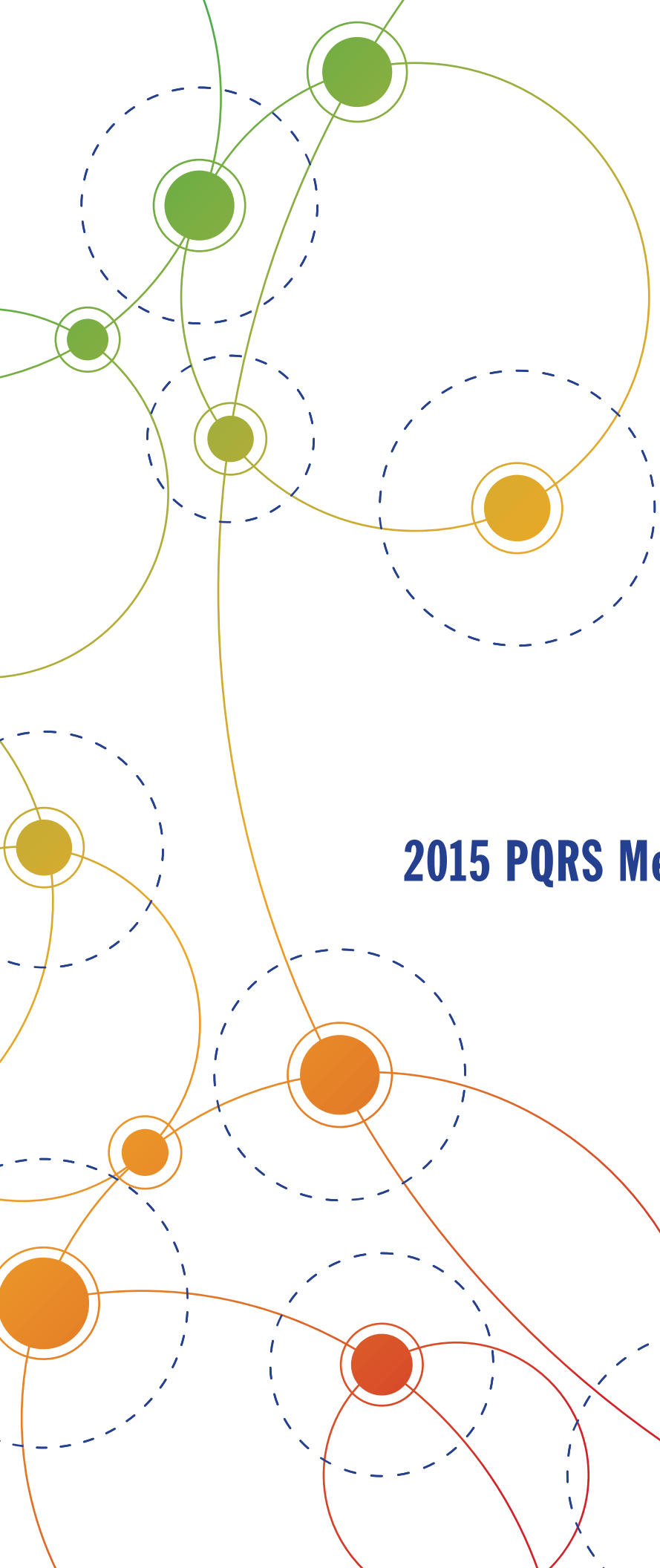

aaPM&R

American Academy of
Physical Medicine and Rehabilitation

# 2015 PQRS Measures for Physiatry

## ACKNOWLEDGMENTS

The Academy gratefully acknowledges the Evidence-Based Practice's Performance Metrics Committee for their extensive review of the measures in the 2015 PQRS program and identifying the measures which may have applicability to PM&R.

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# 2015 PQRS OVERVIEW

## Am I Eligible to Participate?

- If you are providing covered professional services paid under or based on the MPFS you are considered an eligible professional under PQRS.
- If you are a Medicare-enrolled provider, there are no exemptions from PQRS participation.

## Why Participate in PQRS:

- Physicians who successfully participate in PQRS will avoid a penalty in 2017
- Physicians who choose not to participate in 2015 will be subject to a - 2% penalty on all their 2017 Medicare Part B, Medicare as a Secondary Payer, and Railroad Medicare allowables, less durable medical equipment and any injectable drug
- Non-PQRS reporters will also experience an additional - 4% penalty under the value-based payment modifier program

## PQRS changes in 2015:

- The Value-Based Modifier now applies to all PQRS Eligible Medicare Physicians
- The Low Back Pain Measures Group was removed
- Remove Claims-Based only reporting option for all new measures
- Remove Claims-Based reporting option for Measures Groups
- Deadline for Group Practice Registration modified to June 30 of the year in which the reporting period occurs: June 30, 2015
- Group Practices are required to report on at least 2 cross-cutting measures (if they see at least 1 Medicare patient in a face to face encounter)

## 2015 REPORTING REQUIREMENTS & DEADLINES

### Reporting Individual Measures:

EPs and group practices must report 9 measures covering at least 3 NQS Domains for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period.

**National Quality Strategy (NQS) Domains**

- Patient safety
- Communication and care coordination
- Efficiency
- Clinical process and effectiveness
- Population health
- Patient and family experience

### Reporting Measures Groups:

- Individual EPs must report at least 1 measures group on a 20-patient sample, a majority of which (at least 11 out of 20) must be Medicare Part B FFS patients

### Reporting Period:

January 1, 2015 – December 31, 2015

### Reporting Deadlines:

**Claims-Based Reporting:** Claims processed by the MAC must reach the national Medicare claims system data warehouse by February 26, 2016 to be included in analysis. For specific instructions on how to bill appropriately, contact your MAC.

**Registry-Based Reporting:** Registry vendors will provide specific instructions on how and when to submit data. The 2015 PQRS data submission window will be in the first quarter of 2016.

**EHR-Based Reporting:** EPs and group practices must submit final electronic reporting files with quality measure data, or ensure that their EHR DSV submits files by the data submission

# PQRS MEASURES FOR PHYSIATRY

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### Individual Measures



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# PQRS MEASURES FOR PHYSIATRY

## Individual Measures

| MEASURE # | MEASURE TITLE |
|---|---|
| 155 | Falls: Plan of Care |
| 163 | Diabetes: Foot Exam |
| 173 | Preventive Care and Screening: Unhealthy Alcohol Use – Screening |
| 178 | Rheumatoid Arthritis (RA): Functional Status Assessment |
| 181 | Elder Maltreatment Screen and Follow-Up Plan |
| 182 | Functional Outcome Assessment |
| 238 | Use of High-Risk Medications in the Elderly |
| 243 | Cardiac Rehabilitation Patient Referral from an Outpatient Setting |
| 317 | Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented |
| 321 | CAHPS for PQRS Clinician/Group Survey |
| 325 | Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions |
| 386 | Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences |
| 402 | Tobacco Use and Help with Quitting Among Adolescents |

## Measures Groups

| MEASURE # | MEASURE TITLE |
|---|---|
| 280-288 | Dementia Measures Group |
| 289-294 | Parkinson's Measures Group |

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# PQRS MEASURES FOR PHYSIATRY

## Electronic Clinical Quality Measures

Successful submission of CQM data will meet PQRS reporting requirements and the CQM component of the Medicare EHR Incentive Program.

| EID# | PQRS | MEASURE TITLE |
|---|---|---|
| 128 | 9 | Anti-Depressant Medication Management |
| 161 | 107 | Adult Major Depressive Disorder (MDD): Suicide Risk Assessment |
| 147 | 110 | Preventive Care and Screening: Influenza Immunization |
| 127 | 111 | Pneumonia Vaccination Status for Older Adults |
| 69 | 128 | Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan |
| 68 | 130 | Documentation of Current Medications in the Medical Record |
| 2 | 134 | Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan |
| 123 | 163 | Diabetes: Foot Exam |
| 1 | 238 | Use of High-Risk Medications in the Elderly |
| 155 | 239 | Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents |
| 117 | 240 | Childhood Immunization Status |
| 166 | 312 | Use of Imaging Studies for Low Back Pain |
| 22 | 317 | Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented |
| 139 | 318 | Falls: Screening for Fall Risk |
| 136 | 366 | ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication |
| 159 | 370 | Depression Remission at Twelve Months |
| 160 | 371 | Depression Utilization of the PHQ-9 Tool |
| 50 | 374 | Closing the Referral Loop: Receipt of Specialist Report |
| 66 | 375 | Functional Status Assessment for Knee Replacement |
| 56 | 376 | Functional Status Assessment for Hip Replacement |
| 90 | 377 | Functional Status Assessment for Complex Chronic Conditions |
| 177 | 382 | Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment |

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# PQRS MEASURE 9 EMEASURE ID #128

## Anti-Depressant Medication Management

### ELIGIBLE PATIENT POPULATION

Patients 18 years of age and older with a diagnosis of major depression in the 270 days (9 months) prior to the measurement period or the first 90 days (3 months) of the measurement period, who were treated with antidepressant medication, and with a visit during the measurement period

### EXCLUSIONS

Patients who were actively on an antidepressant medication in the 90 days prior to the Index Prescription Start Date

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who have received antidepressant medication

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHODS(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification. **Must download a zip file to access specifications*

## Additional Resources:

- **AAPM&R PQRS Resources**

## CMS Resources:

- **PQRS EHR-based Reporting Option Website**
- **2015 EHR-Based Reporting Made Simple**
- **Medicare EHR Incentive Program Website**
- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 24

## OSTEOPOROSIS: Communication with the Physician Managing On-Going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older

It is anticipated that **clinicians who treat the hip, spine, or distal radial fracture** will submit this measure.

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 50 years on the date of encounter treated for hip, spine, or distal radial fracture with the appropriate diagnosis code (see measure specification).

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

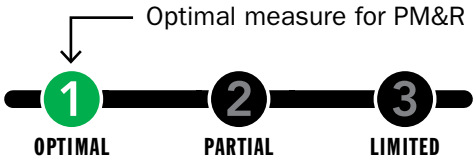
Patients with documentation of communication with the physician managing the patient's on-going care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, *99238, *99239

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Communication and Care Coordination

### TYPE OF MEASURE

Individual Measure

### REPORTING METHODS(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #24 (NQF 0045): Osteoporosis: Communication with the Physician Managing On-going Care Post-Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older – National Quality Strategy Domain: Communication and Care Coordination

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

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

**INSTRUCTIONS:**
This measure is to be reported after **each occurrence** of a fracture during the reporting period. It is anticipated that **clinicians who treat the hip, spine, or distal radial fracture** will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM/ICD-10-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM/ICD-10-CM diagnosis code for fracture or osteoporosis and a CPT procedure code for surgical treatment of a fracture.

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

**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 modifiers allowed for this measure are: 1P- medical reasons, 2P- patient 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:**
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:**
All patients aged 50 years and older treated for hip, spine, or distal radial fracture. Eligible cases are determined, and must be reported, if either of the following conditions are met:

**Option 1 - Denominator Criteria (Eligible Cases):**
Patients aged ≥ 50 years on date of encounter

**AND**

**Diagnosis for hip, spine or distal radial fracture (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 808.0, 808.1, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

**Diagnosis for hip, spine or distal radial fracture (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B,

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**AND**

**Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, G0402

**OR**

**Option 2 - Denominator Criteria (Eligible Cases):**

Patients aged ≥ 50 years on the date of encounter

**AND**

**Diagnosis for hip, spine or distal radial fracture (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 808.0, 808.1, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52,

813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

**Diagnosis for hip, spine or distal radial fracture (ICD-10-CM) [for use 10/01/2015-12/31/2015]:**
M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A, S32.452B, S32.453A, S32.453B, S32.454A, S32.454B, S32.455A, S32.455B, S32.456A, S32.456B, S32.461A, S32.461B, S32.462A, S32.462B, S32.463A, S32.463B, S32.464A, S32.464B, S32.465A, S32.465B, S32.466A, S32.466B, S32.471A, S32.471B, S32.472A, S32.472B, S32.473A, S32.473B, S32.474A, S32.474B, S32.475A, S32.475B, S32.476A, S32.476B, S32.481A, S32.481B, S32.482A,

S32.482B, S32.483A, S32.483B, S32.484A, S32.484B, S32.485A, S32.485B, S32.486A, S32.486B, S32.491A, S32.491B, S32.492A, S32.492B, S32.499A, S32.499B, S52.501A, S52.501B, S52.501C, S52.502A, S52.502B, S52.502C, S52.509A, S52.509B, S52.509C, S52.511A, S52.511B, S52.511C, S52.512A, S52.512B, S52.512C, S52.513A, S52.513B, S52.513C, S52.514A, S52.514B, S52.514C, S52.515A, S52.515B, S52.515C, S52.516A, S52.516B, S52.516C, S52.521A, S52.522A, S52.529A, S52.531A, S52.531B, S52.531C, S52.532A, S52.532B, S52.532C, S52.539A, S52.539B, S52.539C, S52.541A, S52.541B, S52.541C, S52.542A, S52.542B, S52.542C, S52.549A, S52.549B, S52.549C, S52.551A, S52.551B, S52.551C, S52.552A, S52.552B, S52.552C, S52.559A, S52.559B, S52.559C, S52.561A, S52.561B, S52.561C, S52.562A, S52.562B, S52.562C, S52.569A, S52.569B, S52.569C, S52.571A, S52.571B, S52.571C, S52.572A, S52.572B, S52.572C, S52.579A, S52.579B, S52.579C, S52.591A, S52.591B, S52.591C, S52.592A, S52.592B, S52.592C, S52.599A, S52.599B, S52.599C, S52.609A, S52.609B, S52.609C, S52.621A, S52.622A, S52.90XA, S52.90XB, S52.90XC, S72.001A, S72.001B, S72.001C, S72.002A, S72.002B, S72.002C, S72.009A, S72.009B, S72.009C, S72.011A, S72.011B, S72.011C, S72.012A, S72.012B, S72.012C, S72.019A, S72.019B, S72.019C, S72.021A, S72.021B, S72.021C, S72.022A, S72.022B, S72.022C, S72.023A, S72.023B, S72.023C, S72.024A, S72.024B, S72.024C, S72.025A, S72.025B, S72.025C, S72.026A, S72.026B, S72.026C, S72.031A, S72.031B, S72.031C, S72.032A, S72.032B, S72.032C, S72.033A, S72.033B, S72.033C, S72.034A, S72.034B, S72.034C, S72.035A, S72.035B, S72.035C, S72.036A, S72.036B, S72.036C, S72.041A, S72.041B, S72.041C, S72.042A, S72.042B, S72.042C, S72.043A, S72.043B, S72.043C, S72.044A, S72.044B, S72.044C, S72.045A, S72.045B, S72.045C, S72.046A, S72.046B, S72.046C, S72.051A, S72.051B, S72.051C, S72.052A, S72.052B, S72.052C, S72.059A, S72.059B, S72.059C, S72.061A, S72.061B, S72.061C, S72.062A, S72.062B, S72.062C, S72.063A, S72.063B, S72.063C, S72.064A, S72.064B, S72.064C, S72.065A, S72.065B, S72.065C, S72.066A, S72.066B, S72.066C, S72.091A, S72.091B, S72.091C, S72.092A, S72.092B, S72.092C, S72.099A, S72.099B, S72.099C, S72.101A, S72.101B, S72.101C, S72.102A, S72.102B, S72.102C, S72.109A, S72.109B, S72.109C, S72.111A, S72.111B, S72.111C, S72.112A, S72.112B, S72.112C, S72.113A, S72.113B, S72.113C, S72.114A, S72.114B, S72.114C, S72.115A, S72.115B, S72.115C, S72.116A, S72.116B, S72.116C, S72.121A, S72.121B, S72.121C, S72.122A, S72.122B, S72.122C, S72.123A, S72.123B, S72.123C, S72.124A, S72.124B, S72.124C, S72.125A, S72.125B, S72.125C, S72.126A, S72.126B, S72.126C, S72.131A, S72.131B, S72.131C, S72.132A, S72.132B, S72.132C, S72.133A, S72.133B, S72.133C, S72.134A, S72.134B, S72.134C, S72.135A, S72.135B, S72.135C, S72.136A, S72.136B, S72.136C, S72.141A, S72.141B, S72.141C, S72.142A, S72.142B, S72.142C, S72.143A, S72.143B, S72.143C, S72.144A, S72.144B, S72.144C, S72.145A, S72.145B, S72.145C, S72.146A, S72.146B, S72.146C, S72.21XA, S72.21XB, S72.21XC, S72.22XA, S72.22XB, S72.22XC, S72.23XA, S72.23XB, S72.23XC, S72.24XA, S72.24XB, S72.24XC, S72.25XA, S72.25XB, S72.25XC, S72.26XA, S72.26XB, S72.26XC

**AND**

**Patient encounter during the reporting period (CPT Codes):** 22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 25600, 25605, 25606, 25607, 25608, 25609, 27230, 27232, 27235, 27236, 27238, 27240, 27244, 27245, 27246, 27248

**NUMERATOR:**

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

**Definition:**

**Communication** – May include documentation in the medical record indicating that the clinician treating the fracture communicated (eg, verbally, by letter, DXA report was sent) with the clinician managing the patient's on-going care OR a copy of a letter in the medical record outlining whether the patient was or should be treated for osteoporosis.

