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### 2014 | PQRS Measures Supported by the Net Health Specialty Care Registry

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<p>| 130        | Patient Safety           | <strong>Documentation of Current Medications in the Medical Record</strong> - Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration |
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</table>
Measure #246: Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without a prescription or recommendation to use wet to dry dressings

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of a chronic skin ulcer 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.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics 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.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 on date of encounter

AND

Diagnosis for chronic skin ulcer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 454.0, 454.2, 459.11, 459.13, 459.31, 459.33, 707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09, 707.10, 707.11, 707.12, 707.13, 707.14, 707.15, 707.19, 707.8, 707.9

Diagnosis for chronic skin ulcer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I70.231, I70.232, I70.233, I70.234, I70.235, I70.236, I70.237, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.246, I70.247, I70.248, I70.249, I70.25, I70.331, I70.332, I70.333, I70.334, I70.335, I70.336, I70.337, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.351, I70.352, I70.353, I70.354, I70.355, I70.356, I70.357, I70.358, I70.359, I70.531, I70.532, I70.533, I70.534, I70.535, I70.536, I70.537, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.546, I70.547, I70.548, I70.549, I70.55, I70.561, I70.631, I70.632, I70.633, I70.634, I70.635, I70.636, I70.637, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.646, I70.647, I70.648, I70.649, I70.65, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744,
Patient encounter during the reporting period (CPT):
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

NUMERATOR:
Patient visits without a prescription or recommendation to use wet to dry dressings

Numerator Instructions: A higher score indicates appropriate treatment of patients with chronic skin ulcer.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
No Prescription or Recommendation for Use of Wet to Dry Dressings
CPT II 4266F: Use of wet to dry dressings neither prescribed nor recommended
OR
Use of Wet to Dry Dressings Prescribed or Recommended for Medical Reasons
Append a modifier (1P) to Category II code 4265F to report documented circumstances that appropriately exclude patients from the denominator.
4265F with 1P: Documentation of medical reason(s) for prescribing/recommending wet to dry dressings (eg, presence of necrotic tissue requiring debridement, highly exudative wound that is unlikely to dry out between dressing changes)

AND
Patient encounter during the reporting period (CPT): 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
Use of Wet to Dry Dressings Prescribed or Recommended
CPT II 4265F: Use of wet to dry dressings prescribed or recommended

RATIONALE:
A moist wound environment is essential to accelerate wound healing. Nevertheless, “wet to dry and gauze dressings are the most widely used primary dressing material in the United States” and evidence suggests that they are used inappropriately. In a recent study examining wound care practices, the use of dressings to maintain moist wound conditions ranged from 41.7% to 58.5% for diabetic and venous ulcers, respectively. Wet-to-dry dressings should not be utilized in the care of patients with chronic wounds as they may actually impede healing and are associated with an increased risk of infection, prolonged inflammation, and increased patient discomfort.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Use clinical judgment to select a wound dressing that facilitates continued moisture. (Level I) Wet-to-dry dressings are not considered continuously moist. Continuously moist saline gauze dressings are as effective as other types of moist wound healing in terms of healing rate, although they may have other drawbacks such as maceration of the peri-ulcer skin, practicality of use, and cost effectiveness. It can also be very difficult, practically, to keep gauze dressings continuously moist. (WHS, 2006)

Maintain moist environment
- Remove soluble factors detrimental to wound healing
- Use appropriate dressings (available evidence shows no superiority in dressing materials)
- Consider classic dressings (gauze, foam, hydrocolloid, hydrogels)
Consider bioactive dressings (Grade B) (ASPS, 2007)
Measure #245: Chronic Wound Care: Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without the use of a wound surface culture technique

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for patients with a diagnosis of a chronic skin ulcer 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.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics 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.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifier allowed for this measure is: 1P- medical reasons. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 on date of encounter

AND
Diagnosis for chronic skin ulcer (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 454.0, 454.2, 459.11, 459.13, 459.31, 459.33, 707.00, 707.01, 707.02, 707.03, 707.04, 707.05, 707.06, 707.07, 707.09, 707.10, 707.11, 707.12, 707.13, 707.14, 707.15, 707.19, 707.8, 707.9

Diagnosis for chronic skin ulcer (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I70.231, I70.232, I70.233, I70.234, I70.235, I70.236, I70.237, I70.238, I70.239, I70.241, I70.242, I70.243, I70.244, I70.245, I70.248, I70.249, I70.25, I70.331, I70.332, I70.333, I70.334, I70.335, I70.338, I70.339, I70.341, I70.342, I70.343, I70.344, I70.345, I70.348, I70.349, I70.35, I70.431, I70.432, I70.433, I70.434, I70.435, I70.438, I70.439, I70.441, I70.442, I70.443, I70.444, I70.445, I70.448, I70.449, I70.45, I70.531, I70.532, I70.533, I70.534, I70.535, I70.538, I70.539, I70.541, I70.542, I70.543, I70.544, I70.545, I70.548, I70.549, I70.55, I70.631, I70.632, I70.633, I70.634, I70.635, I70.638, I70.639, I70.641, I70.642, I70.643, I70.644, I70.645, I70.648, I70.649, I70.65, I70.731, I70.732, I70.733, I70.734, I70.735, I70.738, I70.739, I70.741, I70.742, I70.743, I70.744,
Patient encounter during the reporting period (CPT): 97001, 97002, 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, 99346, 99347, 99348, 99349, 99350

**NUMERATOR:**

Patient visits **without** the use of a wound surface culture technique

**Numerator Instructions:** A higher score indicates appropriate treatment of patients with chronic skin ulcer.

**NUMERATOR NOTE:** The numerator will also be met if there is documentation that a technique other than surface culture of the wound exudate has been used to acquire the wound culture (eg, Levine/deep swab technique, semiquantitative or quantitative swab technique).

