2009 AAOS PQRI WORKSHEET, No. 1  
Detail Version

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

[Reporting Key:  C-MG-R:  This measure is reportable as Claims-based, part of the Perioperative Measures Group, or through a Registry]

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

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 antibiotics. There is no diagnosis associated with this measure

Documentation of order for prophylactic antibiotic (written order, verbal order, or standing order/protocol)
CPT II 4047F: Documentation of order for prophylactic antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)
OR
Documentation that antibiotic has been given within One Hour Prior to the Surgical Incision (or start of procedure when no incision is required)
CPT II 4048F: Documentation that prophylactic antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)
OR
Order for Prophylactic Antibiotic not Given for Medical Reasons
Append a modifier (1P) to CPT Category II code 4047F to report documented circumstances that appropriately exclude patients from the denominator.
4047 with 1P: Documentation of medical reason(s) for not ordering antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)
OR
Order for or Administration of Prophylactic Antibiotic not Given, Reason Not Specified
Append a reporting modifier (8P) to CPT Category II code 4047F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4047 with 8P: Antibiotics were not ordered 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

<table>
<thead>
<tr>
<th>SURGICAL PROCEDURE</th>
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<tbody>
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<td>Spine</td>
<td>22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042</td>
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**Measure #21: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin**

[Reporting Key:  C-MG-R:  This measure is reportable as Claims-based, part of the Perioperative Measures Group, or through a Registry]

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

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

[Reporting Key: C-MG-R: This measure is reportable as Claims-based, part of the Perioperative Measures Group, or through a Registry]

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

**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.

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 Antibiotics not Discontinued for Medical Reasons**
Append a modifier (1P) to CPT Category II code 4049F to report documented circumstances that appropriately exclude patients from the denominator.

*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 does not meet denominator inclusion because patient did not receive prophylactic antibiotics within specified timeframe, report:
CPT II 4042F: Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively

**OR**

**Prophylactic Antibiotics not Discontinued, Reason Not Specified** 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.

*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

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

[Reporting Key: C-MG-R: This measure is reportable as Claims-based, part of the Perioperative Measures Group, or through a Registry]

**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 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.

* 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.

* 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.

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

[Reporting Key: C-R: This measure is reportable as Claims-based or through a Registry]

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

INSTRUCTIONS:
This measure is to be reported after each occurrence of a fracture during the reporting period. Each occurrence of a fracture is identified by either an ICD-9-CM diagnosis code for fracture and a CPT service code OR a CPT procedure code for surgical treatment of a fracture.

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.
• 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
• 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.
• 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.

ICD-9 diagnosis codes: 733.12-733.14, 805.00-805.08, 805.10-805.18, 805.2, 805.4, 805.6, 805.8, 813.40-813.42, 813.44, 813.45, 813.50-813.52, 813.54, 820.00-820.03, 820.09-820.11, 820.13, 820.20-820.22, 820.8, 820.9
AND
CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245, 99354, 99355
OR
CPT procedure codes: 22305-22327, 22520, 22521, 22522, 22524, 25600-25609, 27230-27248

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

**[Reporting Key: C-MG-R: This measure is reportable as Claims-based, part of the Preventive Care Measures Group, or through a Registry]**

**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 Coding:**
A CPT E/M service code is required to identify female patients aged 65 years and older who were seen by a clinician for denominator inclusion.

**CPT E/M service codes:** 99201-99205, 99212-99215

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Measure #40: Osteoporosis: Management Following Fracture

[Reporting Key: C-R: This measure is reportable as Claims-based or through a Registry]

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 and a CPT service code OR a CPT procedure code for surgical treatment of fractures.

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

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
CPT II 4005F: Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed
OR
Central DXA Measurement not Ordered or Results 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 or 4005F to report documented circumstances that appropriately exclude patients from the denominator.
• 1P: Documentation of medical reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
• 2P: Documentation of patient reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
• 3P: Documentation of system reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or not prescribing pharmacologic therapy for osteoporosis
OR
Central DXA Measurement not Ordered or Results Documented or Pharmacologic Therapy not Prescribed, Reason Not Specified. Append a reporting modifier (8P) to CPT Category II code 3096F or 3095F or 4005F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
• 8P: Central dual energy X-ray absorptiometry (DXA) measurement was not ordered or performed or 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

Denominator Coding:
An ICD-9 diagnosis code and a CPT E/M service code or CPT procedure code are required to identify patients with a recent fracture of the hip, spine or distal radius for denominator inclusion.

