosis of osteoporosis should be prescribed pharmacologic therapy to treat osteoporosis. ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

NUMERATOR: Patients who were prescribed pharmacologic therapy within 12 months

Definition: Pharmacologic Therapy: U.S. Food and Drug Administration approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, ibandronate, and risedronate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modules or SERMs (raloxifene).

Numerator Coding:

Pharmacologic Therapy Prescribed

CPT II 4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed.

OR

Pharmacologic Therapy not Prescribed for Medical, Patient, or System Reasons

Append a modifier (**1P**, **2P** or **3P**) to CPT Category II code **4005F** to report documented circumstances that appropriately exclude patients from the denominator.

4005F with 1P: Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis.

4005F with 2P: Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis.

4005F with 3P: Documentation of system reason for not prescribing pharmacologic therapy for osteoporosis.

OR

Pharmacologic Therapy not Prescribed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4005F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4005F with 8P: Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified.

DENOMINATOR: All patients aged 50 years and older with the diagnosis of osteoporosis.

Denominator Criteria (Eligible Cases):

Patients aged \geq 50 years on date of encounter

AND

Diagnosis for osteoporosis (ICD-9-CM): 733.00, 733.01, 733.02, 733.03, 733.09

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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Measure #109: Osteoarthritis (OA): Function and Pain Assessment

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with assessment for function and pain.

INSTRUCTIONS: This measure is to be reported at each visit occurring during the reporting period for patients with osteoarthritis seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NUMERATOR: Patient visits with assessment for level of function and pain documented.

Numerator Coding:

Osteoarthritis Symptoms and Functional Status Assessed

CPT II 1006F: Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as the SF-36, AAOS Hip & Knee Questionnaire).

OR

Osteoarthritis Symptoms and Functional Status not Assessed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **1006F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1006F with 8P: Osteoarthritis symptoms and functional status not assessed, reason not otherwise specified

DENOMINATOR: All patient visits for patients aged 21 years and older with a diagnosis of OA.

Denominator Criteria (Eligible Cases):

Patients aged ≥ 21 years on date of encounter

AND

Diagnosis for OA (ICD-9-CM): 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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***Measure #124: Health Information Technology (HIT) Adoption/Use of Electronic Health Records (EHR)**

[Reporting Key: C-R-E-GP: This measure is reportable via Claims, Registry, Electronic Health Record, or Group Practice Reporting Option II]

DESCRIPTION: Documents whether provider has adopted and is using health information technology. To report this measure, the eligible professional must have adopted and be using a certified, Physician Quality Reporting System qualified or other acceptable EHR system.

INSTRUCTIONS: This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by clinicians who have adopted and are using certified/qualified health information technology.

NUMERATOR: Patient encounter documentation substantiates use of a certified, Physician Quality Reporting System qualified or other acceptable EHR system. **NUMERATOR NOTE:** *If an eligible professional does not use a qualified system to record the encounter, they should not report any G-code.*

Definitions:

Health Information Technology (HIT) – A system that incorporates both computer hardware and software that deals with the storage, retrieval, sharing, and use of health care information, data, and knowledge for communication and decision making.

Authorized Testing and Certification Bodies (ATCB) – Review bodies that have been authorized to test and certify electronic health record (EHR) systems for compliance with the standards and certification criteria that were issued by the U.S. Department of Health and Human Services.

Certified or Qualified Electronic Health Record – A certified or qualified EHR can be any of the following:

- Certified by an ATCB
- Physician Quality Reporting System qualified* for EHR based reporting

Other Acceptable Systems

Other systems that are not certified or Physician Quality Reporting System qualified as above must meet all of the following criteria:

- Ability to manage a medication list
- Ability to manage a problem list
- Ability to manually enter or electronically receive, store and display laboratory results as discrete searchable data elements
- Ability to meet basic privacy and security elements

*A list of qualified EHR Vendors for the 2011 Physician Quality Reporting System will be available on the Alternative Reporting Mechanisms section available from the navigation bar on the left side of the CMS Physician Quality Reporting website at <http://www.cms.gov/pqri>. Please visit this site periodically for updates and contact your EHR vendor to determine if they are planning to become qualified.

Numerator Coding:

Encounter Documented Using a Certified, Physician Quality Reporting System Qualified or Other Acceptable EHR System

G8447: Patient encounter was documented using an EHR system that has been certified by an Authorized Testing and Certification Body (ATCB).