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

**Wound Surface Culture Technique Not Used**

CPT II 4261F: Technique other than surface culture of the wound exudate used (eg, Levine/deep swab technique, semiquantitative or quantitative swab technique) **or** wound surface culture technique **not** used

**OR**

**Wound Surface Culture Technique Used for Medical Reasons**
Append a modifier (1P) to Category II code 4260F to report documented circumstances that appropriately exclude patients from the denominator.
4260F with 1P: Documentation of medical reason(s) for using a wound surface culture technique (eg, surface culture for methicillin-resistant staphylococcus aureus [MRSA] screening)

OR

Wound Surface Culture Technique Used
CPT II 4260F: Wound surface culture technique used

RATIONALE:
Infections are a potential complication in any patient with a chronic wound. Accurately determining the pathogenic cause of these clinically diagnosed infections has important implications in determining appropriate treatment regimens and minimizing patient complications. Surface swab cultures are inaccurate and unreliable for obtaining specimens for culture. A surface swab of an unprepared wound bed will not necessarily reveal the organism that resides within the tissue but rather only the surface contaminants. A basic tenet of infection within a chronic wound is that the organism must reside in living tissue. Swab culture of the surface may not reveal this in the presence of significant necrotic tissue or exudate. A recent survey of wound care practitioners in the US found that 54% of respondents routinely collect a swab culture while another 42% routinely collect both swab and biopsy specimens depending on the nature of the wound. More importantly, the study demonstrated considerable variability in the type of swab culture commonly obtained - including surface, deep swab and quantitative techniques. Despite their limited utility and the proven efficacy of quantitative swab and other techniques, surface cultures remain a common method for identifying chronic wound infection. The principle here is to avoid swabbing the unprepared wound exudate. Preparation of the wound with physiologic solution and removal of loose tissue matter prior to obtaining the wound culture will not impede the diagnosis of an offending organism, rather it will lessen the probability of identifying and treating a surface contaminant that will not impact progression to healing. In other words, no information is lost by wound bed preparation prior to swab or tissue biopsy technique culture. The goal is to obtain tissue microorganisms from the viable deeper tissue plane.

CLINICAL RECOMMENDATION STATEMENTS:
The following clinical recommendation statements are quoted verbatim from the referenced clinical guidelines and represent the evidence base for the measure:

Avoid swabbing undebrided ulcers or wound drainage. If swabbing the debrided wound base is the only available culture option, use a swab designed for culturing aerobic and anaerobic organisms and rapidly transport it to the laboratory (B-I). (Lipsky et al., IDSA, 2004)

…determine the type and level of infection in the debrided ulcer by tissue biopsy or by a validated quantitative swab technique. (Level II) (WHS, 2006)

[Q]uantitative culture has been shown to have high predictive value, sensitivity, and specificity. Most authors recommend the following technique for acquiring high quality wound cultures: After skin disinfection, a strip of necrotic wound tissue weighing 0.1 to 0.5 gram is excised for quantitative culture. This specimen is placed in an aerobic/anaerobic culture medium. Simultaneously, routine cotton swab is taken from the site of excision-debridement, taking care to avoid the ulcer’s surface. It may occasionally be necessary to biopsy the ulcer in order to rule out [the] uncommon causes of lower extremity ulcers. (ASPS, 2007)

…swab specimens collected from wounds using Levine’s technique performed better than swab specimens collected using either the wound exudate or Z-technique. Equally important, the findings suggest that swab specimens obtained using Levine’s technique and processed using quantitative laboratory procedures are acceptably accurate when compared with the quantitative cultures of wound tissue. …swab specimens obtained with Levine’s technique will enable a wider variety of wounds to be monitored for wound bioburden than tissue cultures. In addition, Levine’s technique will be much more practical for repeating cultures in suspicious wounds that produce negative findings initially than tissue cultures. (Gardner et al., 2006)
Measure #236 (NQF 0018): Controlling High Blood Pressure

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with hypertension seen during the reporting period. The performance period for this measure is 12 months. The most recent quality code submitted will be used for performance calculation. 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.

In reference to the numerator element, only blood pressure readings performed by a clinician in the provider office are acceptable for numerator compliance with this measure. Do not include blood pressure readings that meet the following criteria:
- Blood pressure readings from the patient's home (including readings directly from monitoring devices).
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole).
- Obtained the same day as a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy).

If no blood pressure is recorded during the measurement period, the patient's blood pressure is assumed “not controlled.”

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS code and patient demographics are used to identify patients who are included in the measure’s denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes and the appropriate quality-data code. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.
The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

Denominator Criteria (Eligible Cases):
Patients 18 through 85 years of age on date of encounter AND
Diagnosis for hypertension (ICD-9-CM) [for use 01/01/2014-09/30/2014]: 401.0, 401.1, 401.9

Diagnosis for hypertension (ICD-10-CM) [for use 10/01/2014-12/31/2014]: I10

AND

Patient encounter during reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, G0402, G0438, G0439

NUMERATOR:
Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

Numerator Instructions: To describe both systolic and diastolic blood pressure values, each must be reported separately. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Most Recent Blood Pressure Measurement Performed
Systolic pressure (Select one (1) code from this section):
G8752: Most recent systolic blood pressure < 140 mmHg
OR
G8753: Most recent systolic blood pressure ≥ 140 mmHg
AND
Diastolic pressure (Select one (1) code from this section):
G8754: Most recent diastolic blood pressure < 90 mmHg
OR
G8755: Most recent diastolic blood pressure ≥ 90 mmHg
OR
Patient not Eligible for Recommended Blood Pressure Parameters for Documented Reasons
G9231: Documentation of end stage renal disease (ESRD), dialysis, renal transplant or pregnancy.