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

**Post Fracture Care Communication Documented**

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

**OR**

**Post Fracture Care not Communicated for Medical or Patient Reasons**
Append a modifier (**1P or 2P**) to CPT Category II code **5015F** to report documented circumstances that appropriately exclude patients from the denominator.

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

***Patient Performance Exclusion:* 5015F *with* 2P:** Documentation of patient reason(s) for not communicating with the physician managing on-going care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

**OR**

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

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

**RATIONALE:**
Patients who experience fragility fractures should either be treated or screened for the presence of osteoporosis. Although the fracture may be treated by the orthopedic surgeon, the testing and/or treatment is likely to be under the responsibility of the physician providing on-going care. It is important the physician providing on-going care for the patient be made aware the patient has sustained a non-traumatic fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

**CLINICAL RECOMMENDATION STATEMENTS:**
The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (AACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH) Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AGA)

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# PQRS MEASURE 32

## Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy

It is anticipated that **clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting** will submit this measure.

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter with a diagnosis of ischemic stroke or transient ischemic attack (TIA).

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

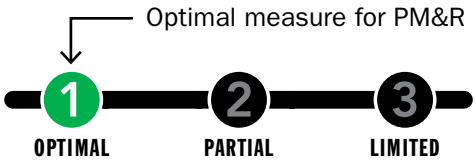
Patients who were prescribed antithrombotic therapy at discharge.

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

*99221, *99222, *99223, *99231, *99232, *99233, *99234, *99235, *99236, *99238, *99239

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #32 (NQF 0325): Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy – National Quality Strategy Domain: Effective Clinical Care

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed antithrombotic therapy at discharge

**INSTRUCTIONS:**
This measure is to be reported for patients under active treatment for ischemic stroke or TIA **at discharge from a hospital** during the reporting period. Part B claims data will be analyzed to determine the hospital discharge. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted. It is anticipated that **clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting** will submit this measure.

**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. Quality-data codes are used to report the numerator of the measure.

When reporting the measures via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and appropriate numerator 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 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 ischemic stroke or transient ischemic attack (TIA)

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 18 years on date of encounter
**AND**
**Diagnosis for ischemic stroke or transient ischemic attack (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9
**Diagnosis for ischemic stroke or transient ischemic attack (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** G45.0, G45.1, G45.2, G45.8, G45.9, G46.0, G46.1, G46.2, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
**AND**

**Patient encounter during the reporting period (CPT):** 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239

**NUMERATOR:**
Patients who were prescribed antithrombotic therapy at discharge

**Numerator Instructions:** If the consulting physician orders or agrees with a prior antithrombotic therapy order (from current or previous episodes of care during the reporting period) and there is supporting documentation, report **G8696**.

**Definitions:**
**Antithrombotic Therapy** – Aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine, warfarin, low molecular weight heparin, dabigatran, rivaroxaban.*
**The above list of medications/drug names is based on clinical guidelines and other evidence. The specified drugs were selected based on the strength of evidence for their clinical effectiveness. This list of selected drugs may not be all-inclusive or current. Physicians and other health care professionals should refer to the FDA's web site page entitled "Drug Safety Communications" for up-to-date drug recall and alert information when prescribing medications.*
**Prescribed** – May include prescription given to the patient for antithrombotic therapy at discharge or antithrombotic therapy to be continued after discharge as documented in the discharge medication list.

***NUMERATOR NOTE:*** *In order to meet the measure, antithrombotic therapy is to be prescribed at the time of discharge. If a physician other than the discharging physician (eg, consulting physician) is reporting on this measure, it should be clear from the documentation that the prescription is being ordered for the patient at the time of discharge, and included in the "medications prescribed at discharge".*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Antithrombotic Therapy Prescribed**
***Performance Met:*** **G8696:** Antithrombotic therapy prescribed at discharge

**OR**

**Antithrombotic Therapy not Prescribed for Documented Reasons**
***Other Performance Exclusion:*** **G8697:** Antithrombotic therapy not prescribed for documented reasons (eg, patient admitted for performance of elective carotid intervention, patient had stroke during hospital stay, patient expired during inpatient stay, other medical reason(s)); (eg, patient left against medical advice, other patient reason(s))

**OR**

**Antithrombotic Therapy Prescription not Prescribed, Reason not Given**
***Performance Not Met:*** **G8698:** Antithrombotic therapy was **not** prescribed at discharge, reason not given

**RATIONALE:**
The focus on stroke as an outcome is important because patients who experience a stroke or TIA are most likely to have a stroke as their next serious vascular outcome. Platelet anti-aggregation drugs prevent strokes. The selection of individual drugs is primarily based on interpretation of their relative efficacy, safety, and cost. Therefore, following a stroke, patients should be prescribed antithrombotic therapy to decrease the risk of additional strokes.

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

For patients with ischemic stroke or TIA with paroxysmal (intermittent) or permanent AF, anticoagulation with a vitamin K antagonist (target INR 2.5; range, 2.0 to 3.0) is recommended. (ASA, 2011)

Patients with ischemic stroke or TIA in the setting of acute MI complicated by LV mural thrombus formation identified by echocardiography or another cardiac imaging technique should be treated with oral anticoagulation (target INR 2.5; range 2.0 to 3.0) for at least 3 months. (ASA, 2011)

Warfarin (INR 2.0 to 3.0), aspirin (81 mg daily), clopidogrel (75 mg daily), or the combination of aspirin (25 mg twice daily) plus extended-release dipyramidamole (200 mg twice daily) may be considered to prevent recurrent ischemic events in patients with previous ischemic stroke or TIA and cardiomyopathy. (ASA, 2011)

For patients with ischemic stroke or TIA who have rheumatic mitral valve disease, whether or not AF is present, long-term warfarin therapy is reasonable with an INR target range of 2.5 (range, 2.0 to 3.0). (ASA, 2011)

For patients with ischemic stroke or TIA who have mechanical prosthetic heart valves, warfarin is recommended with an INR target of 3.0 (range, 2.5 to 3.5). (ASA, 2011)

For patients with non-cardioembolic ischemic stroke or TIA, the use of antiplatelet agents rather than oral anticoagulation is recommended to reduce the risk of recurrent stroke and other cardiovascular events. (ASA, 2011)

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# PQRS MEASURE 33

## Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge

It is anticipated that **clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting** will submit this measure.

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who were prescribed an anticoagulant at discharge.

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

*99221, *99222, *99223, *99231, *99232, *99233, *99238, *99239

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry Only

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #33 (NQF 0241): Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation (AF) at Discharge – National Quality Strategy Domain: Effective Clinical Care

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

**INSTRUCTIONS:**
This measure is to be reported for patients under active treatment for ischemic stroke or TIA with documented atrial fibrillation **at discharge from a hospital** during the reporting period. It is anticipated that **clinicians who care for patients with a diagnosis of ischemic stroke or TIA in the hospital setting** will submit this measure.

**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 ischemic stroke or transient ischemic attack (TIA) with documented permanent, persistent, or paroxysmal atrial fibrillation

**Definitions:**
**First Detected** – Only one diagnosed episode.
**Persistent Atrial Fibrillation** – Recurrent episodes that last more than 7 days.
**Paroxysmal Atrial Fibrillation** – Recurrent episodes that self terminate in less than 7 days.
**Permanent Atrial Fibrillation** – An ongoing long term episode.

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 18 years on date of encounter
**AND**
**Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9
**Diagnosis for ischemic stroke or transient ischemic attack (TIA) (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** G45.0, G45.1, G45.2, G45.8, G45.9, G46.0, G46.1, G46.2, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9
**AND**
**Diagnosis for atrial fibrillation (ICD-9-CM) [for use 1/1/2014-9/30/2014]:** 427.31
**Diagnosis for atrial fibrillation (ICD-10-CM) [for use 10/01/2014-12/31/2014]:** I48.0, I48.1, I48.2
**AND**

**Patient encounter during the reporting period (CPT):** 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239

**NUMERATOR:**
Patients who were prescribed an anticoagulant at discharge

**Definitions:**
**Anticoagulants** – warfarin, low molecular weight heparin, dabigatran, rivaroxaban*
**The above list of medications/drug names is based on clinical guidelines and other evidence. The specified drugs were selected based on the strength of evidence for their clinical effectiveness. This list of selected drugs may not be all-inclusive or current. Physicians and other health care professionals should refer to the FDA's web site page entitled "Drug Safety Communications" for up-to-date drug recall and alert information when prescribing medications.*
**Prescribed** – May include prescription given to the patient for anticoagulant therapy at discharge OR anticoagulant to be continued after discharge as documented in the discharge medication list.

***NUMERATOR NOTE:*** *In order to meet the measure, anticoagulant therapy is to be prescribed at the time of discharge. If a physician other than the discharging physician (eg, consulting physician) is reporting on this measure, it should be clear from the documentation that the prescription is being ordered for the patient at the time of discharge, and included in the "medications prescribed at discharge".*

**Numerator Options:**

| | |
|---|---|
| ***Performance Met:*** | Anticoagulant therapy prescribed at discharge **(4075F)** |
| **OR** | |
| ***Medical Performance Exclusion:*** | Anticoagulant therapy not prescribed at discharge for medical reason (eg, patient expired during inpatient stay, other medical reason(s)) **(4075F *with* 1P)** |
| **OR** | |
| ***Patient Performance Exclusion:*** | Anticoagulant therapy not prescribed at discharge for patient reason (eg, patient left against medical advice, other patient reason(s)) **(4075F *with* 2P)** |
| **OR** | |
| ***Performance Not Met:*** | Anticoagulant therapy **not** prescribed at discharge, reason not otherwise specified **(4075F *with* 8P)** |

**RATIONALE:**
In patients with nonvalvular AF, prior stroke or TIA is the strongest independent predictor of stroke, significantly associated with stroke in all 6 studies in which it was evaluated with incremental relative risk between 1.9 and 3.7 (averaging approximately 3.0). The pathogenic constructs of stroke in AF are incomplete, but available data indicate that all patients with prior stroke or TIA are at high risk of recurrent thromboembolism and require anticoagulation unless there are firm contraindications in a given patient. Patients with atrial fibrillation (permanent, persistent, or paroxysmal) and stroke should be prescribed an anticoagulant to prevent recurrent strokes.

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

Antithrombotic therapy to prevent thromboembolism is recommended for all patients with AF, except those with lone AF or contraindications. (Class I, Level of Evidence A) (ACC/AHA/ESC, 2006)

The selection of the antithrombotic agent should be based upon the absolute risks of stroke and bleeding and the relative risk and benefit for a given patient. (Class I, Level of Evidence A) (ACC/AHA/ESC, 2006)

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# PQRS MEASURE 39

## Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 65 years on date of encounter who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #39 (NQF 0046): Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older – National Quality Strategy Domain: Effective Clinical Care

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

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

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. Female patients aged 65 years and older should have a central DXA measurement ordered or performed at least once since the time they turned 60 years or have pharmacologic therapy prescribed to prevent or treat osteoporosis. There is no diagnosis associated with this measure. 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 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 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 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 female patients aged 65 years and older

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 65 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

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

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

**Prescribed** – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

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

**Central DXA Measurement Ordered or Performed or Pharmacologic Therapy Prescribed**

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

**OR**

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

***Other Performance Exclusion:*** **G8401:** Clinician documented that patient was not an eligible candidate for screening or therapy

**OR**

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

***Performance Not Met:*** **G8400:** Patient with central Dual-energy X-Ray Absorptiometry (DXA) results **not** documented or **not** ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed, reason not given

**RATIONALE:**

Patients with elevated risk for osteoporosis should have the diagnosis of osteoporosis excluded or be on treatment of osteoporosis.

**CLINICAL RECOMMENDATION STATEMENTS:**

The U.S. Preventive Services Task Force (USPSTF) recommends that women aged 65 and older be screened routinely for osteoporosis. (B Recommendation) (USPSTF)

The USPSTF recommends that routine screening begin at age 60 for women at increased risk for osteoporotic fractures. Use of risk factors, particularly increasing age, low weight, and non-use of estrogen replacement, to screen younger women may identify high-risk women. (B Recommendation) (USPSTF)

BMD measurement should be performed in all women beyond 65 years of age. Dual x-ray absorptiometry of the lumbar spine and proximal femur provides reproducible values at important sites of osteoporosis-associated fracture. These sites are preferred for baseline and serial measurements. (AACE)

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD testing should be performed on:

- All women aged 65 and older regardless of risk factors
- Younger postmenopausal women with one or more risk factors (other than being white, postmenopausal, and female)
- Postmenopausal women who present with fractures (NQF)

The decision to test for BMD should be based on an individual's risk profile. Testing is never indicated unless the results could influence a treatment decision. (NQF)

Markers of greater osteoporosis and fracture risk include older age, hypogonadism, corticosteroid therapy, and established cirrhosis. (Level B Evidence) (NQF)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (NQF)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below - 2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below - 1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NQF)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

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# PQRS MEASURE 40

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

It is anticipated that **clinicians who treat hip, spine or distal radial fractures** will submit this measure.

### ELIGIBLE PATIENT POPULATION

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

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

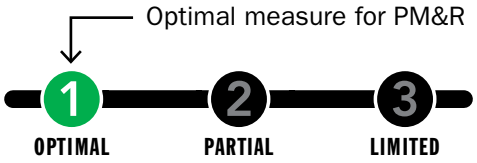
Patients who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, *99238, *99239

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #40 (NQF 0048): Osteoporosis: Management Following Fracture of Hip, Spine or Distal Radius for Men and Women Aged 50 Years and Older – National Quality Strategy Domain: Effective Clinical Care

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

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

**INSTRUCTIONS:**
This measure is to be reported after **each occurrence** of a fracture during the reporting period. It is anticipated that **clinicians who treat hip, spine or distal radial fractures** will submit this measure. Each occurrence of a fracture is identified by either an ICD-9-CM/ICD-10-CM diagnosis code for fracture or osteoporosis and a CPT service code OR an ICD-9-CM/ICD-10-CM diagnosis code for a fracture or osteoporosis and a CPT procedure code for surgical treatment of fractures.