OR

G8448: Patient encounter was documented using a Physician Quality Reporting System qualified EHR or other acceptable systems.

DENOMINATOR:

All patient encounters

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 92506, 92507, 92526, 92541, 92542, 92543, 92544, 92548, 92552, 92553, 92555, 92557, 92561, 92562, 92563, 92564, 92565, 92567, 92568, 92570, 92571, 92572, 92575, 92576, 92577, 92579, 92582, 92584, 92585, 92586, 92587, 92588, 92601, 92602, 92603, 92604, 92610, 92611, 92612, 92620, 92621, 92625, 92626, 92627, 92640, 95920, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0109, G0270, G0271

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Measure #126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

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

INSTRUCTIONS: This measure is to reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. Evaluation of neurological status in patients with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reduces the number and severity of amputations that occur.

Risk categorization and follow up treatment plan should be done according to the following table:

Risk Categorization System: Category	Risk Profile	Evaluation Frequency
0	Normal	Annual
1	Peripheral Neuropathy (LOPS)	Semi-annual
2	Neuropathy, deformity, and/or PAD	Quarterly
3	Previous ulcer or amputation	Monthly to quarterly

NUMERATOR: Patients who had a lower extremity neurological exam performed at least once within 12 months.

Definition:

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

Numerator Coding:

Lower Extremity Neurological Exam Performed

G8404: Lower extremity neurological exam performed and documented.

OR

Lower Extremity Neurological Exam not Performed for Documented Reasons

G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure.

OR

Lower Extremity Neurological Exam not Performed

G8405: Lower extremity neurological exam not performed.

DENOMINATOR: All patients aged 18 years and older with a diagnosis of diabetes mellitus.

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for diabetes (line-item ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

AND

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

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***Measure #127: Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear**

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing.

INSTRUCTIONS: This measure is to reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. This measure may be reported by non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NUMERATOR: Patients who were evaluated for proper footwear and sizing at least once within 12 months.

Definition:

- **Evaluation for Proper Footwear** – Includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device and counseling on appropriate footwear should be based on risk categorization.

Numerator Coding:

Footwear Evaluation Performed

G8410: Footwear evaluation performed and documented.

OR

Footwear Evaluation not Performed

G8415: Footwear evaluation was not performed.

OR

Footwear Evaluation not Performed for Documented Reasons

G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of diabetes mellitus

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for diabetes (line-item ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93

AND

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

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*** Measure #130: Documentation of Current Medications in the Medical Record**

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patients aged 18 years and older with a list of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route.

INSTRUCTIONS: This measure is to be reported at each visit occurring during the reporting period for patients seen during the reporting period. This measure is intended to determine whether or not documentation of a current medication list occurred for all patients aged 18 years and older. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NUMERATOR: Current medications with dosages and verification with patient or authorized representative is documented by the provider

Numerator Coding:

Current Medications with Name, Dosages, Frequency and Route Documented

G8427: List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency and route

OR

Current Medications with Dosages not Documented, Patient not Eligible

G8430: Provider documentation that patient is not eligible for medication assessment

OR

Current Medications with Name, Dosages, Frequency, Route not Documented, Reason not Specified

G8428: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route not documented by the provider, reason not specified

DENOMINATOR: All patients aged 18 years and older.

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0101, G0108, G0270

**Note: A patient is not eligible if one or more of the following condition(s) exist:*

- *Patient refuses to participate*
- *Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status*
- *Patient cognitively impaired and no authorized representative available*

* * * * *

***Measure #131: Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up**

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patients aged 18 years and older with documentation of a pain assessment (if pain is present, including location, intensity and description) through discussion with the patient including the use of a standardized tool on each qualifying visit prior to initiation of therapy AND documentation of a follow-up plan.

INSTRUCTIONS: This measure is to be reported for each qualifying visit occurring during the reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NUMERATOR: Patient's pain assessment prior to initiation of treatment is documented through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented.

Definitions:

Qualifying Visit – Meets denominator criteria (age and CPT encounter codes) as listed above.

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

Follow-up Plan – Proposed outline of treatment to be conducted as a result of pain assessment. Such follow-up must include a reassessment of pain and may include documentation of a future appointment, education, referral, notification or primary care provider, etc.