OR

Blood Pressure Measurement not Documented, Reason not Given
G8756: No documentation of blood pressure measurement, reason not given

RATIONALE:
Hypertension is a very significant health issue in the United States. Fifty million or more Americans have high blood pressure that warrants treatment, according to the National Health and Nutrition Examination Survey (NHANES) survey (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003). The United States Preventive Services Task Force (USPSTF) recommends that clinicians screen adults aged 18 and older for high blood pressure (United States Preventive Services Task Force 2007).

The most frequent and serious complications of uncontrolled hypertension include coronary heart disease, congestive heart failure, stroke, ruptured aortic aneurysm, renal disease, and retinopathy. The increased risks of hypertension are present in individuals ranging from 40 to 89 years of age. For every 20 mmHg systolic or 10 mmHg diastolic increase in blood pressure, there is a doubling of mortality from both ischemic heart disease and stroke (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).

Better control of blood pressure has been shown to significantly reduce the probability that these undesirable and costly outcomes will occur. The relationship between the measure (control of hypertension) and the long-term clinical outcomes listed is well established. In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence (35-40 percent), myocardial infarction incidence (20-25 percent) and heart failure incidence (>50 percent) (Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure 2003).
**CLINICAL RECOMMENDATION STATEMENTS:**
The United States Preventive Services Task Force (2007) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (2003): Treating systolic blood pressure and diastolic blood pressure to targets that are < 140/90 mmHg is associated with a decrease in cardiovascular disease complications.
Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

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

INSTRUCTIONS:
This measure is to be reported once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting via Claims:
CPT or HCPCS codes, and patient demographics 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.

When reporting the measure via claims, submit the appropriate CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.
The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

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

Definitions:
Tobacco Use – Includes use of any type of tobacco.
Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

NUMERATOR NOTE: In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.
Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Patient Screened for Tobacco Use
CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco
CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator

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

OR

Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason Not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4004F with 8P: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified

RATIONALE:
This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

CLINICAL RECOMMENDATION STATEMENTS:
The following evidence statements are quoted verbatim from the referenced clinical guidelines:

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of
effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)
Measure #163 (NQF 0056): Diabetes: Foot Exam

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period

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.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics 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.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
Patients 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter AND
Diagnosis for diabetes (ICD-9-CM) [for use 01/1/2014-09/30/2014]: 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, 362.00, 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
NUMERATOR:
Patients who received a foot exam (i.e., visual inspection, sensory exam with monofilament AND pulse exam) during the measurement period

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

- **Foot Exam Performed**
  - **G9226**: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when all of the 3 components are completed)

OR

- **Foot Exam not Performed for Medical Reason**
  - **G9224**: Documentation of medical reason for not performing foot exam (e.g., patient with bilateral foot/leg amputation)

OR

- **Foot Exam not Performed, Reason not Given**
  - **G9225**: Foot exam was not performed, reason not given

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life-ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage. The consensus among established clinical guidelines is that patients with diabetes should have a foot exam soon after diagnosis and annually thereafter. Comprehensive foot care programs can lower amputation rates by 45-85 percent (American Diabetes Association 2009).

CLINICAL RECOMMENDATION STATEMENTS:
American Diabetes Association (2009) Guidelines/Recommendations: Perform annual comprehensive foot examination to identify risk factors predictive of ulcers and amputations. The foot examination should include inspection, assessment of foot pulses, and testing for loss of protective sensation (10-g monofilament plus testing any one of: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold).
Measure #155 (NQF: 0101): Falls: Plan of Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, 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). 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.

Measure Reporting via Claims:
All eligible instances when 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 reported in the numerator for Measure #154 make up the denominator for this measure. CPT Category II codes are used to report the numerator of the measure.

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. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
All eligible instances when patient is reported in the numerator for Measure #154 as screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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):
Patients aged ≥ 65 years on date of encounter AND
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. AND
Patient encounter during the reporting period (CPT or HCPCS): 97001, 97002, 97003, 97004, 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, G0402, G0438, G0439

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

Definitions:
Plan of Care – Must include: 1) consideration of vitamin D supplementation AND 2) balance, strength, and gait training.
Consideration of Vitamin D Supplementation – Documentation that vitamin D supplementation was advised or considered or documentation that patient was referred to his/her physician for vitamin D supplementation advice.
Balance, Strength, and Gait Training – Medical record must include: documentation that balance, strength, and gait training/instructions were provided OR referral to an exercise program, which includes at least one of the three components: balance, strength or gait OR referral to physical therapy.
Fall – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
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 Otherwise 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

RATIONALE:
Interventions to prevent future falls should be documented for the patient with 2 or more falls or injurious falls.

CLINICAL RECOMMENDATION STATEMENTS:
The USPSTF recommends exercise or physical therapy and vitamin D supplementation to prevent falls in community-dwelling adults aged 65 years or older who are at increased risk for falls.
Grade: B Recommendation.

The AGS 2010 Clinical Practice Guidelines Recommend:
Multifactorial/Multicomponent Interventions to Address Identified Risk(s) and Prevent Falls
1. A strategy to reduce the risk of falls should include multifactorial assessment of known fall risk factors and management of the risk factors identified. [A]

2. The components most commonly included in efficacious interventions were:
   a. Adaptation or modification of home environment [A]
   b. Withdrawal or minimization of psychoactive medications [B]
   c. Withdrawal or minimization of other medications [C]
   d. Management of postural hypotension [C]
   e. Management of foot problems and footwear [C]
   f. Exercise, particularly balance, strength, and gait training [A]

3. All older adults who are at risk of falling should be offered an exercise program incorporating balance, gait, and strength training. Flexibility and endurance training should also be offered, but not as sole components of the program. [A]

4. Multifactorial/multicomponent intervention should include an education component complementing and addressing issues specific to the intervention being provided, tailored to individual cognitive function and language. [C]

5. The health professional or team conducting the fall risk assessment should directly implement the interventions or should assure that the interventions are carried out by other qualified healthcare professionals. [A]
Measure #154 (NQF: 0101): Falls: Risk Assessment

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, 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). 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.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics 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.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II codes OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 65 years and older who have 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):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 97001, 97002, 97003, 97004, 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, G0402, G0438, G0439

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.