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

**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 and/or 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 CPT Category II code **OR** quality-data code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system 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:**
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 50 years and older with a fracture of the hip, spine, or distal radius
Eligible cases are determined, and must be reported, if either of the following conditions are met:

**Option 1 - Denominator Criteria (Eligible Cases):**
Patients aged ≥ 50 years on date of encounter
**AND**

**Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.11, 805.12, 805.13, 805.14, 805.15, 805.16, 805.17, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

**Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB,S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A,

S32.452B, S32.453A, S32.453B, S32.454A, S32.454B, S32.455A, S32.455B, S32.456A, S32.456B, S32.461A, S32.461B, S32.462A, S32.462B, S32.463A, S32.463B, S32.464A, S32.464B, S32.465A, S32.465B, S32.466A, S32.466B, S32.471A, S32.471B, S32.472A, S32.472B, S32.473A, S32.473B, S32.474A, S32.474B, S32.475A, S32.475B, S32.476A, S32.476B, S32.481A, S32.481B, S32.482A, S32.482B, S32.483A, S32.483B, S32.484A, S32.484B, S32.485A, S32.485B, S32.486A, S32.486B, S32.491A, S32.491B, S32.492A, S32.492B, S32.499A, S32.499B, S52.501A, S52.501B, S52.501C, S52.502A, S52.502B, S52.502C, S52.509A, S52.509B, S52.509C, S52.511A, S52.511B, S52.511C, S52.512A, S52.512B, S52.512C, S52.513A, S52.513B, S52.513C, S52.514A, S52.514B, S52.514C, S52.515A, S52.515B, S52.515C, S52.516A, S52.516B, S52.516C, S52.521A, S52.522A, S52.529A, S52.531A, S52.531B, S52.531C, S52.532A, S52.532B, S52.532C, S52.539A, S52.539B, S52.539C, S52.541A, S52.541B, S52.541C, S52.542A, S52.542B, S52.542C, S52.549A, S52.549B, S52.549C, S52.551A, S52.551B, S52.551C, S52.552A, S52.552B, S52.552C, S52.559A, S52.559B, S52.559C, S52.561A, S52.561B, S52.561C, S52.562A, S52.562B, S52.562C, S52.569A, S52.569B, S52.569C, S52.571A, S52.571B, S52.571C, S52.572A, S52.572B, S52.572C, S52.579A, S52.579B, S52.579C, S52.591A, S52.591B, S52.591C, S52.592A, S52.592B, S52.592C, S52.599A, S52.599B, S52.599C, S52.609A, S52.609B, S52.609C, S52.621A, S52.622A, S52.90XA, S52.90XB, S52.90XC, S72.001A, S72.001B, S72.001C, S72.002A, S72.002B, S72.002C, S72.009A, S72.009B, S72.009C, S72.011A, S72.011B, S72.011C, S72.012A, S72.012B, S72.012C, S72.019A, S72.019B, S72.019C, S72.021A, S72.021B, S72.021C, S72.022A, S72.022B, S72.022C, S72.023A, S72.023B, S72.023C, S72.024A, S72.024B, S72.024C, S72.025A, S72.025B, S72.025C, S72.026A, S72.026B, S72.026C, S72.031A, S72.031B, S72.031C, S72.032A, S72.032B, S72.032C, S72.033A, S72.033B, S72.033C, S72.034A, S72.034B, S72.034C, S72.035A, S72.035B, S72.035C, S72.036A, S72.036B, S72.036C, S72.041A, S72.041B, S72.041C, S72.042A, S72.042B, S72.042C, S72.043A, S72.043B, S72.043C, S72.044A, S72.044B, S72.044C, S72.045A, S72.045B, S72.045C, S72.046A, S72.046B, S72.046C, S72.051A, S72.051B, S72.051C, S72.052A, S72.052B, S72.052C, S72.059A, S72.059B, S72.059C, S72.061A, S72.061B, S72.061C, S72.062A, S72.062B, S72.062C, S72.063A, S72.063B, S72.063C, S72.064A, S72.064B, S72.064C, S72.065A, S72.065B, S72.065C, S72.066A, S72.066B, S72.066C, S72.091A, S72.091B, S72.091C, S72.092A, S72.092B, S72.092C, S72.099A, S72.099B, S72.099C, S72.101A, S72.101B, S72.101C, S72.102A, S72.102B, S72.102C, S72.109A, S72.109B, S72.109C, S72.111A, S72.111B, S72.111C, S72.112A, S72.112B, S72.112C, S72.113A, S72.113B, S72.113C, S72.114A, S72.114B, S72.114C, S72.115A, S72.115B, S72.115C, S72.116A, S72.116B, S72.116C, S72.121A, S72.121B, S72.121C, S72.122A, S72.122B, S72.122C, S72.123A, S72.123B, S72.123C, S72.124A, S72.124B, S72.124C, S72.125A, S72.125B, S72.125C, S72.126A, S72.126B, S72.126C, S72.131A, S72.131B, S72.131C, S72.132A, S72.132B, S72.132C, S72.133A, S72.133B, S72.133C, S72.134A, S72.134B, S72.134C, S72.135A, S72.135B, S72.135C, S72.136A, S72.136B, S72.136C, S72.141A, S72.141B, S72.141C, S72.142A, S72.142B, S72.142C, S72.143A, S72.143B, S72.143C, S72.144A, S72.144B, S72.144C, S72.145A, S72.145B, S72.145C, S72.146A, S72.146B, S72.146C, S72.21XA, S72.21XB, S72.21XC, S72.22XA, S72.22XB, S72.22XC, S72.23XA, S72.23XB, S72.23XC, S72.24XA, S72.24XB, S72.24XC, S72.25XA, S72.25XB, S72.25XC, S72.26XA, S72.26XB, S72.26XC

**AND**

**Patient encounter during the reporting period (CPT or HCPCS) -** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, G0402

**OR**

**Option 2 - Denominator Criteria (Eligible Cases):**

Patients aged ≥ 50 years on date of encounter

**AND**

**Diagnosis for hip, spine, or distal radial fracture (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 733.12, 733.13, 733.14, 733.15, 733.19, 805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, 805.2, 805.3, 805.4, 805.5, 805.6, 805.7, 805.8, 813.40, 813.41, 813.42, 813.43, 813.44, 813.45, 813.46, 813.47, 813.50, 813.51, 813.52, 813.53, 813.54, 820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.12, 820.13, 820.19, 820.20, 820.21, 820.22, 820.30, 820.31, 820.32, 820.8, 820.9

**Diagnosis for hip, spine, or distal radial fracture (ICD-10-CM) [for use 10/01/2015-12/31/2015]:**
M84.431A, M84.432A, M84.433A, M84.434A, M84.439A, M84.451A, M84.452A, M84.453A, M84.454A, M84.459A, M84.48XA, S12.000A, S12.000B, S12.001A, S12.001B, S12.01XA, S12.01XB, S12.02XA, S12.02XB, S12.030A, S12.030B, S12.031A, S12.031B, S12.040A, S12.040B, S12.041A, S12.041B, S12.090A, S12.090B, S12.091A, S12.091B, S12.100A, S12.100B, S12.101A, S12.101B, S12.110A, S12.110B, S12.111A, S12.111B, S12.112A, S12.112B, S12.120A, S12.120B, S12.121A, S12.121B, S12.130A, S12.130B, S12.131A, S12.131B, S12.14XA, S12.14XB, S12.150A, S12.150B, S12.151A, S12.151B, S12.190A, S12.190B, S12.191A, S12.191B, S12.200A, S12.200B, S12.201A, S12.201B, S12.230A, S12.230B, S12.231A, S12.231B, S12.24XA, S12.24XB, S12.250A, S12.250B, S12.251A, S12.251B, S12.290A, S12.290B, S12.291A, S12.291B, S12.300A, S12.300B, S12.301A, S12.301B, S12.330A, S12.330B, S12.331A, S12.331B, S12.34XA, S12.34XB, S12.350A, S12.350B, S12.351A, S12.351B, S12.390A, S12.390B, S12.391A, S12.391B, S12.400A, S12.400B, S12.401A, S12.401B, S12.430A, S12.430B, S12.431A, S12.431B, S12.44XA, S12.44XB, S12.450A, S12.450B, S12.451A, S12.451B, S12.490A, S12.490B, S12.491A, S12.491B, S12.500A, S12.500B, S12.501A, S12.501B, S12.530A, S12.530B, S12.531A, S12.531B, S12.54XA, S12.54XB, S12.550A, S12.550B, S12.551A, S12.551B, S12.590A, S12.590B, S12.591A, S12.591B, S12.600A, S12.600B, S12.601A, S12.601B, S12.630A, S12.630B, S12.631A, S12.631B, S12.64XA, S12.64XB, S12.650A, S12.650B, S12.651A, S12.651B, S12.690A, S12.690B, S12.691A, S12.691B, S12.8XXA, S12.9XXA, S22.000A, S22.000B, S22.001A, S22.001B, S22.002A, S22.002B, S22.008A, S22.008B, S22.009A, S22.009B, S22.010A, S22.010B, S22.011A, S22.011B, S22.012A, S22.012B, S22.018A, S22.018B, S22.019A, S22.019B, S22.020A, S22.020B, S22.021A, S22.021B, S22.022A, S22.022B, S22.028A, S22.028B, S22.029A, S22.029B, S22.030A, S22.030B, S22.031A, S22.031B, S22.032A, S22.032B, S22.038A, S22.038B, S22.039A, S22.039B, S22.040A, S22.040B, S22.041A, S22.041B, S22.042A, S22.042B, S22.048A, S22.048B, S22.049A, S22.049B, S22.050A, S22.050B, S22.051A, S22.051B, S22.052A, S22.052B, S22.058A, S22.058B, S22.059A, S22.059B, S22.060A, S22.060B, S22.061A, S22.061B, S22.062A, S22.062B, S22.068A, S22.068B, S22.069A, S22.069B, S22.070A, S22.070B, S22.071A, S22.071B, S22.072A, S22.072B, S22.078A, S22.078B, S22.079A, S22.079B, S22.080A, S22.080B, S22.081A, S22.081B, S22.082A, S22.082B, S22.088A, S22.088B, S22.089A, S22.089B, S32.000A, S32.000B, S32.001A, S32.001B, S32.002A, S32.002B, S32.008A, S32.008B, S32.009A, S32.009B, S32.010A, S32.010B, S32.011A, S32.011B, S32.012A, S32.012B, S32.018A, S32.018B, S32.019A, S32.019B, S32.020A, S32.020B, S32.021A, S32.021B, S32.022A, S32.022B, S32.028A, S32.028B, S32.029A, S32.029B, S32.030A, S32.030B, S32.031A, S32.031B, S32.032A, S32.032B, S32.038A, S32.038B, S32.039A, S32.039B, S32.040A, S32.040B, S32.041A, S32.041B, S32.042A, S32.042B, S32.048A, S32.048B, S32.049A, S32.049B, S32.050A, S32.050B, S32.051A, S32.051B, S32.052A, S32.052B, S32.058A, S32.058B, S32.059A, S32.059B, S32.10XA, S32.10XB, S32.110A, S32.110B, S32.111A, S32.111B, S32.112A, S32.112B, S32.119A, S32.119B, S32.120A, S32.120B, S32.121A, S32.121B, S32.122A, S32.122B, S32.129A, S32.129B, S32.130A, S32.130B, S32.131A, S32.131B, S32.132A, S32.132B, S32.139A, S32.139B, S32.14XA, S32.14XB, S32.15XA, S32.15XB, S32.16XA, S32.16XB, S32.17XA, S32.17XB, S32.19XA, S32.19XB, S32.2XXA, S32.2XXB, S32.401A, S32.401B, S32.402A, S32.402B, S32.409A, S32.409B, S32.411A, S32.411B, S32.412A, S32.412B, S32.413A, S32.413B, S32.414A, S32.414B, S32.415A, S32.415B, S32.416A, S32.416B, S32.421A, S32.421B, S32.422A, S32.422B, S32.423A, S32.423B, S32.424A, S32.424B, S32.425A, S32.425B, S32.426A, S32.426B, S32.431A, S32.431B, S32.432A, S32.432B, S32.433A, S32.433B, S32.434A, S32.434B, S32.435A, S32.435B, S32.436A, S32.436B, S32.441A, S32.441B, S32.442A, S32.442B, S32.443A, S32.443B, S32.444A, S32.444B, S32.445A, S32.445B, S32.446A, S32.446B, S32.451A, S32.451B, S32.452A, S32.452B, S32.453A, S32.453B, S32.454A, S32.454B, S32.455A, S32.455B, S32.456A, S32.456B, S32.461A, S32.461B, S32.462A, S32.462B, S32.463A, S32.463B, S32.464A, S32.464B, S32.465A, S32.465B, S32.466A, S32.466B, S32.471A, S32.471B, S32.472A, S32.472B, S32.473A, S32.473B, S32.474A, S32.474B, S32.475A, S32.475B, S32.476A, S32.476B, S32.481A, S32.481B, S32.482A, S32.482B, S32.483A, S32.483B, S32.484A, S32.484B, S32.485A, S32.485B, S32.486A, S32.486B, S32.491A, S32.491B, S32.492A, S32.492B, S32.499A, S32.499B, S52.501A, S52.501B, S52.501C,

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**AND**

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

**NUMERATOR:**

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

**Definitions:**

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

**Prescribed** – May include prescription given to the patient for treatment of osteoporosis (as listed above) at one or more encounters during the reporting period, or documentation that patient is already taking pharmacologic therapy for osteoporosis, as documented in the current medical list.

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

**Central DXA Measurement Ordered or Results Documented or Pharmacologic Therapy Prescribed**

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

**OR**

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

**OR**

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

**OR**

**Central DXA Measurement not Ordered or Results not Documented for Medical, Patient, or System Reasons**

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

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

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

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

**OR**

**Pharmacologic Therapy not Prescribed for Documented Reasons**

***Other Performance Exclusion:*** **G8634:** Clinician documented patient not an eligible candidate to receive pharmacologic therapy for osteoporosis

**OR**

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

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

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

**OR**

**Pharmacologic Therapy not Prescribed, Reason not Given**

***Performance Not Met:*** **G8635:** Pharmacologic therapy for osteoporosis was **not** prescribed, reason not given

**RATIONALE:**

Patients with a history of fracture should have a baseline bone mass measurement and/or receive treatment for osteoporosis. Given that the majority of osteoporotic fractures occur in patients with a diagnosis of osteoporosis by bone mass measurement, exclusion of osteoporosis by bone mass testing does not preclude treatment of osteoporosis in a patient with a history of fracture. There is a high degree of variability and consensus by experts of what constitutes a fragility fracture and predictor of an underlying problem of osteoporosis. The work group determined that only those fractures, which have the strongest consensus and evidence that they are predictive of

osteoporosis, should be included in the measure at this time. We anticipate that the list of fractures will expand as further evidence is published supporting the inclusion of other fractures.

**CLINICAL RECOMMENDATION STATEMENTS:**

The most important risk factors for osteoporosis-related fractures are a prior low-trauma fracture as an adult and a low BMD in patients with or without fractures. (AACE)

BMD measurement should be performed in all women 40 years old or older who have sustained a fracture. (AACE)

The single most powerful predictor of a future osteoporotic fracture is the presence of previous such fractures. (AACE)

The decision to measure bone density should follow an individualized approach. It should be considered when it will help the patient decide whether to institute treatment to prevent osteoporotic fracture. It should also be considered in patients receiving glucocorticoid therapy for 2 months or more and patients with other conditions that place them at high risk for osteoporotic fracture. (NIH)

The most commonly used measurement to diagnose osteoporosis and predict fracture risk is based on assessment of BMD by dual-energy X-ray absorptiometry (DXA). (NIH)

Measurements of BMD made at the hip predict hip fracture better than measurements made at other sites while BMD measurement at the spine predicts spine fracture better than measures at other sites. (NIH)

Pharmacologic therapy should be initiated to reduce fracture risk in women with:

- BMD T-scores below -2.0 by central dual x-ray absorptiometry (DXA) with no risk factors
- BMD T-scores below -1.5 by central dual x-ray absorptiometry (DXA) with one or more risk factors
- A prior vertebral or hip fracture (NOF)

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# PQRS MEASURE 41

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

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

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 50 years on the date of encounter with the diagnosis of osteoporosis

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who were prescribed pharmacologic therapy for osteoporosis within 12 months

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #41 (NQF 0049): Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older – National Quality Strategy Domain: Effective Clinical Care

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

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

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. Patients with a diagnosis of osteoporosis should be prescribed pharmacologic therapy to treat osteoporosis. It is anticipated that **clinicians who provide services for patients with the diagnosis of osteoporosis** will submit this measure.