Not Eligible – A patient is not eligible if the following condition(s) exist:

- **Pain Assessment**
 - Patient refuses to participate
 - Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
 - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status

- **Follow-Up Plan**
 - Absence of pain on assessment
 - Diagnosis/condition/illness if not situationally related to pain

Numerator Coding:

Pain Assessment Documented AND Follow-Up Plan Documented

G8440: Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented
OR

Pain Assessment not Documented, Patient not Eligible

G8442: Documentation that patient is not eligible for a pain assessment
OR

Pain Assessment Documented, Follow-up Plan not Documented, Patient not Eligible

G8508: Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, patient not eligible
OR

Pain Assessment not Documented, Reason not Specified

G8441: No documentation of pain assessment (including location, intensity and description) prior to initiation of therapy

OR

Pain Assessment Documented, Follow-up Plan not Documented, Reason not Specified

G8509: Documentation of pain assessment (including location, intensity and description) prior to initiation of therapy or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, reason not specified

DENOMINATOR: All patients aged 18 years and older on day of encounter.

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT): 90801, 90802, 96116, 96150, 97001, 97003, 98940, 98941, 98942

**Note: A patient is not eligible if the following condition(s) exist:*

- **Pain Assessment**
 - Patient refuses to participate
 - Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools
 - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status
- **Follow-Up Plan**
 - Absence of pain on assessment
 - Diagnosis/condition/illness if not situationally related to pain

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Measure #142: Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of patient visits for patients aged 21 years and older with a diagnosis of OA with an assessment for use of anti-inflammatory or analgesic OTC medications.

INSTRUCTIONS: This measure is to be reported at each visit occurring during the reporting period for OA patients seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NUMERATOR: Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented.

Numerator Coding:

Assessment for Anti-inflammatory or Analgesic OTC Medications Performed

CPT II 1007F: Use of anti-inflammatory or analgesic over-the-counter (OTC) medications for symptom relief assessed.

OR

Assessment for Anti-inflammatory or Analgesic OTC Medications not Performed, Reason not Specified:

Append a reporting modifier (**8P**) to CPT Category II code **1007F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

1007F with 8P: Use of anti-inflammatory or analgesic OTC medications not assessed, reason not otherwise specified.

DENOMINATOR: All patient visits for patients aged 21 years and older with a diagnosis of OA.

Denominator Criteria (Eligible Cases):

Patients aged \geq 21 years on date of encounter

AND

Diagnosis for OA (ICD-9-CM): 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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***Measure #147: Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy**

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

DESCRIPTION: Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.) that were performed.

INSTRUCTIONS: This measure is to be reported each time bone scintigraphy is performed during the reporting period. There is no diagnosis associated with this measure.

NUMERATOR: Final reports that include physician documentation of correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT, etc.).

Definition: Relevant Imaging Studies – Studies that correspond to the same anatomical region in question.

Numerator Coding:

Bone Scintigraphy Report Correlated with Existing Studies

CPT II 3570F: Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (e.g., x-ray, MRI, CT) corresponding to the same anatomical region in question.

OR

Bone Scintigraphy Report not correlated for System Reasons

Append a modifier (**3P**) to CPT Category II code **3570F** to report documented circumstances that appropriately exclude patients from the denominator.

3570F with 3P: Documentation of system reason(s) for not documenting correlation with existing relevant imaging studies in final report (e.g. no existing relevant imaging study available, patient did not have a previous relevant imaging study).

Note: Correlative studies are considered to be unavailable if relevant studies (reports and/or actual examination material) from other imaging modalities exist but could not be obtained after reasonable efforts to retrieve the studies are made by the interpreting physician prior to the finalization of the bone scintigraphy report.

OR

Bone Scintigraphy Report not Correlated, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3570F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3570F with 8P: Bone scintigraphy report not correlated, reason not otherwise specified.

DENOMINATOR: All final reports for patients, regardless of age, undergoing bone scintigraphy.