**Definitions:**
- **Fall** – A sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force.
- **Risk Assessment** – Comprised of balance/gait AND one or more of the following: postural blood pressure, vision, home fall hazards, and documentation on whether medications are a contributing factor or not to falls 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.

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

**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
- **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 (ie, reduced mobility, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair)
- **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 Otherwise Specified**

(2 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

**RATIONALE:**

Screening for specific medical conditions may direct the therapy. Although the clinical guidelines and supporting evidence calls for an evaluation of many factors, it was felt that for the purposes of measuring performance and facilitating implementation this initial measure must be limited in scope. For this reason, the work group defined an evaluation of balance and gait as a core component that must be completed on all patients with a history of falls as well as four additional evaluations – at least one of which must be completed within the 12 month period. Data elements required for the measure can be captured and the measure is actionable by the physician.

**CLINICAL RECOMMENDATION STATEMENTS:**

Older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance should be offered a multifactorial falls risk assessment. This assessment should be performed by a health care professional with appropriate skills and experience, normally in the setting of a specialist falls service. This assessment should be part of an individualized, multifactorial intervention. (NICE) (Grade C)

Multifactorial assessment may include the following:

- identification of falls history
- assessment of gait, balance and mobility, and muscle weakness
- assessment of osteoporosis risk
- assessment of the older person’s perceived functional ability and fear relating to falling
- assessment of visual impairment
- assessment of cognitive impairment and neurological examination
- assessment of urinary incontinence
- assessment of home hazards
- cardiovascular examination and medication review (NICE) (Grade C)

A falls risk assessment should be performed for older persons who present for medical attention because of a fall, report recurrent falls in the past year, report difficulties in walking or balance or fear of falling, or demonstrate unsteadiness or difficulty performing a gait and balance test.

The falls risk evaluation should be performed by a clinician with appropriate skills and experience. [C]

A falls risk assessment is a clinical evaluation that should include the following, but are not limited to:

- a history of fall circumstances
- review of all medications and doses
- evaluation of gait and balance, mobility levels and lower extremity joint function
- examination of vision
- examination of neurological function, muscle strength, proprioception, reflexes, and tests of cortical, extrapyramidal, and cerebellar function
- cognitive evaluation
- screening for depression
- assessment of postural blood pressure
• assessment of heart rate and rhythm
• assessment of heart rate and rhythm, and blood pressure responses to carotid sinus stimulation if appropriate
• assessment of home environment

The falls risks assessment should be followed by direct intervention on the identified risk. [A] (AGS)
**Measure #131 (NQF 0420): Pain Assessment and Follow-Up**

**2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
CLAIMS, REGISTRY

**DESCRIPTION:**
Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

**INSTRUCTIONS:**
This measure is to be reported **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 eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. The documented follow up plan must be related to the presence of pain, example: “Patient referred to pain management specialist for back pain” or “Return in two weeks for re-assessment of pain”.

**Measure Reporting via Claims:**
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure’s denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

**Measure Reporting via Registry:**
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

**DENOMINATOR:**
All visits for patients aged 18 years and older

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 96116, 96118, 96150, 97001, 97002, 97003, 97004, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0402, G0438, G0439

**NUMERATOR:**
Patient visits with a documented pain assessment using a standardized tool(s) AND documentation of a follow-up plan when pain is present

**Numerator Note:** The standardized tool used to assess the patient’s pain must be documented in the medical record (exception; A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity)

**Definitions:**

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Pain Assessment - Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.

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, 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), and Visual Analog Scale (VAS).

Follow-Up Plan – A documented outline of care for a positive pain assessment is required. This must include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.

Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

- 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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Pain Assessment Documented as Positive AND Follow-Up Plan Documented
(One quality-data code [G8730 or G8731] is required on the claim form to submit this numerator option)
G8730: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented

OR

Pain Assessment Documented as Negative, No Follow-Up Plan Required
G8731: Pain assessment using a standardized tool is documented as negative, no follow-up plan required

OR

Pain Assessment NOT Documented Patient not Eligible
(One quality-data code [G8442 or G8939] is required on the claim form to submit this numerator option)
G8442: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible
G8939: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible

OR

Pain Assessment not Documented, Reason not Given
(One quality-data code [G8732 or G8509] is required on the claim form to submit this numerator option)
G8732: No documentation of pain assessment, reason not given

OR

Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given
G8509: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given

RATIONALE:
Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the Affordable Care Act (ACA) of 2010 to improve pain care. The legislation includes:

- Mandating an Institute of Medicine (IOM) conference on pain to address key medical and policy issues affecting the delivery of quality pain care
Establishing a training program to improve the skills of health care professionals to assess and treat pain

Enhancing the pain research agenda for the National Institute of Health (NIH)

The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- 76.5 million Americans suffering from pain.
- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at $100 billion annually in healthcare expenses, lost income, and lost productivity– extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings. Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine’s (IOM) Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc.)
- Increase in obesity which is associated with chronic conditions that have painful symptoms
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain
- Surgical patients are at risk for acute and chronic pain
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.