**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 modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system 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:**
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:**
All patients aged 50 years and older with the diagnosis of osteoporosis

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 50 years on date of encounter
**AND**
**Diagnosis for osteoporosis (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 733.00, 733.01, 733.02, 733.03, 733.09
**Diagnosis for osteoporosis (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** M80.00XA, M80.00XD, M80.00XG, M80.00XK, M80.00XP, M80.00XS, M80.011A, M80.011D, M80.011G, M80.011K, M80.011P, M80.011S, M80.012A, M80.012D, M80.012G, M80.012K, M80.012P, M80.012S, M80.019A, M80.019D, M80.019G, M80.019K, M80.019P, M80.019S, M80.021A, M80.021D, M80.021G, M80.021K, M80.021P, M80.021S, M80.022A, M80.022D, M80.022G, M80.022K, M80.022P, M80.022S, M80.029A, M80.029D, M80.029G, M80.029K, M80.029P, M80.029S, M80.031A, M80.031D, M80.031G, M80.031K, M80.031P, M80.031S, M80.032A, M80.032D, M80.032G, M80.032K, M80.032P, M80.032S, M80.039A, M80.039D, M80.039G, M80.039K, M80.039P, M80.039S, M80.041A, M80.041D, M80.041G, M80.041K, M80.041P, M80.041S, M80.042A, M80.042D, M80.042G, M80.042K, M80.042P, M80.042S, M80.049A, M80.049D,

M80.049G, M80.049K, M80.049P, M80.049S, M80.051A, M80.051D, M80.051G, M80.051K, M80.051P, M80.051S, M80.052A, M80.052D, M80.052G, M80.052K, M80.052P, M80.052S, M80.059A, M80.059D, M80.059G, M80.059K, M80.059P, M80.059S, M80.061A, M80.061D, M80.061G, M80.061K, M80.061P, M80.061S, M80.062A, M80.062D, M80.062G, M80.062K, M80.062P, M80.062S, M80.069A, M80.069D, M80.069G, M80.069K, M80.069P, M80.069S, M80.071A, M80.071D, M80.071G, M80.071K, M80.071P, M80.071S, M80.072A, M80.072D, M80.072G, M80.072K, M80.072P, M80.072S, M80.079A, M80.079D, M80.079G, M80.079K, M80.079P, M80.079S, M80.08XA, M80.08XD, M80.08XG, M80.08XK, M80.08XP, M80.08XS, M80.80XA, M80.80XD, M80.80XG, M80.80XK, M80.80XP, M80.80XS, M80.811A, M80.811D, M80.811G, M80.811K, M80.811P, M80.811S, M80.812A, M80.812D, M80.812G, M80.812K, M80.812P, M80.812S, M80.819A, M80.819D, M80.819G, M80.819K, M80.819P, M80.819S, M80.821A, M80.821D, M80.821G, M80.821K, M80.821P, M80.821S, M80.822A, M80.822D, M80.822G, M80.822K, M80.822P, M80.822S, M80.829A, M80.829D, M80.829G, M80.829K, M80.829P, M80.829S, M80.831A, M80.831D, M80.831G, M80.831K, M80.831P, M80.831S, M80.832A, M80.832D, M80.832G, M80.832K, M80.832P, M80.832S, M80.839A, M80.839D, M80.839G, M80.839K, M80.839P, M80.839S, M80.841A, M80.841D, M80.841G, M80.841K, M80.841P, M80.841S, M80.842A, M80.842D, M80.842G, M80.842K, M80.842P, M80.842S, M80.849A, M80.849D, M80.849G, M80.849K, M80.849P, M80.849S, M80.851A, M80.851D, M80.851G, M80.851K, M80.851P, M80.851S, M80.852A, M80.852D, M80.852G, M80.852K, M80.852P, M80.852S, M80.859A, M80.859D, M80.859G, M80.859K, M80.859P, M80.859S, M80.861A, M80.861D, M80.861G, M80.861K, M80.861P, M80.861S, M80.862A, M80.862D, M80.862G, M80.862K, M80.862P, M80.862S, M80.869A, M80.869D, M80.869G, M80.869K, M80.869P, M80.869S, M80.871A, M80.871D, M80.871G, M80.871K, M80.871P, M80.871S, M80.872A, M80.872D, M80.872G, M80.872K, M80.872P, M80.872S, M80.879A, M80.879D, M80.879G, M80.879K, M80.879P, M80.879S, M80.88XA, M80.88XD, M80.88XG, M80.88XK, M80.88XP, M80.88XS, M81.0, M81.6, M81.8, M81.0, M81.6, M81.8

**AND**

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

**NUMERATOR:**

Patients who were prescribed pharmacologic therapy for osteoporosis within 12 months

**Definitions:**

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

**Prescribed** – May include prescription given to the patient for treatment of osteoporosis (as listed above) at one or more encounters during the reporting period, OR documentation that patient is already taking pharmacologic therapy for osteoporosis, as documented in the current medication list.

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

**Pharmacologic Therapy Prescribed**

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

**OR**

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

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

***Medical Performance Exclusion:* 4005F *with* 1P:** Documentation of medical reason(s) for not prescribing pharmacologic therapy for osteoporosis

**Patient Performance Exclusion: 4005F *with* 2P:** Documentation of patient reason(s) for not prescribing pharmacologic therapy for osteoporosis

***System Performance Exclusion:* 4005F *with* 3P:** Documentation of system reason(s) for not prescribing pharmacologic therapy for osteoporosis

**OR**

**Pharmacologic Therapy not Prescribed, Reason not Otherwise Specified**

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

***Performance Not Met:* 4005F *with* 8P:** Pharmacologic therapy for osteoporosis was **not** prescribed, reason not otherwise specified

**RATIONALE:**

Pharmacologic therapy is an evidence-based recommendation for the treatment of osteoporosis.

**CLINICAL RECOMMENDATION STATEMENTS:**

Agents approved by the FDA for osteoporosis prevention and/or treatment include (in alphabetical order) bisphosphonates (alendronate, ibandronate, risedronate), salmon calcitonin, estrogen, raloxifene, and teriparatide. All act by reducing bone resorption, except for teriparatide, which has anabolic effects on bone.

Although estrogen is not approved for treatment of osteoporosis, there is level 1 evidence for its efficacy in reducing vertebral fractures, nonvertebral fractures, and hip fractures.

Level 1 evidence of efficacy in reducing the risk of vertebral fractures is available for all the agents approved for treatment of osteoporosis (bisphosphonates, calcitonin, raloxifene, and teriparatide). Prospective trials have demonstrated the effectiveness of bisphosphonates and teriparatide in reducing the risk of nonvertebral fractures (level 1), but only bisphosphonates have been shown to reduce the risk of hip fractures in prospective controlled trials (level 1). (AACE)

US Food and Drug Administration-approved pharmacologic options for osteoporosis prevention and/or treatment of postmenopausal osteoporosis include, in alphabetical order: bisphosphonates (alendronate, alendronate plus D, ibandronate, and risedronate, risedronate with 500 mg of calcium as the carbonate), calcitonin, estrogens (estrogens and/or hormone therapy), parathyroid hormone [PTH (1-34), teriparatide], and selective estrogen receptor modulators or SERMS (raloxifene). (NOF)

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# PQRS MEASURE 46

## Medication Reconciliation

**This measure is not to be reported unless a patient has been discharged from an inpatient facility within 30 days prior to the outpatient visit.**

### ELIGIBLE PATIENT POPULATION

All patients 18 years of age and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care

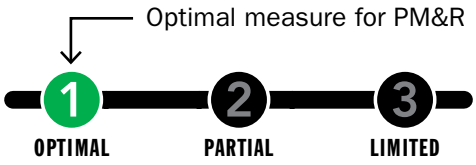
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

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, 99495, 99496

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Communication and Care Coordination

### TYPE OF MEASURE

Individual or Crosscutting Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #46 (NQF 0097): Medication Reconciliation – National Quality Strategy Domain: Communication and Care Coordination

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of patients aged 18 years and older **discharged from any inpatient facility** (eg, hospital, skilled nursing facility, or rehabilitation facility) and **seen within 30 days following discharge** in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.

This measure is reported as two rates stratified by age group:

- Reporting Age Criteria 1: 18-64 years of age
- Reporting Age Criteria 2: 65 years and older

**INSTRUCTIONS:**
This measure is to be reported at an outpatient visit occurring within 30 days of **each inpatient facility discharge date** during the reporting period. This measure is appropriate for use in the ambulatory setting only. There is no diagnosis associated with this measure. 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. **This measure is not to be reported unless a patient has been discharged from an inpatient facility within 30 days prior to the outpatient visit.**

This measure will be calculated with 2 performance rates:

1) Percentage of patients 18-64 years of age who were discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

**AND**

2) Percentage of patients 65 years and older who were discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

**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(s) **OR** the CPT Category II code(s) **with** the modifier. The reporting modifier allowed for this 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:**

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 18 years of age and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care

**Denominator Criteria (Eligible Cases):**
**REPORTING CRITERIA 1:** Patients 18-64 years of age on date of encounter
**REPORTING CRITERIA 2:** Patients aged 65 years and older on date of encounter

**AND**

**Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90839, 90845, 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, 99495, 99496, G0402, G0438, G0439

**NUMERATOR (Reporting Criteria 1 & 2):**
Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented

**Definition:**
**Medical Record** – Must indicate: The physician, prescribing practitioner, registered nurse, or clinical pharmacist providing ongoing care is aware of the inpatient facility discharge medications and will either keep the inpatient facility discharge medications or change the inpatient facility discharge medications or the dosage of an inpatient facility discharge medication.

***NUMERATOR NOTE:*** *Medication reconciliation should be completed and documented within 30 days of discharge. If the patient has an eligible discharge but medication reconciliation is not performed and documented within 30 days, report 1111F with 8P.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Documentation of Reconciliation of Discharge Medication with Current Medication List in the Medical Record**
***Performance Met:*** **CPT II 1111F:** Discharge medications reconciled with the current medication list in outpatient medical record

**OR**

**If patient is not eligible for this measure because patient was not discharged from an inpatient facility within the last 30 days, there are no reporting requirements in this case.**

**OR**

**Discharge Medication not Reconciled with Current Medication List in the Medical Record, Reason Not Otherwise Specified**
Append a reporting modifier (**8P**) to CPT Category II code **1111F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
***Performance Not Met:*** **1111F *with* 8P:** Discharge medications not reconciled with the current medication list in outpatient medical record, reason not otherwise specified

**RATIONALE:**
Medications are often changed while a patient is hospitalized. Continuity between inpatient and on-going care is essential.

**CLINICAL RECOMMENDATION STATEMENTS:**
Medication reconciliation post-discharge is an important step to catch potentially harmful omissions or changes in prescribed medications, particularly in elderly patients that are prescribed a greater quantity and variety of medications (Leape, 1991). Although the magnitude of the effect of medication reconciliation alone on patient outcomes is not well studied, there is agreement among experts that potential benefits outweigh the harm (Coleman, 2003; Pronovost, 2003; IOM, 2002; IOM, 2006). Medication reconciliation post-discharge is recommended by the Joint Commission patient safety goals (Kienle, 2008), the American Geriatric Society (Coleman, 2003), Society of Hospital Medicine (Kripalani, 2007; Grennwald, 2010), ACOVE (Assessing Care of Vulnerable Elders; Knight, 2001),and the Task Force on Medicines Partnership (2005). Additionally, measurement of medication reconciliation post-discharge has been cited by the National Quality Forum and the National Priorities Partnership as a measurement priority area (NQF, 2010)

No trials of the effects of physician acknowledgment of medications post-discharge were found. However, patients are likely to have their medications changed during a hospitalization. Estimates suggest that 46% of medication errors occur on admission or discharge from a hospital (Pronovost, 2003). Therefore, medication reconciliation is a critical piece of care coordination post-discharge for all individuals who use prescription medications. Prescription medication use is common among adults of all ages, particularly older adults and adults with chronic conditions. On average, 82% of adults in the U.S. are taking at least one medication (prescription or nonprescription, vitamin/mineral, herbal/natural supplement); 29% are taking five or more. Older adults are the biggest consumers of medications with 17-19% of people 65 and older taking at least ten medications in a given week (Slone Survey, 2006).

One observational study showed that 1.5 new medications were initiated per patient during hospitalization, and 28% of chronic medications were canceled by the time of hospital discharge. Another observational study showed that at one week post-discharge, 72% of elderly patients were taking incorrectly at least one medication started in the inpatient setting, and 32% of medications were not being taken at all. One survey study faulted the quality of discharge communication as contributing to early hospital readmission, although this study did not implicate medication discontinuity as the cause. (ACOVE)

Implementing routine medication reconciliation after discharge from an inpatient facility is an important step to ensure medication errors are addressed and patients understand their new medications. The process of resolving discrepancies in a patient's medication list reduces the risk of these adverse drug interactions being overlooked and helps physicians minimize the duplication and complexity of the patient's medication regimen (Wenger, 2004). This in turn may increase patient adherence to the medication regimen and reduce hospital readmission rates.

First, a medication list must be collected. It is important to know what medications the patient has been taking or receiving prior to the outpatient visit in order to provide quality care. This applies regardless of the setting from which the patient came — home, long-term care, assisted living, etc. The medication list should include all medications (prescriptions, over-the-counter, herbals, supplements, etc.) with dose, frequency, route, and reason for taking it. It is also important to verify whether the patient is actually taking the medication as prescribed or instructed, as sometimes this is not the case.

At the end of the outpatient visit, a clinician needs to verify three questions:

1) Based on what occurred in the visit, should any medication that the patient was taking or receiving prior to the visit be discontinued or altered?
2) Based on what occurred in the visit, should any prior medication be suspended pending consultation with the prescriber?

3) Have any new prescriptions been added today?

These questions should be reviewed by the physician who completed the procedure, or the physician who evaluated and treated the patient.

- If the answer to ***all three questions*** is "no," the process is complete.
- If the answer to ***any question*** is "yes," the patient needs to receive clear instructions about what to do — all changes, holds, and discontinuations of medications should be specifically noted. Include any follow-up required, such as calling or making appointments with other practitioners and a timeframe for d

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# PQRS MEASURE 47

## Advance Care Plan

**This measure is appropriate for use in all healthcare settings.**

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 65 years on date of encounter

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, *99231, *99232, *99233, *99234, *99235, *99236, 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

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Communication and Care Coordination

### TYPE OF MEASURE

Individual or Crosscutting Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #47 (NQF 0326): Care Plan – National Quality Strategy Domain: Communication and Care Coordination

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**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 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.

This measure is appropriate for use in all healthcare settings (eg, inpatient, nursing home, ambulatory) except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.

**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 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:**
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 65 years and older

> ***DENOMINATOR NOTE:*** **Clinicians indicating the Place of Service as the emergency department will not be included in this measure.*
>
> **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, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291*, 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 have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**Numerator Instructions:** If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report **1124F**.

**Definition:**
**Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan** – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Advance Care Planning Discussed and Documented**

| | |
|---|---|
| ***Performance Met:* CPT II 1123F:** | Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record |

**OR**

| | |
|---|---|
| ***Performance Met:* CPT II 1124F:** | Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan |

**OR**

**Advance Care Planning not Documented, Reason not Otherwise Specified**
Append a reporting modifier (**8P**) to CPT Category II code **1123F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

| | |
|---|---|
| ***Performance Not Met:* 1123F *with* 8P:** | Advance care planning **not** documented, reason not otherwise specified |

**RATIONALE:**
It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno, 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

**CLINICAL RECOMMENDATION STATEMENTS:**
Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

Oral statements:

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills):

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy:

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national

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# PQRS MEASURE 48

## Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

### ELIGIBLE PATIENT POPULATION

All female patients aged ≥ 65 years on date of encounter with a visit during the measurement period.