Denominator Criteria (Eligible Cases):

Patient encounter during the reporting period (CPT): 78300, 78305, 78306, 78315, 78320

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***Measure #148: Back Pain: Initial Visit – MEASURE GROUP REPORTING OPTION ONLY**

[Reporting Key: MG: This measure is reportable ONLY as part of the Back Pain Measure Group which includes Measure #149: Back Pain: Physical Exam; Measure, #150: Back Pain: Advice for Normal Activities; and Measure #151: Back Pain: Advice Against Bed Rest]

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

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

G8493: I intend to report the Back Pain Measures Group

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

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

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

Definitions:

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

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

OR

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

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

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

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

OR

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

- Eating

- Bathing
- Using the toilet
- Dressing
- Getting up from bed or a chair

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

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

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

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

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

- Sickness Impact Profile
- Multidimensional Pain Inventory

OR

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

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

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

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

Numerator Coding:

Back Pain and Function Assessed

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

OR

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

CPT II 0526F: Subsequent visit for episode.

OR

Back Pain and Function not Assessed, Reason not Specified

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

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

DENOMINATOR: Patients aged 18-79 years with a specific diagnosis for back pain accompanied by a specific patient encounter **OR** patients aged 18-79 years that have a specific back surgical procedure performed:

ICD-9 diagnosis codes: 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

AND

CPT service codes: 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

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

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***Measure #149: Back Pain: Physical Exam - MEASURE GROUP REPORTING OPTION ONLY**

[Reporting Key: MG: This measure is reportable ONLY as part of the Back Pain Measure Group which includes Measure #148: Back Pain: Initial Visit; Measure #150: Back Pain: Advice for Normal Activities; and Measure #151: Back Pain: Advice Against Bed Rest]

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

INSTRUCTIONS: SEE MEASURE #148: Back Pain: Initial Visit.

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

Definitions:

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

- Indication of straight leg raise test

AND

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

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

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

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

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

Numerator Coding:

Physical Exam Performed

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

OR

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

CPT II 0526F: Subsequent visit for episode

OR

Physical Exam not Performed, Reason not Specified

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

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

DENOMINATOR: Patients aged 18-79 years with a specific diagnosis for back pain accompanied by a specific patient encounter **OR** patients aged 18-79 years that have a specific back surgical procedure performed:

ICD-9 diagnosis codes: 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80,

722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

AND

CPT service codes: 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

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

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*** Measure #150: Back Pain: Advice for Normal Activities - MEASURE GROUP REPORTING OPTION ONLY**

[Reporting Key: MG: This measure is reportable ONLY as part of the Back Pain Measure Group which includes Measure #148: Back Pain: Initial Visit; Measure #149: Back Pain: Physical Exam; and Measure #151: Back Pain: Advice Against Bed Rest]

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

INSTRUCTIONS: SEE MEASURE #148: Back Pain: Initial Visit.

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

Definitions:

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

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

Numerator Coding:

Advice for Normal Activities Performed

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

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

CPT II 0526F: Subsequent visit for the episode

OR

Advice for Normal Activities not Performed, Reason not Specified

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

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

DENOMINATOR: Patients aged 18-79 years with a specific diagnosis for back pain accompanied by a specific patient encounter **OR** patients aged 18-79 years that have a specific back surgical procedure performed:

ICD-9 diagnosis codes: 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

AND

CPT service codes: 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

CPT procedure codes: 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044,

63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078,
63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172,
63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200

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*** Measure #151: Back Pain: Advice Against Bed Rest - MEASURE GROUP REPORTING OPTION ONLY**

[Reporting Key: MG: This measure is reportable ONLY as part of the Back Pain Measure Group which includes Measure #148: Back Pain: Initial Visit; Measure #149: Back Pain: Physical Exam; and Measure #150: Back Pain: Advice for Normal Activities]

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

INSTRUCTIONS: SEE MEASURE #148: Back Pain: Initial Visit.

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

Definitions:

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

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

Numerator Coding:

Advice Against Bed Rest Performed

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

OR

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

CPT II 0526F: Subsequent visit for episode

OR

Advice Against Bed Rest not Performed, Reason not Specified

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

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

DENOMINATOR: Patients aged 18-79 years with a specific diagnosis for back pain accompanied by a specific patient encounter **OR** patients aged 18-79 years that have a specific back surgical procedure performed:

ICD-9 diagnosis codes: 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

AND

CPT service codes: 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

OR

CPT procedure codes: 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819,

22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003,
63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044,
63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078,
63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103, 63170, 63172,
63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200

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Measure # 154: Falls: Risk Assessment
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[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

This is a two-part measure which is paired with Measure #155: Falls: Plan of Care. If the falls risk assessment indicates the patient has documentation of two or more falls in the past year or any fall with injury in the past year (CPT II code 1100F is submitted), #155 *should* also be reported.