ICD-9 diagnosis codes: 733.12-733.14, 805.00-805.08, 805.10-805.18, 805.2, 805.4, 805.6, 805.8, 813.40-813.42, 813.44, 813.45, 813.50-813.52, 813.54, 820.00-820.03, 820.09-820.11, 820.20-820.22, 820.13, 820.8, 820.9
AND
CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245
OR
CPT procedure codes: 22305-22327, 22520, 22521, 22522, 22524, 25600-25609, 27230-27248

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*Measure #41: Osteoporosis: Pharmacologic Therapy*

[Reporting Key: C-R: This measure is reportable as Claims-based or through a Registry]

**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. It is anticipated that clinicians who provide services for patients with the diagnosis of osteoporosis will submit this measure.

This measure can be reported using CPT Category II codes: 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.

• 1P: Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis
• 2P: Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis
• 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.

• 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 Coding:**
An ICD-9 diagnosis code to identify patients with osteoporosis and a CPT E/M service code are required for denominator inclusion.

**ICD-9 diagnosis codes:** 733.00-733.03, 733.09

**AND**

**CPT E/M service codes:** 99201-99205, 99212-99215, 99241-99245, 99354, 99355, 99386, 99387, 99396, 99397, 99401-99404

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

[Reporting Key: C-R: This measure is reportable as Claims-based or through a Registry]

**DESCRIPTION:**
Documents whether provider has adopted and is using health information technology. To qualify, the provider must have adopted and be using a certified/qualified EHR. A qualified EHR can be either certified by the Certification Commission for Healthcare Information Technology (CCHIT) or, if not CCHIT certified, the system must be capable of all of the following:

a) Manage a medication list; b) Manage a problem list, c) Meet basic privacy and security elements; and
d) Manually enter or electronically receive, store, and display laboratory tests as discrete searchable data elements

**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 is reported using G-codes: CPT E/M codes, CPT service codes, CPT procedure codes, HCPCS D-codes and HCPCS G-codes are used to identify patients who are included in the measure’s denominator. G-codes are used to report the numerator of the measure. When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

**NUMERATOR:**
Patient encounter documentation substantiates use of certified/qualified EHR

**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.

**Basic Privacy and Security Elements** – a) ability to audit the date/time and user of each time patient chart printed; b) ability to archive and retrieve health record information.

**CCHIT** – The Certification Commission for Healthcare Information Technology (www.cchit.org) – an independent, nonprofit organization that has been recognized by the federal government as an official certification body for electronic health record products.

**Discrete searchable data elements** – Laboratory data that can be recorded in predefined fields in predefined formats within the EHR that allow for reports to be generated, such as trends of a specific element over time. This cannot be easily done if data is entered via a free text format or by merely scanning a report into the EHR.

**Numerator Coding:**

**Encounter Documented Using CCHIT Certified or Qualified EHR**

G8447: Patient encounter was documented using a CCHIT certified EHR

**OR**

G8448: Patient encounter was documented using a qualified (non-CCHIT) certified EHR. To qualify, the system must be capable of: managing a medication list; managing a problem list; meeting basic privacy and security elements; entering or receiving, storing, and displaying laboratory tests as discrete searchable data elements;

**DENOMINATOR:**
All patient encounters

**Denominator Coding:**

A CPT service code, CPT E/M code, HCPCS D-code or HCPCS G-code is required to identify patients for denominator inclusion.

**CPT service codes, CPT E/M codes, HCPCS D-codes or HCPCS G-codes:** 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 97750, 97802, 97803, 97804, 98940, 98941, 98942, 98943, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, D7140, D7210, G0101, G0108, G0109, G0270, G0271

Note: While it is preferable to encourage adoption of CCHIT certified EHRs, it became apparent during measure field testing that CCHIT certified EHRs are not currently available for all provider settings and specialty groups that may report this measure. Therefore, additional numerator coding was added to enable providers who have adopted a non-CCHIT certified product, which meets a set of standards, to also report this measure. Providers have until August 1, 2011 to transition to a CCHIT certified product; after that date they will not meet the performance requirements of the measure with a CCHIT certified EHR in use.

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

[Reporting Key:  C-R:  This measure is reportable as Claims-based or through a Registry]  

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

INSTRUCTIONS:
This measure is to be 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.

This measure is reported using G-codes:  ICD-9 diagnosis codes, CPT codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure’s denominator. G-codes are used to report the numerator of the measure. When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

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

Definition:  A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection.