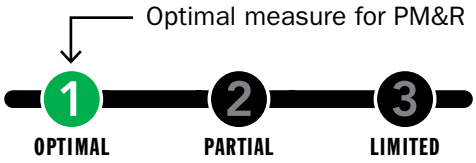
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who were assessed for the presence or absence of urinary incontinence within 12 months

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older – National Quality Strategy Domain: Effective Clinical Care

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. This measure is appropriate for use in the ambulatory setting only and is considered a general screening measure. There is no diagnosis associated with this measure. 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 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 female patients aged 65 years and older with a visit during the measurement period.

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

**NUMERATOR:**
Patients who were assessed for the presence or absence of urinary incontinence within 12 months

**Definition:**
**Urinary Incontinence** – Any involuntary leakage of urine.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Presence or Absence of Urinary Incontinence Assessed**
***Performance Met:*** **CPT II 1090F:** Presence or absence of urinary incontinence assessed

**OR**

**Presence or Absence of Urinary Incontinence not Assessed for Medical Reasons**
Append a modifier (**1P**) to CPT Category II code **1090F** to report documented circumstances that appropriately exclude patients from the denominator.
***Medical Performance Exclusion:*** **1090F *with* 1P:** Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence

**OR**

**Presence or Absence of Urinary Incontinence not Assessed, Reason not Otherwise Specified**
Append a reporting modifier (**8P**) to CPT Category II code **1090F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
***Performance Not Met:*** **1090F *with* 8P:** Presence or absence of urinary incontinence **not** assessed, reason not otherwise specified

**RATIONALE:**
Female patients may not volunteer information regarding incontinence so they should be asked by their physician.

**CLINICAL RECOMMENDATION STATEMENTS:**
Strategies to increase recognition and reporting of UI are required and especially the perception that it is an inevitable consequence of aging for which little or nothing can be done. (ICI)

Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of post-void residual volume, and urinalysis. (ACOG) (Level C)

Health care providers should be able to initiate evaluation and treatment of UI basing their judgment on the results of history, physical examination, post-voiding residual and urinalysis. (ICI) (Grade

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# PQRS MEASURE 50

## Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

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

### ELIGIBLE PATIENT POPULATION

All female patients aged ≥ 65 years on date of encounter with a diagnosis of urinary incontinence.

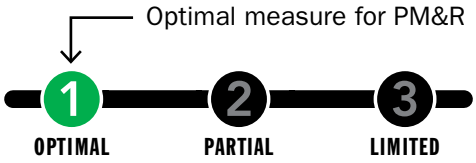
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients with a documented plan of care for urinary incontinence at least once within 12 months

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Person and Caregiver-Centered Experience and Outcomes

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #50: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. This measure is appropriate for use in the ambulatory setting only. It is anticipated that **clinicians who provide services for patients with the diagnosis of urinary incontinence** will submit this measure.

**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 female patients aged 65 years and older with a diagnosis of urinary incontinence

**Denominator Criteria (Eligible Cases):**
All female patients aged ≥ 65 years on date of encounter
**AND**
**Diagnosis for urinary incontinence (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 307.6, 625.6, 788.30, 788.31, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39
**Diagnosis for urinary incontinence (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** F98.0, N39.3, N39.41, N39.42, N39.43, N39.44, N39.45, N39.46, N39.490, N39.498, R32
**AND**
**Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

**NUMERATOR:**

Patients with a documented plan of care for urinary incontinence at least once within 12 months

**Definition:**
**Plan of Care** – May include behavioral interventions (eg, bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Plan of Care for Urinary Incontinence Documented**
***Performance Met:* CPT II 0509F:** Urinary incontinence plan of care documented

**OR**

**Plan of Care for Urinary Incontinence not Documented, Reason not Otherwise Specified**
Append a reporting modifier (**8P**) to CPT Category II code **0509F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
***Performance Not Met:* 0509F *with* 8P:** Urinary incontinence plan of care **not** documented, reason not otherwise specified

**RATIONALE:**
A treatment option should be documented for the patient with incontinence.

**CLINICAL RECOMMENDATION STATEMENTS:**
All conservative management options used in younger adults can be used in selected frail, older, motivated people. This includes:

- Bladder retraining
- Pelvic muscle exercises including biofeedback and/or electro-stimulation (ICI) (Grade B)

Pharmacologic agents, especially oxybutynin and tolterodine, may have a small beneficial effect on improving symptoms of detrusor overactivity in women. (ACOG) (Level A)

Oxybutynin and potentially other bladder relaxants can improve the effectiveness of behavioral therapies in frail older persons. (ICI) (Grade B)

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# PQRS MEASURE 107 EMEASURE ID #161

## Adult Major Depressive Disorder (MDD): Suicide Risk Assessment

### ELIGIBLE PATIENT POPULATION

All patients aged 18 years and older with a diagnosis of major depressive disorder (MDD)

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS Resources:

- **PQRS EHR-based Reporting Option Website**
- **2015 EHR-Based Reporting Made Simple**
- **Medicare EHR Incentive Program Website**
- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 109

## Osteoarthritis (OA): Function and Pain Assessment

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 21 years on date of encounter with a diagnosis of OA

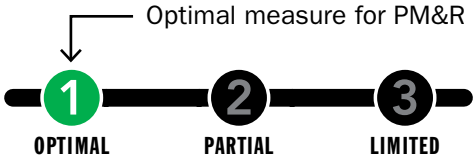
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patient visits with assessment for level of function and pain documented (may include the use of a standardized scale or the completion of an assessment questionnaire, such as an SF-36, AAOS Hip & Knee Questionnaire)

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Person and Caregiver-Centered Experience and Outcomes

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #109: Osteoarthritis (OA): Function and Pain Assessment – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

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

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

**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 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, 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 patient visits for patients aged 21 years and older with a diagnosis of OA

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 21 years on date of encounter
**AND**
**Diagnosis for osteoarthritis (OA) (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
**Diagnosis for osteoarthritis (OA) (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.10, M16.11, M16.12, M16.2, M16.30, M16.31, M16.32, M16.4, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.10, M17.11, M17.12, M17.2, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.10, M18.11, M18.12, M18.2, M18.30, M18.31, M18.32, M18.4, M18.50, M18.51, M18.52, M18.9, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.111, M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142, M19.149, M19.171, M19.172, M19.179, M19.211, M19.212, M19.219, M19.221, M19.222, M19.229, M19.231,

M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.90, M19.91, M19.92, M19.93

**AND**

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

**NUMERATOR:**

Patient visits with assessment for level of function and pain documented (may include the use of a standardized scale or the completion of an assessment questionnaire, such as an SF-36, AAOS Hip & Knee Questionnaire)

***NUMERATOR NOTE:*** *For the purposes of this measure, the method for assessing function and pain is left up to the discretion of the individual clinician and based on the needs of the patient. The assessment may be done via a validated instrument (though one is not required) that measures pain and various functional elements including a patient's ability to perform activities of daily living (ADLs).*

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

**Osteoarthritis Symptoms and Functional Status Assessed**

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

**OR**

**Osteoarthritis Symptoms and Functional Status not Assessed, Reason not Otherwise Specified**

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

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

**RATIONALE:**

Osteoarthritis can be a debilitating condition. An assessment of patient symptoms and functional status is important as it serves as the basis for making treatment modifications, which in turn, assists in improving the patient's quality of life.

**CLINICAL RECOMMENDATION STATEMENTS:**

Any persistent pain that has an impact on physical function, psychosocial function, or other aspects of quality of life should be recognized as a significant problem. (AGS; IIA Recommendation)

Control of pain and maintenance of activity correlate well with satisfactory quality of life. If the patient is not satisfied with the outcome due to continued pain and limitation of activity, more aggressive intervention may be warranted. (AAOS, 2003)

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# PQRS MEASURE 110 EMEASURE ID #147

## Preventive Care and Screening: Influenza Immunization

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 6 months seen for a visit between October 1 and March 31

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Community / Population Health

### TYPE OF MEASURE

Individual, Crosscutting, or Clinical Quality Measure

### REPORTING METHOD(S)

Claims, Registry, Direct EHR Vendor / Data Submission Vendor or GPRO Web Interface

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS Resources:

- **2015 EHR-Based Reporting Made Simple**
- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **2015 GPRO Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #110 (NQF 0041): Preventive Care and Screening: Influenza Immunization – National Quality Strategy Domain: Community/Population Health

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once for visits for patients seen** between January and March for the 2014-2015 influenza season AND a minimum of **once for visits for patients seen** between October and December for the 2015-2016 influenza season. This measure is intended to determine whether or not all patients aged 6 months and older received (either from the reporting physician or from an alternate care provider) the influenza immunization during the flu season. There is no diagnosis associated with this measure. 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.

- If reporting this measure between January 1, 2015 and March 31, 2015, quality-data code **G8482** should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2014 or January, February, and March of 2015 for the flu season ending March 31, 2015.
- If reporting this measure between October 1, 2015 and December 31, 2015, quality-data code **G8482** should be reported when the influenza immunization is administered to the patient during the months of August, September, October, November, and December of 2015 for the flu season ending March 31, 2016.
- Influenza immunizations administered during the month of August or September of a given flu season (either 2014-2015 flu season OR 2015-2016 flu season) can be reported when a visit occurs during the flu season (October 1 - March 31). In these cases, **G8482** should be reported.

**Measure Reporting via Claims:**
CPT 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 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 6 months and older seen for a visit between October 1 and March 31

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 6 months seen for a visit between October 1 and March 31
**AND**
**Patient encounter during the reporting period (CPT or HCPCS):** 90945, 90947, 90951, 90952, 90953, 90954, 90955, 90956, 90957, 90958, 90959, 90960, 90961, 90962, 90963, 90964, 90965, 90966, 90967,

90968, 90969, 90970, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439

**NUMERATOR:**
Patients who received an influenza immunization OR who reported previous receipt of an influenza immunization

**Definition:**
**Previous Receipt** – Receipt of the current season's influenza immunization from another provider OR from same provider prior to the visit to which the measure is applied (typically, prior vaccination would include influenza vaccine given since August 1st).

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Influenza Immunization Administered**
***Performance Met:* G8482:** Influenza immunization administered or previously received

**OR**

**Influenza Immunization not Administered for Documented Reasons**
***Other Performance Exclusion:* G8483:** Influenza immunization was not administered for reasons documented by clinician (eg, patient allergy or other medical reasons, patient declined or other patient reasons, vaccine not available or other system reasons)

**OR**

**Influenza Immunization not Administered, Reason not Given**
***Performance Not Met:* G8484:** Influenza immunization was **not** administered, reason not given

**RATIONALE:**
Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Influenza vaccine is recommended for all persons aged ≥ 6 months who do not have contraindications to vaccination.

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

Routine annual influenza vaccination is recommended for all persons aged ≥ 6 months. To permit time for production of protective antibody levels, vaccination should optimally occur before onset of influenza activity in the community, and providers should offer vaccination as soon as vaccine is available. Vaccination also should continue to be offered throughout the influenza season. (CDC/ACIP, 2011)

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# PQRS MEASURE 111 EMEASURE ID #127

## Pneumonia Vaccination Status for Older Adults

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 65 years on date of encounter with a visit during the measurement period

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who have ever received a pneumococcal vaccination

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

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

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Community/Population Health

### TYPE OF MEASURE

Individual, Electronic Clinical Quality Measure (CQM) , or Crosscutting

### REPORTING METHOD(S)

Claims, Direct EHR Vendor / Data Submission Vendor, GPRO Web Interface or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS Resources:

- **2015 EHR-Based Reporting Made Simple**
- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **2015 GPRO Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #111 (NQF 0043): Pneumonia Vaccination Status for Older Adults – National Quality Strategy Domain: Community/Population Health

**2015 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 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:**
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**
> ***Performance Met:***

**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.

***Performance Not Met:***

**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.

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# PQRS MEASURE 116

## Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis

### ELIGIBLE PATIENT POPULATION

All patients aged 18 through 64 years of age with an outpatient or emergency department (ED) visit with a diagnosis of acute bronchitis during the measurement period.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who were not prescribed or dispensed antibiotics on or within 3 days of the initial date of service

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, *99218, *99219, *99220

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Efficiency and Cost Reduction

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry Only

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #116 (NQF 0058): Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis – National Quality Strategy Domain: Efficiency and Cost Reduction

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of adults 18 through 64 years of age with a diagnosis of acute bronchitis who **were not prescribed or dispensed** an antibiotic prescription on or 3 days after the episode

**INSTRUCTIONS:**
This measure is to be reported at **each occurrence** of acute bronchitis 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 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:**
All patients aged 18 through 64 years of age with an outpatient or emergency department (ED) visit with a diagnosis of acute bronchitis during the measurement period

**Definition:**
To determine eligibility, look for any of the listed antibiotic drugs below in the 30 days prior to the visit with the acute bronchitis diagnosis. As long as there are no prescriptions for the listed antibiotics during this time period, the patient is eligible for denominator inclusion.

**Denominator Criteria (Eligible Cases):**
Patients 18 through 64 years of age on date of encounter
**AND**
**Diagnosis for acute bronchitis (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 466.0
**Diagnosis for acute bronchitis (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** J20.0, J20.1, J20.2, J20.3, J20.4, J20.5, J20.6, J20.7, J20.8, J20.9
**AND**
**Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99281, 99282, 99283, 99284, 99285, G0402

**Antibiotic Medications**

| Description | Prescription |
|---|---|
| Aminoglycosides | • Amikacin • Gentamicin • Kanamycin • Streptomycin • Tobramycin |
| Aminopenicillins | • Amoxicillin • Ampicillin |
| Antipseudomonal penicillins | • Piperacillin |

| Description | Prescription | | |
|---|---|---|---|
| Beta-lactamase inhibitors | • Amoxicillin-clavulanate<br>• Ampicillin-sulbactam | • Piperacillin-tazobactam | • Ticarcillin-clavulanate |
| First-generation cephalosporins | • Cefadroxil | • Cefazolin | • Cephalexin |
| Fourth-generation cephalosporins | • Cefepime | | |
| Ketolides | • Telithromycin | | |
| Lincomycin derivatives | • Clindamycin | • Lincomycin | |
| Macrolides | • Azithromycin<br>• Clarithromycin | • Erythromycin<br>• Erythromycin ethylsuccinate | • Erythromycin lactobionate<br>• Erythromycin stearate |
| Miscellaneous antibiotics | • Aztreonam<br>• Chloramphenicol<br>• Dalfopristin-quinupristin | • Daptomycin<br>• Erythromycin-sulfisoxazole<br>• Linezolid | • Metronidazole<br>• Vancomycin |
| Natural penicillins | • Penicillin G benzathine-procaine<br>• Penicillin G potassium | • Penicillin G procaine<br>• Penicillin G sodium | • Penicillin V potassium<br>• Penicillin G benzathine |
| Penicillinase resistant penicillins | • Dicloxacillin | • Nafcillin | • Oxacillin |
| Quinolones | • Ciprofloxacin<br>• Gemifloxacin | • Levofloxacin<br>• Moxifloxacin | • Norfloxacin<br>• Ofloxacin |
| Rifamycin derivatives | • Rifampin | | |
| Second generation cephalosporin | • Cefaclor<br>• Cefotetan | • Cefoxitin<br>• Cefprozil | • Cefuroxime |
| Sulfonamides | • Sulfadiazine | • Sulfamethoxazole-trimethoprim | |
| Tetracyclines | • Doxycycline | • Minocycline | • Tetracycline |
| Third generation cephalosporins | • Cefdinir<br>• Cefditoren<br>• Cefixime | • Cefotaxime<br>• Cefpodoxime<br>• Ceftazidime | • Ceftibuten<br>• Ceftriaxone |
| Urinary anti-infectives | • Fosfomycin<br>• Nitrofurantoin<br>• Nitrofurantoin macrocrystals | • Nitrofurantoin macrocrystals-monohydrate<br>• Trimethoprim | |

**NUMERATOR:**
Patients who were not prescribed or dispensed antibiotics on or within 3 days of the initial date of service

**Numerator Instructions:** For performance, the measure will be calculated as the number of patient encounters where antibiotics were neither prescribed nor dispensed on or within 3 days of the episode for acute bronchitis over the total number of encounters in the denominator (patients aged 18 through 64 years with an outpatient or ED visit for acute bronchitis). A higher score indicates appropriate treatment of patients with acute bronchitis (eg, the proportion for whom antibiotics were not prescribed or dispensed on or three days after the encounter).