Persistent chronic pain costs $560 to $635 billion in the USA. Additional healthcare costs due to pain range from $261 to $300 billion. Lost productive time amounts to $299 to $334 billion. Productivity is affected by number of days missed, number of annual hours worked and hourly wages (Gaskin, 2012). Stewart et al. (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition: 5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

There are no current estimates of the total cost of poorly controlled pain in today's dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President’s Council of Economic Advisors, 2009), the cost of health care due to pain is estimated to be between $261 to $300 billion. The value of lost productivity based on estimates of days of work missed is $11.6 to 12.7 billion, hours of work lost is $95.2 to $96.5 billion and lower wages is $190.6 to $226.3 billion. Total financial cost of pain to society, combining healthcare cost estimates and productivity estimates, ranges from $560 to $635 billion in 2010 dollars (Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research, Appendix C, 2011).

“Medical care, specifically specialty care, rather than primary care, chiropractic care, or physical therapy is responsible for the rising costs of ambulatory care for spine conditions” (Davis 2012).

Chronic pain is defined as persistent pain which can be either continuous or recurrent and of sufficient duration and intensity to adversely affect a patient’s well-being, level of function, and quality of life. If the patient has not been previously evaluated, attempt to differentiate between untreated acute pain and ongoing chronic pain. If a patient's pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the course of the chronic pain is warranted. (ICSI, 2011).
Chronic pain affects approximately 100 million adults in the USA. (Gaskin, 2012). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (The Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003, Chronic Pain Research Alliance 2011). Although women may have higher baseline pain, differences in pain levels may not persist at one month (Peterson, 2012).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g., acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007). Black race is associated with neighborhood socio-economic status (SES) and race plays a role in pain outcomes beyond SES (Green, 2012).

**CLINICAL RECOMMENDATION STATEMENTS:**

Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.

A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors, spiritual and cultural issues are also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2011) *Assessment and Management of Chronic Pain Guideline, Fifth Edition* was chosen because it addresses the key factors of the plan of care, pain assessment, and outcomes. In addition, it is based on a very broad foundation of evidence, and addresses a wide range of clinical conditions.

The Institute for Clinical Systems Improvement (ICSI, 2012) Adult acute and sub-acute low back pain guideline: Provides guidelines for more expedient evaluation, treatment, use of outcome measures and collaboration among healthcare professionals to allow patients to make informed decisions.

Low Back Pain: Clinical Guidelines Linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (Delitto, 2012). Provides evidence to classify musculoskeletal conditions, specify interventions and identify appropriate outcome measures.

“Early physical therapy following a new primary care consultation can decrease risk of subsequent healthcare” (Fritz, 2012) and does not increase healthcare costs or utilization (Fritz, 2013).
Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.

INSTRUCTIONS:
This measure is to be reported each visit during the 12 month reporting period. Eligible professionals meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. 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.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure’s denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits for patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92548, 92549, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97110, 97140, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:
Eligible professional attests to documenting, updating or reviewing a patient’s current medications using all immediate resources available on the date of encounter. This list must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosages, frequency and route of administration.
Definitions:
Current Medications - Medications the patient is presently taking including all prescriptions, over-the-counters, herbas and vitamin/mineral/dietary (nutritional) supplements with each medication’s name, dosage, frequency and administered route.
Route - Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)
Not Eligible - A patient is not eligible if the following reason is documented:
  • Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status

NUMERATOR NOTE: The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Current Medications Documented
G8427: Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient’s current medications

OR

Current Medications not Documented, Patient not Eligible
G8430: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional

OR

Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given
G8428: Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given

RATIONALE:
In the American Medical Association’s (AMA) Physician’s Role in Medication Reconciliation (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to The Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs of $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million VADEs in 2001 might have been prevented with improved systems of care and better patient education,
yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

In the Institute for Safe Medication Practices, *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists (2007)*, the American Pharmaceutical Association identified that Americans spend more than $75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated $20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of $8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005 in the United States, 701,547 patients were treated for ADEs in emergency departments, and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs (AMA, 2007).

The Agency for Healthcare Quality’s (AHRQ) The National Healthcare Disparities Report (2008) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows: older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the all the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

**CLINICAL RECOMMENDATION STATEMENTS:**

The Joint Commission’s 2011 National Patient Safety Goals guides providers to maintain and communicate accurate patient medication information guiding elements of performance to obtain and/or update information on the medications the patient is currently taking. The National Quality Forum’s 2010 update of the *Safe Practices for Better Healthcare*, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA’s published report, *The Physician’s Role in Medication Reconciliation*, identified the best practice medication reconciliation team as one that is multidisciplinary and—in all settings of care—will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team’s variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as
possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.
Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a documented BMI during the current encounter or during the previous six months AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter.

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. The most recent quality code submitted will be used for performance calculation. 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 at the time of the qualifying visit and the measure-specific denominator coding. The BMI documented in the medical record may be reported if done in the provider’s office/facility or if a BMI is documented within the previous six months in outside medical records obtained by the provider. If the most recent documented BMI is outside of normal parameters, then a follow-up plan must be documented within six months of the abnormal BMI. The documented follow-up interventions must be related to the BMI outside of normal parameters, example: “Patient referred to nutrition counseling for BMI above normal parameters”.

Measure Reporting via Claims:
CPT codes or HCPCS codes, and patient demographics are used to identify patients who are included in the measure’s denominator. Quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes or HCPCS codes, and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged >18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447

NUMERATOR:
Patients with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, follow-up is documented during the encounter or during the previous six months of the encounter with the BMI outside of normal parameters

**Numerator Instructions:** An eligible professional or their staff is required to measure both height and weight. Both the height and the weight must be measured within the same six months. Self-reported values cannot be used. The documentation of a follow-up plan must be based on the most recent documented BMI within the previous six months

**Definitions:**

**BMI** – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared (W/H²) and is commonly used to classify weight categories. BMI can be calculated using:

- **Metric Units:** 
  \[ \text{BMI} = \frac{\text{Weight (kg)}}{(\text{Height (m)})^2} \]

- **English Units:** 
  \[ \text{BMI} = \frac{\text{Weight (lb)}}{(\text{Height (in)})^2} \times 703 \]

**Follow-Up Plan** – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up may include but is not limited to: documentation education, a referral (e.g., a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.