DESCRIPTION: Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months.

INSTRUCTIONS: This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals) and may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

NUMERATOR: Patients who had a risk assessment for falls completed within 12 months.

Numerator Instructions: All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes. All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Numerator Coding:

Risk Assessment for Falls Completed

(Two CPT II codes [3288F & 1100F] are required on the claim form to submit this numerator option)

CPT II 3288F: Falls risk assessment documented

AND

CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

Risk Assessment for Falls not Completed for Medical Reasons

(Two CPT II codes [3288F-1P & 1100F] are required on the claim form to submit this numerator option)

Append a modifier (**1P**) to CPT Category II code **3288F** to report documented circumstances that appropriately exclude patients from the denominator.

3288F with 1P: Documentation of medical reason(s) for not completing a risk assessment for falls

AND

CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year

OR

If patient is not eligible for this measure because patient has documentation of no falls or only one fall without injury the past year, report:

Patient not at Risk for Falls

(One CPT II code [1101F] is required on the claim form to submit this numerator option)

CPT II 1101F: Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year.

OR

If patient is not eligible for this measure because falls status is not documented, report:

Falls Status not Documented

One CPT II code [1101F-8P] is required on the claim form to submit this numerator option

Append a reporting modifier (**8P**) to CPT Category II code **1101F** to report circumstances when the patient is not eligible for the measure.

1101F with 8P: No documentation of falls status

OR

Risk Assessment for Falls not Completed, Reason not Specified

(Two CPT II codes [3288F-8P & 1100F] are required on the claim form to submit this numerator option). Append a reporting modifier (8P) to CPT Category II code 3288F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3288F with 8P: Falls risk assessment not completed, reason not otherwise specified.

AND

CPT II 1100F: Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year.

DENOMINATOR: All patients aged 65 years and older who have a history of falls

Denominator Criteria (Eligible Cases):

Patients aged ≥ 65 years on date of encounter

AND

Patient encounter during the reporting period (CPT): 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

* * * * *

***Measure #155: Falls: Plan of Care**

[Reporting Key: C-R-GP: This measure is reportable via Claims, Registry, or Group Practice Reporting Option II]

This is a two-part measure which is paired with Measure #154: Falls: Risk Assessment.

This measure *should* be reported if CPT II code 1100F “Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year” is submitted for Measure #154.

DESCRIPTION: Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months.

INSTRUCTIONS: This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all non-acute settings (excludes emergency departments and acute care hospitals) and may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

When CPT II code 1100F is reported with Measure #154, add the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier.

NUMERATOR: Patients with a plan of care for falls documented within 12 months.

Numerator Coding:

All components do not need to be completed during one patient visit, but should be documented in the medical record as having been performed within the past 12 months.

Plan of Care Documented

CPT II 0518F: Falls plan of care documented

OR

Plan of Care not Documented for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **0518F** to report documented circumstances that appropriately exclude patients from the denominator.

- **0518F with 1P:** Documentation of medical reason(s) for no plan of care for falls

OR

Plan of Care not Documented, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **0518F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- **0518F with 8P:** Plan of care not documented, reason not otherwise specified

DENOMINATOR:

All patients aged 65 years and older with a history of falls (history of falls is defined as 2 or more falls in the past year or any fall with injury in the past year)

Denominator Criteria (Eligible Cases):

All eligible instances when CPT II code 1100F (Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year) is reported in the numerator for Measure #154.

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***Measure #163: Diabetes Mellitus: Foot Exam**

[Reporting Key: C-MG-R-GPI-GP: This measure is reportable via Claims, Diabetes Mellitus Measures Group, Group Practice Reporting Option I, or Group Practice Reporting Option II]

DESCRIPTION: The percentage of patients aged 18 through 75 years with diabetes who received a foot exam.

INSTRUCTIONS: This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

Numerator Coding:

Foot Exam Performed

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

OR

Foot Exam not Performed for Medical Reason

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

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

OR

Foot Exam not Performed, Reason not Specified

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

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

DENOMINATOR: Patients aged 18 through 75 years with a diagnosis of diabetes.

Denominator Criteria (Eligible Cases):

Patients aged 18 through 75 years on date of encounter

Denominator Coding:

ICD-9-CM: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

AND

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

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