**Numerator Options:**

***Performance Met:*** Antibiotic neither prescribed nor dispensed **(4124F)**

**OR**

***Medical Performance Exclusion:*** Documentation of medical reason(s) for prescribing or dispensing antibiotic (eg,intestinal infection, pertussis, bacterial infection, Lyme disease, otitis media, acute sinusitis, acute pharyngitis, acute tonsillitis, chronic sinusitis, infection of the pharynx/larynx/tonsils/adenoids, prostatitis, cellulitis/ mastoiditis/bone infections, acute lymphadenitis, impetigo, skin staph infections, pneumonia, gonococcal infections/venereal disease (syphilis, chlamydia, inflammatory diseases [female reproductive organs]), infections of the kidney, cystitis/UTI, acne, HIV disease/asymptomatic HIV, cystic fibrosis, disorders of the immune system, malignancy neoplasms, chronic bronchitis, emphysema, bronchiectasis, extrinsic allergic alveolitis, chronic airway obstruction, chronic obstructive asthma, pneumoconiosis and other lung disease due to external agents, other diseases of the respiratory system, and tuberculosis) **(4120F *with* 1P)**

**OR**

***Performance Not Met:*** Antibiotic prescribed or dispensed **(4120F)**

**RATIONALE:**

Antibiotics are commonly misused and overused for a number of viral respiratory conditions where antibiotic treatment is not clinically indicated. (Scott J.G., D. Cohen, B. Dicicco-Bloom, 2001) About 80 percent of antibiotics prescribed for acute respiratory infections in adults are unnecessary, according to CDC prevention guidelines. In adults, antibiotics are most often (65–80 percent) prescribed for acute bronchitis, despite its viral origin. The misuse and overuse of antibiotics contributes to antibiotic drug resistance, which is of public health concern due to the diminished efficacy of antibiotics against bacterial infections, particularly in sick patients and the elderly. (Austin D.J., K.G. Kristinsson, R.M. Anderson, 1999, Patterson, JE, 2001, Cohen ML, 1992, Lipsitch M, 2001)

A HEDIS measure that highlights inappropriate antibiotic prescribing in adults for a common respiratory condition will help to raise awareness among clinicians and patients about inappropriate antibiotic use. Antibiotics are most often inappropriately prescribed in adults with acute bronchitis. This measure builds on an existing HEDIS measure targeting inappropriate antibiotic prescribing for children with upper respiratory infection (common cold), where antibiotics are also most often inappropriately prescribed. (Chandran R., 2001, Gonzales R., J.F. Steiner, et al, 1999)

**CLINICAL RECOMMENDATION STATEMENTS:**

Clinical guidelines do not support antibiotic treatment of otherwise healthy adults with acute bronchitis due to the viral origin of acute bronchitis. Patients with chronic bronchitis, COPD or other chronic comorbidity may be treated with antibiotics and are therefore excluded from the measure denominator. (Gonzales R., D.C. Malone, J.H. Maselli, et al, 2001)

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# PQRS MEASURE 126

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

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter with a diagnosis of diabetes mellitus.

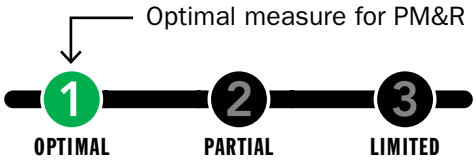
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

11042, 11043, 11044, 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

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry Only

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #126 (NQF 0417): Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation – National Quality Strategy Domain: Effective Clinical Care

**2015 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:**

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

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 1/1/2015-9/30/2015]:** 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
**Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331,

E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

**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

**AND NOT**

Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure, for example patient bilateral amputee, patient has condition that would not allow them to accurately respond to a neurological exam (dementia, Alzheimer´s, etc.), patient has previously documented diabetic peripheral neuropathy with loss of protective sensation

**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 should include: 10-g monofilament plus testing any one of the following: vibration using 128-Hz tuning fork, pinprick sensation, ankle reflexes, or vibration perception threshold), however the clinician should perform all necessary tests to make the proper evaluation.

**Numerator Options:**

| | |
|---|---|
| ***Performance Met:*** | Lower extremity neurological exam performed and documented (**G8404)** |
| **OR** | |
| ***Performance Not Met:*** | Lower extremity neurological exam **not** performed (**G8405)** |

**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)

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# PQRS MEASURE 127

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

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years years on date of encounter with a diagnosis of diabetes mellitus

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

11042, 11043, 11044, 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

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1

Optimal measure for PM&R


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry Only

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #127 (NQF 0416): Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear – National Quality Strategy Domain: Effective Clinical Care

**2015 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 1/1/2015-9/30/2015]:** 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
**Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9
**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 Options:**

| | |
|---|---|
| ***Performance Met:*** | Footwear evaluation performed and documented(**G8410)** |
| **OR** | |
| ***Other Performance Exclusion:*** | Clinician documented that patient was not an eligible candidate for footwear evaluation measure(**G8416)** |
| **OR** | |
| ***Performance Not Met:*** | Footwear evaluation was **not** performed(**G8415)** |

**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 (ie, 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)

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# PQRS MEASURE 128 EMEASURE ID #69

## Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up

### ELIGIBLE PATIENT POPULATION

All patients aged ≥18 years on date of encounter

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients with a documented BMI during the 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 current encounter

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Community / Population Health

### TYPE OF MEASURE

Individual, Electronic Clinical Quality Measure (CQM) or Crosscutting

### REPORTING METHOD(S)

Claims, Registry, Direct EHR Vendor / Data Submission Vendor or GPRO Web Interface

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS Resources:

- **2015 EHR-Based Reporting Made Simple**
- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **2015 GPRO Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

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

**Normal Parameters:**
Age 65 years and older BMI ≥ 23 and < 30 kg/$m^2$
Age 18 – 64 years BMI ≥ 18.5 and < 25 kg/$m^2$

**INSTRUCTIONS:**
There is no diagnosis associated with this measure. This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. 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 may be documented in the medical record of the provider or 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 during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent document BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters"(See Definitions for examples of a follow-up plan treatments). *If more than one BMI is reported during the measure period, the most recent BMI will be used to determine if the performance has been met.*

**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, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

**Numerator Instructions:**

- Height and Weight - An eligible professional or their staff is required to measure both height and weight. Both height and weight must be measured within six months of the current encounter and may be obtained from separate encounters. Self-reported values cannot be used.
- Follow-Up Plan – If the most recent documented BMI is outside of normal parameters, then a follow-up plan is documented during the encounter or during the previous six months of the current encounter. The documented follow-up plan must be based on the most recent documented BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters". (See Definitions for examples of a follow-up plan treatments)
- Performance Met for G8417 & G8418

    - If the provider documents a BMI and a follow-up plan at the current visit **OR**
    - If the patient has a documented BMI within the previous six months of the current encounter, the provider documents a follow-up plan at the current visit **OR**
    - If the patient has a documented BMI within the previous six months of the current encounter **AND** the patient has a documented follow-up plan for a BMI outside normal parameters within the previous six months of the current visit

**Definitions:**

**BMI** – Body mass index (BMI), is a number calculated using the Quetelet index: weight divided by height squared ($W/H^2$) and is commonly used to classify weight categories. BMI can be calculated using:

Metric Units: BMI = Weight (kg) / (Height (m) x Height (m))

**OR**

English Units: BMI = Weight (lbs) / (Height (in) x Height (in)) x 703

**Follow-Up Plan** – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. A follow-up plan may include but is not limited to:

- Documentation of education
- Referral (eg, a registered dietitian/nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon)
- Pharmacological interventions
- Dietary supplements
- Exercise counseling
- 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 measurement was not appropriate
- Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

**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)*

***Performance Met:*** **G8420:** BMI is documented within normal parameters and no follow-up plan is required

**OR**

**BMI Documented as Above Normal Parameters, AND Follow-Up Documented**

***Performance Met:*** **G8417:** BMI is documented above normal parameters and a follow-up plan is documented

**OR**

**BMI Documented as Below Normal Parameters, AND Follow-Up Documented**

***Performance Met:*** **G8418:** BMI is documented below normal parameters and a follow-up plan is documented

**OR**

**BMI not Documented, Patient not Eligible**

*(One quality-data code [**G8422 or G8938**] is required on the claim form to submit this numerator option)*

***Other Performance Exclusion:*** **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**

***Other Performance Exclusion:*** **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)*

***Performance Not Met:*** **G8421:** BMI **not** documented and no reason is given

**OR**

**BMI Documented Outside of Normal Parameters, Follow-Up Plan not Documented, Reason not Given**

***Performance Not Met:*** **G8419:** BMI documented outside normal parameters, **no** follow-up plan documented, no reason given

**RATIONALE:**

**Normal Parameters for Age 65 Years and Older**

Winter et al. (2014) performed a meta-analysis looking at the relationship between BMI and all-cause mortality among adults 65 and older. They identified a higher risk of mortality among those with a BMI <23 kg/m$^2$ and recommended monitoring weight status in this group to address any modifiable causes of weight loss promptly with due consideration of individual comorbidities. Dahl et al. (2013) reported that old persons (70-79) who were overweight had a lower mortality risk than old persons who were of normal weight, even after controlling for weight change and multimorbidity. The study also shows that persons who increased or decreased in BMI had a greater mortality risk than those who had a stable BMI, particularly those aged 70 to 79. Their results provide support to the belief that the World Health Organization guidelines for BMI are overly restrictive in old age.

**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, 2010) reported 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).Ogden, Carroll, Kit and Flegal (2013) reported the prevalence of BMI-defined obesity in adults is high and continues to exceed 30% in most sex-age groups (34.9% overall). They also stated the overall prevalence of obesity

did not differ between men and women in 2011–2012; however, among non-Hispanic black adults, 56.6% of women were obese compared with 37.1% of men. In addition to the continued high prevalence rate for adults in general, Flegal, Carroll & Kit (2012) report 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). Masters, et al. (2013) also showed mortality due to obesity varied by race and gender. They estimated adult deaths between 1986 and 2006 associated with overweight and obesity was 5.0% and 15.6% for Black and White men, and 26.8% and 21.7% for Black and White women, respectively. They also found a stronger association than previous research demonstrated between obesity and mortality risk at older ages.

Finkelstein, 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.

Padula, Allen and Nair (2014) examined data from a commercial claims and encounters database to estimate the cost for obesity and associated comorbidities among working-age adults who had a claim with a primary or secondary diagnosis of obesity in 2006-2007. The mean net expenditure for inpatient and outpatient claims was $1,907 per patient per visit. The increases in cost for comorbidities ranged from $527 for obesity with CHF to $15,733 for the combination of obesity, diabetes mellitus, hypertension and depression.

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 (NCHS) Health E-Stat, Fryer and Ogden (2012) reported that poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2010 National Health and Nutrition Examination Survey (NHANES), 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).

In a cohort study conducted by Borrell and Lalitha (2014), data from NHANES III (1988-1994) was linked to the National Death Index mortality file with follow-up to 2006, and showed that when compared to their normal weight counterparts (BMI 18.5-25 kg/m$^2$), underweight (BMI <18.5 kg/m$^2$) had significantly higher death rates (Hazard Ratio= 2.27; 95% confidence interval (CI) = 1.78, 2.90).

Ranhoff, Gjoen and Mowe (2005) recommended using BMI < 23 kg/m$^2$ 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. (2013), 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
    - Clinicians should consider waist circumference measurement to estimate disease risk for patients who have BMI scores indicative of overweight or obesity class I. For adult patients with a BMI of 25 to 34.9 $kg/m^2$, sex-specific waist circumference cutoffs should be used in conjunction with BMI to identify increased disease risk.
- 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.

Similarly, the 2013 joint report/guideline from the American Heart Association, American College of Cardiology and The Obesity Society also recommend measuring height and weight and calculating BMI at annual visits or more frequently, using the current cutpoints for overweight (BMI>25.0-29.9 $kg/m^2$) and obesity (BMI ≥30 $kg/m^2$) to identify adults who may be at elevated risk of CVD and the current cutpoints for obesity to identify adults who may be at elevated risk of mortality from all causes. They also recommend counseling overweight and obese individuals on their increased risk for CVD, type 2 diabetes, all-cause mortality and need for lifestyle changes.

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# PQRS MEASURE 130 EMEASURE ID #68

## Documentation of Current Medications in the Medical Record

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter

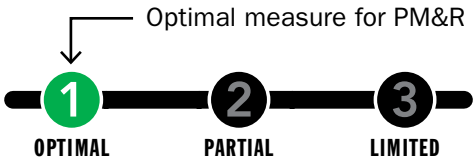
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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 known prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosages, frequency and route of administration

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

92541, 92542, 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

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Patient Safety

### TYPE OF MEASURE

Individual, Electronic Clinical Quality Measure (CQM) or Crosscutting

### REPORTING METHOD(S)

Claims, Registry, Direct EHR Vendor / Data Submission Vendor or GPRO Web Interface

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS Resources:

- **2015 EHR-Based Reporting Made Simple**
- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **2015 GPRO Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record – National Quality Strategy Domain: Patient Safety

**2015 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, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97001, 97002, 97003, 97004, 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 known 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, herbals 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**

***Performance Met:*** **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**

***Other Performance Exclusion:*** **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**

***Performance Not Met:*** **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 were $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million visit related ADEs (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).

A Systematic Review on “Prevalence of Adverse Drug Events in Ambulatory Care” finds that “The median ADE prevalence rate for retrospective studies was 3.3% (interquartile range [IQR] 2.3–7.1%) vs 9.65% (IQR 3.3–17.35%) for prospective studies. Median preventable ADE rates in ambulatory care-based studies were 16.5%, and 52.9% for hospital-based studies. Median prevalence rates by age group ranged from 2.45% for children to 5.27% for adults, 16.1% for elderly patients, and 3.45% for studies including all ages (Tache et al., 2011)”.

The Agency for Healthcare Research and Quality’s (AHRQ) The National Healthcare Disparities Report (2011) 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 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 2014 Ambulatory Care National Patient Safety Goals guide providers to maintain and communicate accurate patient medication information. Specifically, the section “Use Medicines Safely NPSG.03.06.01” includes the following: “Record and pass along correct information about a patient’s medicines. Find out what medicines the patient is taking. Compare those medicines to new medicines given to the patient. Make sure

the patient knows which medicines to take when they are at home. Tell the patient it is important to bring their up-to-date list of medicines every time they visit a doctor".

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.

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# PQRS MEASURE 131

## Pain Assessment and Follow-Up

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter

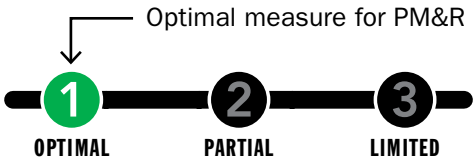
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Community / Population Health

### TYPE OF MEASURE

Individual or Crosscutting Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #131 (NQF 0420): Pain Assessment and Follow-Up – National Quality Strategy Domain: Community/Population Health*

*Please note that PQRS 131 is incorrectly listed under the Communication and Care Coordination domain in the CY 2015 PFS Final Rule. PQRS 131 was finalized in the CY 2013 PFS Final Rule under the Community and Population Health domain and will therefore remain under the Community and Population Health domain for 2015

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURE:**
**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, 96151, 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

**Definitions:**

**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 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)*

**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)*
***Performance Met*: 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**
***Performance Met*: 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)*
***Other Performance Exclusion*: 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**
***Other Performance Exclusion:* 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)*
***Performance Not Met*: G8732:** **No** documentation of pain assessment, reason not given

**OR**

**Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given**

***Performance Not Met*: 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:

- Approximately 76.5 million Americans suffer 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).

Medical Expenditures Panel (MEP) data from 2000-2007 show that prevalence of back pain has increased by 29% and chronic back pain has increased 64%. Inflation adjusted ($2010) biennial expenditures on ambulatory services for chronic back pain increased by 129% from $15.6 billion in 2000-2001 to $35.7 billion in 2006-2007 (Smith, 2013).