**Not Eligible for BMI Calculation or Follow-Up Plan** – A patient is not eligible if one or more of the following reasons are documented:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement (refuses height and/or weight)
- Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient’s health status

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

- **BMI Documented as Normal, No Follow-Up Plan Required**
  (One quality-data code [G8417, G8418 or G8420] is required on the claim form to submit this numerator option)
  
  G8420: BMI is documented within normal parameters and no follow-up plan is required

- **BMI Documented as Above Normal Parameters, AND Follow-Up Documented**
  G8417: BMI is documented above normal parameters and a follow-up plan is documented

- **BMI Documented as Below Normal Parameters, AND Follow-Up Documented**
  G8418: BMI is documented below normal parameters and a follow-up plan is documented

- **BMI not Documented, Patient not Eligible**
  (One quality-data code [G8422 or G8938] is required on the claim form to submit this numerator option)
  
  G8422: BMI not documented, documentation the patient is not eligible for BMI calculation

OR

**BMI Documented Outside of Normal Limits, Follow-up Plan not Documented, Patient not Eligible**
G8938: BMI is documented as being outside of normal limits, follow-up plan is not documented, documentation the patient is not eligible

OR

BMI not Documented, Reason not Given
(One quality-data code [G8419 or G8421] is required on the claim form to submit this numerator option)
G8421: BMI not documented and no reason is given
OR
BMI Documented Outside of Normal Parameters, Follow-Up Plan not Documented, Reason not Given
G8419: BMI documented outside normal parameters, no follow-up plan documented, no reason given

RATIONALE:
BMI Above Upper Parameters
Obesity continues to be a costly public health concern in the United States. The Centers for Disease Control and Prevention (CDC) reported that in 2009, no state met the Healthy People 2010 obesity target of 15 percent and the self reported overall prevalence of obesity among adults had increased 1.1 percentage points in 2007 to 26.7 percent (2010). Flegal, Carroll, Kit and Ogden (2012) reported the prevalence of BMI-defined obesity in adults is high and continues to exceed 30% in most sex-age groups. In addition to the continued high prevalence rate for adults in general, there has been a significant increase for men and for non-Hispanic black and Mexican American women over the 12-year period from 1999 through 2010 (2012). Moyer (2012) reported: Obesity is associated with such health problems as an increased risk for coronary artery disease, type 2 diabetes, various types of cancer, gallstones and disability. These comorbid medical conditions are associated with higher use of health care services and costs among obese patients (p. 373).

Obesity is also associated with an increased risk of death, particularly in adults younger than age 65 years and has been shown to reduce life expectancy by 6 to 20 years depending on age and race (LeBlanc et al., 2011).

Finklestein, Trogdon, Cohen and Dietz (2009) found that in 2006, across all payers, per capita medical spending for the obese is $1,429 higher per year, (42 percent) than for someone of normal weight. Using 2008 dollars, this was estimated to be equivalent to $147 billion dollars in medical care costs related to obesity.

In addition to a high prevalence rate of obesity, less than 50% of obese adults in 2010 received advice to exercise or perform physical activity (Barnes & Schoenborn, 2012).

BMI Below Normal Parameters
In the National Center for Health Statistics Health E-Stat, Fryer and Ogden reported that poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2010 National Health and Nutrition Examination Survey (NHANE), using measured heights and weights, indicate an estimated 1.7% of U.S. adults are underweight with women more likely to be underweight than men (2012).

Ranhoff, Gjoen and Mowe (2005) recommended using BMI < 23 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

CLINICAL RECOMMENDATION STATEMENTS:
Although multiple clinical recommendations addressing obesity have been developed by professional organizations, societies and associations, two recommendations have been identified which exemplify the intent of the measure and address the numerator and denominator.

The US Preventive Health Services Task Force (USPSTF) recommends screening all adults (aged 18 years and older) for obesity. Clinicians should offer or refer patients with a BMI of 30 or higher to intensive, multicomponent behavioral interventions. This is a B recommendation (Moyer, 2012)
As cited in Wilkinson et al. (2012), Institute for Clinical Systems Improvement (ICSI) Preventive Services for Adults, Obesity Screening (Level II) Recommendation provides the following guidance:

- Record height, weight and calculate body mass index at least annually
- A BMI greater or equal to 30 is defined as obese
- A BMI of 25-29 is defined as overweight
- Intensive intervention for obese individuals, based on BMI, is recommended by the U.S. Preventive Services to help control weight.
Measure #127 (NQF 0416): Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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 (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
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 Quality-Data Coding Options for Reporting Satisfactorily:
Footwear Evaluation Performed
G8410: Footwear evaluation performed and documented

OR

Footwear Evaluation not Performed for Documented Reasons
G8416: Clinician documented that patient was not an eligible candidate for footwear evaluation measure

OR

Footwear Evaluation not Performed
G8415: Footwear evaluation was not performed

RATIONALE:
Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Shoe trauma, in concert with loss of protective sensation and concomitant foot deformity, is the leading event precipitating foot ulceration in persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of non-diabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:
The multifactorial etiology of diabetic foot ulcers is evidenced by the numerous pathophysiologic pathways that can potentially lead to this disorder. Among these are two common mechanisms by which foot deformity and neuropathy may induce skin breakdown in persons with diabetes. The first mechanism of injury refers to prolonged low pressure over a bony prominence (i.e., bunion or hammertoe deformity). This generally causes wounds over the medial, lateral, and dorsal aspects of the forefoot and is associated with tight or ill-fitting shoes. The other common mechanism of ulceration involves prolonged repetitive moderate stress. (ACFAS/ACFAOM Clinical Practice Guidelines)
2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