Numerator Coding:
G8404:  Lower Extremity Neurological Exam Performed:  Lower extremity neurological exam performed and documented
OR
G8406:  Lower Extremity Neurological Exam not Performed for Documented Reasons:  Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure
OR
G8405:  Lower Extremity Neurological Exam not Performed:  Lower extremity neurological exam not performed

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

Denominator Coding:
An ICD-9 diagnosis code for diabetes mellitus and a CPT code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes:  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
CPT codes:  10060, 10061, 10180, 11000, 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

[Reporting Key:  C-R:  This measure is reportable as Claims-based or through a Registry]

**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 be 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.

This measure is reported using G-codes: ICD-9 diagnosis codes, CPT E/M service codes, CPT procedure codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure’s denominator. G-codes are used to report the numerator of the measure. When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

**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:**
- **G8410:** Footwear Evaluation Performed: Footwear evaluation performed and documented
- **OR**
- **G8416:** Footwear Evaluation not Performed for Documented Reasons: Clinician documented that patient was not an eligible candidate for footwear evaluation measure
- **OR**
- **G8415:** Footwear Evaluation not Performed: Footwear evaluation was not performed

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

**Denominator Coding:**
An ICD-9 diagnosis code for diabetes mellitus and a CPT code are required to identify patients for denominator inclusion.

**ICD-9 diagnosis codes:** 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

**CPT codes:** 10060, 10061, 10180, 11000, 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

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

[Reporting Key: C-R: This measure is reportable as Claims-based or through a Registry]

DESCRIPTION:
Percentage of patients aged 18 years and older with a list of current medications with dosages (includes prescription, over-the-counter, herbas, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative is documented by the provider

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 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 Coding:
Current Medications with Dosages AND Verification Documented
G8427: List of current medications with dosages (includes prescription, over-the-counter, herbas, vitamin/mineral/dietary [nutritional] supplements) and verification with the patient or authorized representative documented by the provider

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

G8507: Provider documentation that patient is not eligible for patient verification of current medications

G8428: Provider documentation of current medications with dosages (includes prescription, over-the-counter, herbas, vitamin/mineral/dietary [nutritional] supplements) without documented patient verification

G8429: Incomplete or no provider documentation that the patient's current medications with dosages (includes prescription, over-the-counter, herbas, vitamin/mineral/dietary [nutritional] supplements) were assessed

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

Denominator Coding:
CPT or HCPCS codes: 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01632, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01660, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01916, 01920, 01922, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01953, 01958, 01960, 01961, 01962, 01963, 01965, 01966, 01967, 01968, 01969, 01990, 01991, 01992, 01996, 01999, 09081, 09082, 92002, 92004, 92012, 92014, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92557, 92567, 92568, 92569, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0270
**Measure #131: Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up**

[Reporting Key: C-R: This measure is reportable as Claims-based or through a Registry]

**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 non-MD/DO clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

**Definition:** Qualifying visit – Meets the denominator criteria (age and CPT encounter code)

**Numerator Coding:**
- **Pain Assessment Documented AND Follow-up Plan Documented**
  - G8440: Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment 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 treatment 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 treatment
  - 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 treatment 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.

**CPT codes:** 90801, 90802, 96116, 96150, 97001, 97003, 98940, 98941, 98942
Measure #142: Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

[Reporting Key:   C-R:  This measure is reportable as Claims-based or through a Registry]

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. Submit the listed ICD-9-CM diagnosis code, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier.

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

DENOMINATOR:
All visits for patients aged 21 years and older with OA on day of encounter.

Denominator coding:
ICD-9 diagnosis codes: 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, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
AND
CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Measure # 154: Falls: Risk Assessment

[Reporting Key: C-R: This measure is reportable as Claims-based or through a Registry]

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 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)
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

**OR**

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

**DENOMINATOR:**
All patients aged 65 years and older who have a history of falls AND
CPT codes: 97001, 97002, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350
**Measure #155: Falls: Plan of Care**

[Reporting Key: C-R: This measure is reportable as Claims-based or through a Registry]

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 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

- **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.
    - • 1P: Documentation of medical reason(s) for no plan of care for falls

- **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.
    - • 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)

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.
Measure #163: Diabetes Mellitus: Foot Exam

[Reporting Key: C-MG-R: This measure is reportable as Claims-based, part of the Diabetes Mellitus Measures Group, or through a Registry]

DESCRIPTION:
The percentage of patients aged 18 through 75 years with diabetes who received a foot exam (visual inspection, sensory exam with monofilament, or pulse 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 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 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, 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, 99349, 99350, G0270, G0271