Chronic pain is defined as pain without biological values that has persisted beyond the normal time and despite the usual customary efforts to diagnose and treat the original condition and injury. 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, 2013).

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 (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, Weimer 2013). 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 (Burgess, 2013; 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 (eg, acute, chronic, cancer-related) and medical settings (eg, 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 biopsychosocial factors, as well as spiritual and cultural issues. It is important to have an interdisciplinary team approach which includes the primary care physician and specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2013) Assessment and Management of Chronic Pain Guideline, Sixth Edition is based on a very broad foundation of evidence addressing a wide range of clinical conditions. It was chosen because it addresses the key factors of the comprehensive plan of care which incorporates self-management and active input from the patient and primary care clinician, pain assessment outcomes and referral to a pain medicine specialist or pain medicine specialty clinic.

The Institute for Clinical Systems Improvement (ICSI, 2012) Adult Acute and Sub-acute Low Back Pain guideline provides guidelines for physical therapists for low back pain assessment criteria, reducing or eliminating imaging for diagnosis of non-specific low back pain in patients 18 years and older, first-line treatment which emphasizes patient education and a core treatment plan that includes encouraging activity, use of heat, no imaging, cautious and responsible use of opioids, anti-inflammatory and analgesic over-the-counter medications and return to work assessment, advising patients with acute or subacute low back pain to stay active and the use of opioids.

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.

“Initial physical therapy management was not associated with increased health care costs or utilization of specific services following a new primary care LBP consultation” (Fritz, 2013, p. 1).

# PQRS MEASURE 134 EMEASURE ID #2

## Screening for Clinical Depression and Follow-up Plan

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 12 years on date of encounter

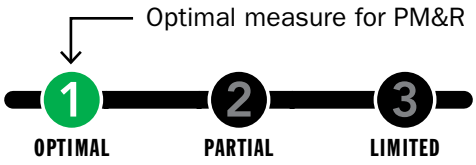
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Community / Population Health

### TYPE OF MEASURE

Individual, Electronic Clinical Quality Measure (CQM) or Crosscutting

### REPORTING METHOD(S)

Claims, Registry, Direct EHR Vendor / Data Submission Vendor or GPRO Web Interface

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS Resources:

- **2015 EHR-Based Reporting Made Simple**
- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **2015 GPRO Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #134 (NQF 0418): Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan – National Quality Strategy Domain: Community/Population Health

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. 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 follow up plan must be related to a positive depression screening, example: "Patient referred for psychiatric evaluation due to positive depression screening".

**Measure Reporting via Claims:**
CPT 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 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 12 years and older

> **Denominator Criteria (Eligible Cases):**
> Patients aged ≥ 12 years on date of encounter
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90839, 92625, 96116, 96118, 96150, 96151, 97003, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439, G0444

**NUMERATOR:**
Patients screened for clinical depression on the date of the encounter using an age appropriate standardized tool AND, if positive, a follow-up plan is documented on the date of the positive screen

> **Numerator Instructions:** The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record. The depression screening must be reviewed and addressed in the office of the provider filing the code on the date of the encounter.
>
> **Definitions:**

**Screening** – Completion of a clinical or diagnostic tool used to identify people at risk of developing or having a certain disease or condition, even in the absence of symptoms.
**Standardized Depression Screening Tool** – A normalized and validated depression screening tool developed for the patient population in which it is being utilized. The name of the age appropriate standardized depression screening tool utilized must be documented in the medical record.
Examples of depression screening tools include but are not limited to:

- **Adolescent Screening Tools (12-17 years)**
  Patient Health Questionnaire for Adolescents (PHQ-A), Beck Depression Inventory-Primary Care Version (BDI-PC), Mood Feeling Questionnaire (MFQ), Center for Epidemiologic Studies Depression Scale (CES-D), and PRIME MD-PHQ2
- **Adult Screening Tools (18 years and older)**
  Patient Health Questionnaire (PHQ-9), Beck Depression Inventory (BDI or BDI-II), Center for Epidemiologic Studies Depression Scale (CES-D), Depression Scale (DEPS), Duke Anxiety-Depression Scale (DADS), Geriatric Depression Scale (GDS), Cornell Scale Screening, and PRIME MD-PHQ2

**Follow-Up Plan** – Documented follow-up for a positive depression screening ***must*** include one or more of the following:

- Additional evaluation for depression
- Suicide Risk Assessment
- Referral to a practitioner who is qualified to diagnose and treat depression
- Pharmacological interventions
- Other interventions or follow-up for the diagnosis or treatment of depression

**Not Eligible** – A patient is **not** eligible if one or more of the following conditions are documented:

- Patient refuses to participate
- 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
- Situations where the patient's functional capacity or motivation to improve may impact the accuracy of results of standardized depression assessment tools. For example: certain court appointed cases or cases of delirium
- Patient has an active diagnosis of Depression
- Patient has a diagnosed Bipolar Disorder

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Screening for Clinical Depression Documented as Positive, AND Follow-Up Plan Documented**
*(One quality-data code [**G8431or G8510**] is required on the claim form to submit this numerator option)*
***Performance Met:*** **G8431:** Screening for clinical depression is documented as being positive AND a follow-up plan is documented

**OR**
**Screening for Clinical Depression Documented as Negative, Follow-Up Plan not Required**
***Performance Met:*** **G8510:** Screening for clinical depression is documented as negative, a follow-up plan is not required

**OR**

**Screening for Clinical Depression not Documented, Patient not Eligible**
*(One quality-data code [**G8433 or G8940**] is required on the claim form to submit this numerator option)*
***Other Performance Exclusion:*** **G8433:** Screening for clinical depression not documented, documentation stating the patient is not eligible

**OR**
**Screening for Clinical Depression Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible**

***Other Performance Exclusion:* G8940:** Screening for clinical depression documented as positive, a follow-up plan not documented, documentation stating the patient is not eligible

**OR**

**Screening for Clinical Depression not Documented, Reason not Given**
*(One quality-data code [**G8432 or G8511**] is required on the claim form to submit this numerator option)*
***Performance Not Met:* G8432:** Clinical depression screening **not** documented, reason not given

**OR**

**Screening for Clinical Depression Documented as Positive, Follow-Up Plan not Documented, Reason not Given**
***Performance Not Met:* G8511:** Screening for clinical depression documented as positive, follow-up plan **not** documented, reason not given

**RATIONALE:**
The World Health Organization (WHO), as seen in Pratt & Brody (2008), found that major depression was the leading cause of disability worldwide. Depression causes suffering, decreases quality of life, and causes impairment in social and occupational functioning. It is associated with increased health care costs as well as with higher rates of many chronic medical conditions. Studies have shown that a higher number of depression symptoms are associated with poor health and impaired functioning, whether or not the criteria for a diagnosis of major depression are met. Persons 40-59 years of age had higher rates of depression than any other age group. Persons 12-17, 18-39 and 60 years of age and older had similar rates of depression. Depression was more common in females than in males. Non-Hispanic black persons had higher rates of depression than non-Hispanic white persons. In the 18-39 and 40-59 age groups, those with income below the federal poverty level had higher rates of depression than those with higher income. Among persons 12-17 and 60 years of age and older, raters of depression did not vary significantly by poverty status. Overall, approximately 80% of persons with depression reported some level of difficulty in functioning because of their depressive symptoms. In addition, 35% of males and 22% of females with depression reported that their depressive symptoms make it very or extremely difficult for them to work, get things done at home, or get along with other people. More than one-half of all persons with mild depressive symptoms also reported some difficulty in daily functioning attributable to their symptoms.

15–20 percent of adults older than age 65 in the United States have experienced depression (Geriatric Mental Health Foundation, 2008). 7 million adults aged 65 years and older are affected by depression (Steinman, 2007). Chronically ill Medicare beneficiaries with accompanying depression have significantly higher health care costs than those with chronic diseases alone (Unützer, 2009). People aged 65 years and older accounted for 16 percent of suicide deaths in 2004 (Centers for Disease Control and Prevention, 2007).

The negative outcomes associated with early onset depression, make it crucial to identify and treat depression in its early stages. As reported in Borner (2010), a study conducted by the World Health Organization (WHO) concluded that in North America, primary care and family physicians are likely to provide the first line of treatment for depressive disorders. Others consistently report a 10% prevalence rate of depression in primary care patients. But studies have shown that primary care physicians fail to recognize up to 50% of depressed patients, purportedly because of time constraints and a lack of brief, sensitive, easy-to administer psychiatric screening instruments. Coyle et al. (2003), suggested that the picture is more grim for adolescents, and that more than 70% of children and adolescents suffering from serious mood disorders go unrecognized or inadequately treated. Healthy People 2020 recommends routine screening for mental health problems as a part of primary care for both children and adults (U.S. Department of Health and Human Services, 2014).

Major depressive disorder (MDD) is a debilitating condition that has been increasingly recognized among youth, particularly adolescents. The prevalence of current or recent depression among children is 3% and among adolescents is 6%. The lifetime prevalence of MDD among adolescents may be as high as 20%. Adolescent-onset

MDD is associated with an increased risk of death by suicide, suicide attempts, and recurrence of major depression by young adulthood. MDD is also associated with early pregnancy, decreased school performance, and impaired work, social, and family functioning during young adulthood (Williams et al., 2009). Every fifth adolescent may have a history of depression by age 18. The increase in the onset of depression occurs around puberty. According to Zalsman et al., (2006) as reported in Borner et al. (2010), depression ranks among the most commonly reported mental health problems in adolescent girls.

The economic burden of depression is substantial for individuals as well as society. Costs to an individual may include suffering, possible side effects from treatment, fees for mental health and medical visits and medications, time away from work and lost wages, transportation, and reduced quality of personal relationships. Costs to society may include loss of life, reduced productivity (because of both diminished capacity while at work and absenteeism from work), and increased costs of mental health and medical care. In 2000, the United States spent an estimated $83.1 billion in direct and indirect costs of depression (USPSTF, 2009).

**CLINICAL RECOMMENDATION STATEMENTS:**

**Adolescent Recommendation (12-18 years)**
The USPSTF recommends screening of adolescents (12-18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up (AHRQ, 2010, p.141).

Clinicians and health care systems should try to consistently screen adolescents ages 12-18 for major depressive disorder, but only when systems are in place to ensure accurate diagnosis, careful selection of treatment, and close follow-up (ICSI, 2013, p.16).

**Adult Recommendation (18 years and older)**
The USPSTF recommends screening adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up (AHRQ, 2010, p.136).

A system that has embedded the elements of best practice and has capacity to effectively manage the volume should consider routine screening of all patients, based on the recommendations of the U.S. Preventive Services Task Force (ICSI, 2013, p.7). Clinicians should use a standardized instrument to screen for depression if it is suspected based on risk factors or presentation. Clinicians should assess and treat for depression in patients with some comorbidities. Clinicians should acknowledge the impact of culture and cultural differences on physician and mental health. Clinicians should screen and monitor depression in pregnant and post-partum women (ICSI, 2013, p.4).

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# PQRS MEASURE 144

## Oncology: Medical and Radiation – Plan of Care for Pain

It is anticipated that **clinicians providing care for patients with cancer** will submit this measure.

### ELIGIBLE PATIENT POPULATION

All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patient visits that included a documented plan of care to address pain

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Person and Caregiver-Centered Experience and Outcomes

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #144 (NQF 0383): Oncology: Medical and Radiation – Plan of Care for Pain – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain

**INSTRUCTIONS:**
This measure is to be reported at **each visit** occurring during the reporting period for patients with a diagnosis of cancer and in which pain is present who are seen during the reporting period. It is anticipated that **clinicians providing care for patients with cancer** will submit this measure.

**Measure Reporting via Registry:**
All eligible instances when patient reports pain for Measure #143 make up the denominator for this measure. 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 visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

**Denominator Criteria (Eligible Cases):**
All eligible instances when pain severity quantified; pain present **(1125F)** is reported in the numerator for Measure #143
**AND**
**Diagnosis for cancer (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9, 160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.00, 173.01, 173.02, 173.09, 173.10, 173.11, 173.12, 173.19, 173.20, 173.21, 173.22, 173.29, 173.30, 173.31, 173.32, 173.39, 173.40, 173.41, 173.42, 173.49, 173.50, 173.51, 173.52, 173.59, 173.60, 173.61, 173.62, 173.69, 173.70, 173.71, 173.72, 173.79, 173.80, 173.81, 173.82, 173.89, 173.90, 173.91, 173.92, 173.99, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4,

188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 199.2, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48, 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57, 201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.02, 203.10, 203.11, 203.12, 203.80, 203.81, 203.82, 204.00, 204.01, 204.02, 204.10, 204.11, 204.12, 204.20, 204.21, 204.22, 204.80, 204.81, 204.82, 204.90, 204.91, 204.92, 205.00, 205.01, 205.02, 205.10, 205.11, 205.12, 205.20, 205.21, 205.22, 205.30, 205.31, 205.32, 205.80, 205.81, 205.82, 205.90, 205.91, 205.92, 206.00, 206.01, 206.02, 206.10, 206.11, 206.12, 206.20, 206.21, 206.22, 206.80, 206.81, 206.82, 206.90, 206.91, 206.92, 207.00, 207.01, 207.02, 207.10, 207.11, 207.12, 207.20, 207.21, 207.22, 207.80, 207.81, 207.82, 208.00, 208.01, 208.02, 208.10, 208.11, 208.12, 208.20, 208.21, 208.22, 208.80, 208.81, 208.82, 208.90, 208.91, 208.92, 209.00, 209.01, 209.02, 209.03, 209.10, 209.11, 209.12, 209.13, 209.14, 209.15, 209.16, 209.17, 209.20, 209.21, 209.22, 209.23, 209.24, 209.25, 209.26, 209.27, 209.29, 209.30, 209.31, 209.32, 209.33, 209.34, 209.35, 209.36, 209.70, 209.71, 209.72, 209.73, 209.74, 209.75, 209.79, 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.73, 237.79, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.77, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.81, 239.89, 239.9

**Diagnosis for cancer (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C14.0, C14.2, C14.8, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C24.8, C24.9, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C26.0, C26.1, C26.9, C30.0, C30.1, C31.0, C31.1, C31.2, C31.3, C31.8, C31.9, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C39.0, C39.9, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30,

C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C45.7, C45.9, C46.0, C46.1, C46.2, C46.3, C46.4, C46.50, C46.51, C46.52, C46.7, C46.9, C47.0, C47.10, C47.11, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11, C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C51.8, C51.9, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C57.10, C57.11, C57.12, C57.20, C57.21, C57.22, C57.3, C57.4, C57.7, C57.8, C57.9, C58, C60.0, C60.1, C60.2, C60.8, C60.9, C61, C62.00, C62.01, C62.02, C62.10, C62.11, C62.12, C62.90, C62.91, C62.92, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C63.7, C63.8, C63.9, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C68.1, C68.8, C68.9, C69.00, C69.01, C69.02, C69.10, C69.11, C69.12, C69.20, C69.21, C69.22, C69.30, C69.31, C69.32, C69.40, C69.41, C69.42, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C69.80, C69.81, C69.82, C69.90, C69.91, C69.92, C70.0, C70.1, C70.9, C71.0, C71.1, C71.2, C71.3, C71.4, C71.5, C71.6, C71.7, C71.8, C71.9, C72.0, C72.1, C72.20, C72.21, C72.22, C72.30, C72.31, C72.32, C72.40, C72.41, C72.42, C72.50, C72.59, C72.9, C73, C74.00, C74.01, C74.02, C74.10, C74.11, C74.12, C74.90, C74.91, C74.92, C75.0, C75.1, C75.2, C75.3, C75.4, C75.5, C75.8, C75.9, C76.0, C76.1, C76.2, C76.3, C76.40, C76.41, C76.42, C76.50, C76.51, C76.52, C76.8, C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C7B.00, C7B.01, C7B.02, C7B.03, C7B.04, C7B.09, C7B.1, C7B.8, C80.0, C80.1, C80.2, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66,