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 be 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:

<table>
<thead>
<tr>
<th>Category</th>
<th>Risk Profile</th>
<th>Evaluation Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal</td>
<td>Annual</td>
</tr>
<tr>
<td>1</td>
<td>Peripheral Neuropathy (LOPS)</td>
<td>Semi-annual</td>
</tr>
<tr>
<td>2</td>
<td>Neuropathy, deformity, and/or PAD</td>
<td>Quarterly</td>
</tr>
<tr>
<td>3</td>
<td>Previous ulcer or amputation</td>
<td>Monthly to quarterly</td>
</tr>
</tbody>
</table>

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.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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 (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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
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, 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

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 Quality-Data Coding Options for Reporting Satisfactorily:
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

RATIONALE:
Foot ulceration is the most common single precursor to lower extremity amputations among persons with diabetes. Treatment of infected foot wounds accounts for up to one-quarter of all inpatient hospital admissions for people with diabetes in the United States. Peripheral sensory neuropathy in the absence of perceived trauma is the primary factor leading to diabetic foot ulcerations. Approximately 45-60% of all diabetic ulcerations are purely neuropathic. Other forms of neuropathy may also play a role in foot ulcerations. Motor neuropathy resulting in anterior crural muscle atrophy or intrinsic muscle wasting can lead to foot deformities such as foot drop, equinus, and hammertoes. In people with diabetes, 22.8% have foot problems – such as amputations and numbness – compared with 10% of nondiabetics. Over the age of 40 years old, 30% of people with diabetes have loss of sensation in their feet.

CLINICAL RECOMMENDATION STATEMENTS:
Recognizing important risk factors and making a logical, treatment-oriented assessment of the diabetic foot requires a consistent and thorough diagnostic approach using a common language. Without such a method, the practitioner is more likely to overlook vital information and to pay inordinate attention to less critical points in the evaluation. A
useful examination will involve identification of key risk factors and assignment into appropriate risk category. Only then can an effective treatment plan be designed and implemented. (ACFAS/ACFAOM Clinical Practice Guidelines)
Measure #117 (NQF 0055): Diabetes: Eye Exam

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period

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 clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics 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.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period

**Denominator Criteria (Eligible Cases):**
Patients 18 through 75 years of age on date of encounter

AND


AND

Patient encounter during the reporting period (CPT or HCPCS): 92002, 92004, 92012, 92014, 92019, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439

NUMERATOR:
Patients who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement period. For retinal or dilated eye exams performed 12 months prior to the measurement period, an automated result must be available.

Definition:
Automated Result – Electronic system-based data that includes results generated from test or procedures. For administrative data collection automated/electronic results are necessary in order to show that the exam during the 12 months prior was negative for retinopathy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Retinal or Dilated Eye Exam Performed by an Eye Care Professional
CPT II 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
OR
CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
OR
CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
OR
CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)*
*Note: This code can only be used if the claim/encounter was during the measurement period because it indicates that the patient had “no evidence of retinopathy in the prior year”. This code definition indicates results were negative; therefore an automated result is not required.

OR
Retinal or Dilated Eye Exam not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2022F or 2024F or 2026F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
CPT II 2022F or 2024F or 2026F with 8P: Dilated eye exam was not performed, reason not otherwise specified

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including glaucoma and blindness. Diabetic retinopathy is the most common...
diabetic eye disease and causes 21,000–24,000 new cases of blindness annually. The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilated and comprehensive eye exam soon after diagnosis. Guidelines also recommend consultation with an ophthalmologist for treatment options if a patient has any level of macular edema or diabetic retinopathy (proliferative and nonproliferative). (American Diabetes Association 2009)

**CLINICAL RECOMMENDATION STATEMENTS:**
American Diabetes Association (ADA) (2009):
- Adults and children aged 10 years or older with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 5 years after the onset of diabetes. (B recommendation)
- Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after the diagnosis of diabetes. (B recommendation)
- Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist. Less frequent exams (every 2–3 years) may be considered following one or more normal eye exams. Examinations will be required more frequently if retinopathy is progressing. (B recommendation)
- Women with preexisting diabetes who are planning pregnancy or who have become pregnant should have a comprehensive eye examination and be counseled on the risk of development and/or progression of diabetic retinopathy. (B recommendation)
- Eye examination should occur in the first trimester with close follow-up throughout pregnancy and for 1 year postpartum. (B recommendation)
- Promptly refer patients with any level of macular edema, severe nonproliferative diabetic retinopathy (NPDR), or any proliferative diabetic retinopathy (PDR) to an ophthalmologist who is knowledgeable and experienced in the management and treatment of diabetic retinopathy. (A recommendation)
- Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A recommendation)
- The presence of retinopathy is not a contraindication to aspirin therapy for cardioprotection, as this therapy does not increase the risk of retinal hemorrhage. (A recommendation)

American Geriatric Society (AGS) (Brown et al. 2003): The older adult who has new-onset DM should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training. (Level I, Grade B)
Measure #111 (NQF 0043): Pneumonia Vaccination Status for Older Adults

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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

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. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics 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.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients 65 years of age and older with a visit during the measurement period

DENOMINATOR NOTE: Pneumococcal vaccination is expected once ever for patients 65 years of age or older.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 65 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99356, 99357, G0402

NUMERATOR:
Patients who have ever received a pneumococcal vaccination

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pneumococcal Vaccination Administered or Previously Received
CPT II 4040F: Pneumococcal vaccine administered or previously received

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

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

RATIONALE:
Pneumonia is a common cause of illness and death in the elderly and persons with certain underlying conditions such as heart failure, diabetes, cystic fibrosis, asthma, sickle cell anemia, or chronic obstructive pulmonary disease (NHLBI, 2011). In 1998, an estimated 3,400 adults aged > 65 years died as a result of invasive pneumococcal disease (IPD) (CDC, 2003).

Among the 91.5 million US adults aged > 50 years, 29,500 cases of IPD, 502,600 cases of nonbacteremic pneumococcal pneumonia and 25,400 pneumococcal-related deaths are estimated to occur yearly; annual direct and indirect costs are estimated to total $3.7 billion and $1.8 billion, respectively. Pneumococcal disease remains a substantial burden among older US adults, despite increased coverage with 23-valent pneumococcal polysaccharide vaccine, (PPV23) and indirect benefits afforded by PCV7 vaccination of young children (Weycker, et al., 2011).

Vaccination has been found to be effective against bacteremic cases (OR: 0.34; 95% CI: 0.27–0.66) as well as nonbacteremic cases (OR: 0.58; 95% CI: 0.39–0.86). Vaccine effectiveness was highest against bacteremic infections caused by vaccine types (OR: 0.24; 95% CI: 0.09–0.66) (Vila-Corcoles, et al., 2009).

CLINICAL RECOMMENDATION STATEMENTS:
The Advisory Committee on Immunization Practices’ (ACIP) Updated Recommendations for Prevention of Invasive Pneumococcal Disease Among Adults Using the 23-Valent Pneumococcal Polysaccharide Vaccine recommends pneumococcal vaccine for all immunocompetent individuals who are 65 and older or otherwise at increased risk for pneumococcal disease. Routine revaccination is not recommended, but a second dose is appropriate for those who received PPV23 before age 65 years for any indication if at least 5 years have passed since their previous dose (USPSTF, 1989; ACIP, 2010).

The major updates for the 2010 update are: 1) the indications for which PPSV23 vaccination is recommended now include smoking and asthma, and 2) routine use of PPSV23 is no longer recommended for Alaska Natives or American Indians aged <65 years unless they have medical or other indications for PPV23.
Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes seen during the reporting period. The performance period for this measure is 12 months from date of encounter. The most recent quality-data code submitted will be used for performance calculation. 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.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics 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.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes or HCPCS codes and patient demographics are used to identify patients who are included in the measure’s denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
Patients 18 - 75 years of age with diabetes with a visit during the measurement period

Denominator Criteria (Eligible Cases):
Patients 18 through 75 years of age on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 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

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0270, G0271, G0402, G0438, G0439

NUMERATOR:
Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

Numerator Instructions:
A lower calculated performance rate for this measure indicates better clinical care or control. Patient is numerator compliant if most recent HbA1c level >9% or is missing a result or if an HbA1c test was not done during the measurement year.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Most Recent Hemoglobin A1c Level > 9.0%
CPT II 3046F: Most recent hemoglobin A1c level > 9.0%
OR
Hemoglobin A1c not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 3046F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3046F with 8P: Hemoglobin A1c level was not performed during the performance period (12 months)
OR
Most Recent Hemoglobin A1c Level ≤ 9.0%
CPT II 3044F: Most recent hemoglobin A1c (HbA1c) level < 7.0%
OR
CPT II 3045F: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

RATIONALE:
Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage (American Diabetes Association 2009).

Randomized clinical trials have demonstrated that improved glycemic control, as evidenced by reduced levels of glycohemoglobin, correlates with a reduction in the development of microvascular complications in both Type 1 and Type 2 diabetes (Diabetes Control and Complications Trial Research Group 1993; Ohkubo 1995). In particular, the Diabetes Control and Complications Trial (DCCT) showed that for patients with Type 1 diabetes mellitus, important clinical outcomes such as retinopathy (an important precursor to blindness), nephropathy (which precedes renal failure), and neuropathy (a significant cause of foot ulcers and amputation in patients with diabetes) are directly related to level of glycemic control (Diabetes Control and Complications Trial Research Group 1993). Similar reductions in complications were noted in a smaller study of intensive therapy of patients with Type 2 diabetes by Ohkubo and co-workers, which was conducted in the Japanese population (Ohkubo et al. 1995).
CLINICAL RECOMMENDATION STATEMENTS:
American Geriatrics Society (Brown et al. 2003):

For frail older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive
glycemic control appear to outweigh the benefits, a less stringent target such as 8% is appropriate. (Quality of
Evidence: Level III; Strength of Evidence: Grade B)

American Diabetes Association (2009):

Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of
type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for non-pregnant adults
in general is <7%. (Level of Evidence: A)

In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not
shown a significant reduction in CVD outcomes during the randomized portion of the trials. Long-term follow-up of
the Diabetes Control and Complications Trial (DCCT) and UK Prospective Diabetes Study (UKPDS) cohorts
suggests that treatment to A1C targets below or around 7% in the years soon after the diagnosis of diabetes is
associated with long-term reduction in risk of macrovascular disease. Until more evidence becomes available, the
general goal of <7% appears reasonable for many adults for macrovascular risk reduction. (Level of Evidence: B)

Subgroup analyses of clinical trials such as the DCCT and UKPDS and the microvascular evidence from the Action in
Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation (ADVANCE) trial suggest a small
but incremental benefit in microvascular outcomes with A1C values closer to normal. Therefore, for selected
individual patients, providers might reasonably suggest even lower A1C goals than the general goal of <7%, if this
can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include
those with short duration of diabetes, long life expectancy, and no significant CVD. (Level of Evidence: B)

Conversely, less stringent A1C goals than the general goal of <7% may be appropriate for patients with a history of
severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and
extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to attain
despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple
glucose lowering agents including insulin. (Level of Evidence: C)