C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.00, C83.01, C83.02, C83.03, C83.04, C83.05, C83.06, C83.07, C83.08, C83.09, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.30, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.50, C83.51, C83.52, C83.53, C83.54, C83.55, C83.56, C83.57, C83.58, C83.59, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C83.90, C83.91, C83.92, C83.93, C83.94, C83.95, C83.96, C83.97, C83.98, C83.99, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, C90.00, C90.01, C90.02, C90.10, C90.11, C90.12, C90.20, C90.21, C90.22, C90.30, C90.31, C90.32, C91.00, C91.01, C91.02, C91.10, C91.11, C91.12, C91.30, C91.31, C91.32, C91.40, C91.41, C91.42, C91.50, C91.51, C91.52, C91.60, C91.61, C91.62, C91.90, C91.91, C91.92, C91.A0, C91.A1, C91.A2, C91.Z0, C91.Z1, C91.Z2, C92.00, C92.01, C92.02, C92.10, C92.11, C92.12, C92.20, C92.21, C92.22, C92.30, C92.31, C92.32, C92.40, C92.41, C92.42, C92.50, C92.51, C92.52, C92.60, C92.61, C92.62, C92.90, C92.91, C92.92, C92.A0, C92.A1, C92.A2, C92.Z0, C92.Z1, C92.Z2, C93.00, C93.01, C93.02, C93.10, C93.11, C93.12, C93.30, C93.31, C93.32, C93.90, C93.91, C93.92, C93.Z0, C93.Z1, C93.Z2, C94.00, C94.01, C94.02, C94.20, C94.21, C94.22, C94.30, C94.31, C94.32, C94.40, C94.41, C94.42, C94.6, C94.80, C94.81, C94.82, C95.00, C95.01, C95.02, C95.10, C95.11, C95.12, C95.90, C95.91, C95.92, C96.0, C96.2, C96.4, C96.5, C96.6, C96.9, C96.A, C96.Z, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8, D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D45, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.A, D46.B, D46.C, D46.Z, D47.0, D47.1, D47.2, D47.3, D47.4, D47.9, D47.Z1, D47.Z9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

**AND**

**Patient encounter during the reporting period (CPT) – Procedure codes:** 77427, 77431, 77432, 77435, 77470

**OR**

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

**AND**

**Patient encounter during the reporting period (CPT) – Procedure codes:** 51720, 96401, 96402, 96405, 96406, 96409, 96413, 96416, 96420, 96422, 96425, 96440, 96446, 96450, 96521, 96522, 96523, 96542, 96549

**NUMERATOR:**

Patient visits that included a documented plan of care to address pain

**Numerator Instructions:** A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

**Numerator Options:**

***Performance Met:*** Plan of care to address pain documented **(0521F)**

**OR**

***Performance Not Met:*** Plan of care for pain **not** documented, reason not otherwise specified **(0521F *with* 8P)**

**RATIONALE:**

Inadequate cancer pain management is widely prevalent, harmful to the patient and costly.

**CLINICAL RECOMMENDATION STATEMENTS:**

If the Pain Rating Scale score is above 0, a comprehensive pain assessment is initiated. (NCCN, 2011)

For management of cancer related pain in adults, the algorithm distinguishes three levels of pain intensity, based on a 0-10 numerical value obtained using numerical or the pictorial rating scale (with 0 being no pain to 10 being the worst pain). The three levels of pain intensity listed in the algorithm are mild pain (1-3); moderate pain (4-6); and severe pain (7-10). (NCCN, 2011)

The [NCCN] guidelines acknowledge the range of complex decisions faced in caring for these patients. As a result, they provide dosing guidelines for opioids, non-opioid analgesics, and adjuvant analgesics. They also provide specific suggestions for titrating and rotating opioids, escalation of opioid dosage, management of opioid adverse effects, and when and how to proceed to other techniques/interventions for the management of cancer pain. (NCCN, 2011)

Treatment must be individualized based on clinical circumstances and patient wishes, with the goal of maximizing function and quality of life. (NCCN, 2011)

Clinicians must respond to pain reports in a manner appropriate to the type of pain (eg, acute vs. chronic) and setting (eg, inpatient vs. outpatient)… Appropriate responses may not always include more opioids but rather more detailed assessments, use of nonopioid analgesics or techniques, or non-pharmacologic interventions (eg, education, relaxation, and use of heat or cold). (APS, 2005)

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# PQRS MEASURE 145

## Radiology: Exposure Time Reported for Procedures Using Fluoroscopy

It is anticipated that **clinicians providing the services for procedures using fluoroscopy** will submit this measure.

### ELIGIBLE PATIENT POPULATION

All final reports for procedures using fluoroscopy.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time.

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

62263, 62264, 62280, 62281, 62282, 63610, 64610, 64620, 77002, 77003

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Patient Safety

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #145 (NQF 0510): Radiology: Exposure Time Reported for Procedures Using Fluoroscopy – National Quality Strategy Domain: Patient Safety

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

**INSTRUCTIONS:**
This measure is to be reported **each time** fluoroscopy is performed in a hospital or outpatient setting during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians providing the services for procedures using fluoroscopy** will submit this measure.

**Measure Reporting via Claims:**
CPT or HCPCS codes 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 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:**
CPT or HCPCS codes 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 final reports for procedures using fluoroscopy

**Denominator Criteria (Eligible Cases):**
**Patient encounter during the reporting period (CPT or HCPCS):**
0075T, 0234T, 0235T, 0 236T, 0237T, 0238T, 0338T, 0339T, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27235, 27244, 27245, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 36147, 36221, 36222, 36223, 36224, 36225, 36226, 36251, 36252, 36253, 36254, 36598, 37182, 37183, 37184, 37187, 37188, 37211, 37212, 37213, 37214, 37215, 37217, 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37233, 37234, 37235, 37236, 37238, 37241, 37242, 37243, 37244, 43260, 43261, 43262, 43263, 43264, 43265, 43275, 43276, 43277, 43278, 43752, 44500, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465, 50382, 50384, 50385, 50386, 50387, 50389, 50590, 61623, 61630, 61635, 62263, 62264, 62280, 62281, 62282, 63610, 64610, 64620, 70010, 70015, 70170, 70332, 70370, 70371, 70373, 70390, 71023, 71034, 72240, 72255, 72265, 72270, 72275, 72285, 72295, 73040, 73085, 73115, 73525, 73580, 73615, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74300, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74430, 74440, 74445, 74450, 74455, 74470, 74475, 74480, 74485, 74740, 74742, 75600, 75605, 75625, 75630, 75658, 75705, 75710, 75716, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75791, 75801, 75803, 75805, 75807, 75809, 75810, 75825, 75827, 75831, 75833, 75840, 75842, 75860, 75870, 75872, 75880, 75885, 75887, 75889, 75891, 75893, 75894, 75896, 75898, 75901

75902, 75952, 75953, 75954, 75956, 75957, 75958, 75959, 75962, 75966, 75970, 75978, 75980, 75982, 75984, 76000, 76001, 76080, 76120, 76496, 77001, 77002, 77003, 92611, 93565, 93566, 93567, 93568, G0106, G0120, G0278

**NUMERATOR:**
Final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Radiation Exposure or Exposure Time Documented in Final Procedure Report**
***Performance Met:* CPT II 6045F:** Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented

**OR**

**Radiation Exposure or Exposure Time not Documented in Final Procedure Report, Reason not Otherwise Specified**
Append a reporting modifier (**8P**) to CPT Category II code **6045F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
***Performance Not Met:* 6045F *with* 8P:** Radiation exposure or exposure time **not** documented in final report for procedure using fluoroscopy, reason not otherwise specified

**RATIONALE:**
Increasing physician awareness of patient exposure to radiation is an important step towards reducing the potentially harmful effects of radiation as a result of imaging studies. One study by Darling et al found a significant correlation between documentation of fluoroscopy time by the radiologist in the dictated radiology report and reduced overall fluoroscopy time. Additional studies demonstrate that providing physicians with feedback regarding their fluoroscopy time leads to a reduction in average fluoroscopy times.

**CLINICAL RECOMMENDATION STATEMENTS:**
All available radiation dose data should be recorded in the patient's medical record. If cumulative air kerma or air kerma-area-product data are not available, the fluoroscopic exposure time and the number of acquired images (radiography, cine, or digital subtraction angiography) should be recorded in the patient's medical record. (ACR, 2013)

For the present, and for the purpose of this guideline, adequate recording of dose metrics is defined as documentation in the patient record of at least one of the following for all interventional procedures requiring fluoroscopy (in descending order of desirability): skin dose mapping, PSD, Ka,r, PKA, and fluoroscopic time/number of fluorographic images. Note, however, that this is adequate recording; this document recommends recording of all available dose metrics. (SIR, 2012)

[ACR] should now encourage practices to record actual fluoroscopy time for all fluoroscopic procedures. The fluoroscopy time for various procedures (eg, upper gastrointestinal, pediatric voiding cystourethrography, diagnostic angiography) should then be compared with benchmark figures…More complete patient radiation dose data should be recorded for all high-dose interventional procedures, such as embolizations, transjugular intrahepatic portosystemic shunts, and arterial angioplasty or stent placement anywhere in the abdomen and pelvis. (Amis et al., ACR, 2007)

Measure & record patient radiation dose:

- Record fluoroscopy time
- Record available measures - DAP (dose area product), cumulative dose, skin dose (NCI, 2005)

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# PQRS MEASURE 154

## Falls: Risk Assessment

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 65 years on date of encounter 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). Documentation of patient reported history of falls is sufficient.

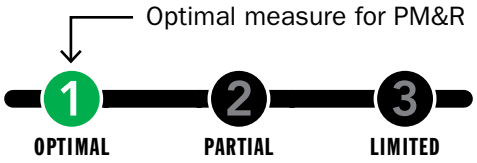
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

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

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Patient Safety

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #154 (NQF: 0101): Falls: Risk Assessment – National Quality Strategy Domain: Patient Safety

**2015 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 that 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). Documentation of patient reported history of falls is sufficient.

**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)*
**Performance Met:**

| | |
|---|---|
| **CPT II 3288F:** | Falls risk assessment documented |
| **AND** | |
| **CPT II 1100F:** | Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year |

**OR**

**Risk Assessment for Falls not Completed for Medical Reasons**
*(Two CPT II codes [**3288F-1P & 1100F**] are required on the claim form to submit this numerator option)*
Append a modifier (**1P**) to CPT Category II code **3288F** to report documented circumstances that appropriately exclude patients from the denominator.
**Medical Performance Exclusion:**

| | |
|---|---|
| **3288F *with* 1P:** | Documentation of medical reason(s) for not completing a risk assessment for falls (ie, patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair) |
| **AND** | |
| **CPT II 1100F**: | Patient screened for future fall risk; documentation of two or more falls in the past year or any fall with injury in the past year |

**OR**

**If patient is not eligible for this measure because patient has documentation of no falls or only one fall without injury the past year, report:**
**Patient not at Risk for Falls**
*(One CPT II code [**1101F**] is required on the claim form to submit this numerator option)*

| | |
|---|---|
| **Other Performance Exclusion: 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.
**Other Performance Exclusion: 1101F *with* 8P:** No documentation of falls status

**OR**

**Risk Assessment for Falls not Completed, Reason not Otherwise Specified**
*(Two CPT II codes [**3288F-8P & 1100F**] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 3288F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified**.**
***Performance Not Met:***

| | |
|---|---|
| **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)

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# PQRS MEASURE 155

## Falls: Plan of Care

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 65 years on date of encounter 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). Documentation of patient reported history of falls is sufficient.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

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

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Communication and Care Coordination

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #155 (NQF: 0101): Falls: Plan of Care – National Quality Strategy Domain: Communication and Care Coordination

**2015 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 that 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). Documentation of patient reported history of falls is sufficient.

> **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**
**Performance Met:**
**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.
***Medical Performance Exclusion:* 0518F *with* 1P:** Documentation of medical reason(s) for no plan of care for falls (ie, patient is not ambulatory, bed ridden, immobile, confined to chair, wheelchair bound, dependent on helper pushing wheelchair, independent in wheelchair or minimal help in wheelchair)

**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.
***Performance Not Met:* 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]

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# PQRS MEASURE 163 EMEASURE ID #123

## Diabetes: Foot Exam

### ELIGIBLE PATIENT POPULATION

All patients 18 through 75 years of age on date of encounter who had a diagnosis of diabetes with a visit during the measurement period

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

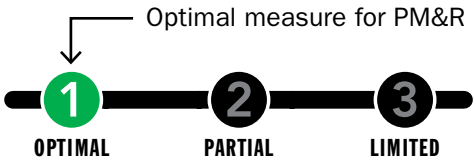
Patients who received a foot exam (ie, visual inspection, sensory exam with monofilament **AND** pulse exam) during the measurement period

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, *99217, *99218, *99219, *99221, *99222, *99223, *99231, *99232, *99233, *99238, *99239, 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

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual or Electronic Clinical Quality Measure (CQM) Measure

### REPORTING METHOD(S)

Claims, Registry or Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS Resources:

- **2015 EHR-Based Reporting Made Simple**
- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #163 (NQF 0056): Diabetes: Foot Exam – National Quality Strategy Domain: Effective Clinical Care

**2015 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 01/1/2015-09/30/2015]:** 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
**Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** E10.8, E10.9, E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.65, E11.69, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

**AND**

**Patient encounter during the reporting period (CPT or HCPCS):** 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, G0402, G0438, G0439

**NUMERATOR:**

Patients who received a foot exam (ie, visual inspection, sensory exam with monofilament **AND** pulse exam) during the measurement period

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

**Foot Exam Performed**

| | |
|---|---|
| ***Performance Met:*** **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, Reason not Given**

| | |
|---|---|
| ***Performance Not Met:*** **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).

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# PQRS MEASURE 173

## Preventive Care and Screening: Unhealthy Alcohol Use – Screening

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Community/Population Health

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry Only

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #173: Preventive Care and Screening: Unhealthy Alcohol Use – Screening – National Quality Strategy Domain: Community/Population Health

**20154 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for all patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 18 years and older were screened for unhealthy alcohol use within 24 months. There is no diagnosis associated with this measure. 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 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, 90845, 96150, 96151, 96152, 97003, 97004, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271, G0438, G0439

**NUMERATOR:**
Patients who were screened for unhealthy alcohol use at least once within 24 months using a systematic screening method

**Definition:**
**Unhealthy Alcohol Use** – Covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as > 7 standard drinks per week or > 3 drinks per occasion for women and persons > 65 years of age; > 14 standard drinks per week or > 4 drinks per occasion for men ≤ 65 years of age.
**Systematic Screening Method** – A systematic method of assessing for unhealthy alcohol use should be utilized. Systemic screening methods include but are not limited to:

- AUDIT Screening Instrument
- AUDIT-C Screening Instrument
- Single Question Screening

Alternative approaches may also include questions regarding quantity/frequency of consumption (ie, drinks per week or drinks per occasion).

**Numerator Options:**

***Performance Met:*** Patient screened for unhealthy alcohol use using a systematic screening method **(3016F)**

**OR**

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

**OR**

***Performance Not Met:*** Unhealthy alcohol use screening **not** performed, reason not otherwise specified **(3016F *with* 8P)**

**RATIONALE:**

Screening for unhealthy alcohol use can identify patients whose habits may put them at risk for adverse health outcomes due to their alcohol use. While this measure does not require counseling for those patients to be found at risk, brief counseling interventions for unhealthy alcohol use have shown to be effective in reducing alcohol use. It would be expected that if a provider found their patient to be at risk after screening that intervention would be provided.

A systematic method of assessing for unhealthy alcohol use should be utilized. Please refer to the National Institute on Alcohol Abuse and Alcoholism publication: *Helping Patients Who Drink Too Much: A Clinician's Guide* for additional information regarding systematic screening methods.

**CLINICAL RECOMMENDATION STATEMENTS:**

The USPSTF recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. (B Recommendation) (USPSTF, 2013)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

All patients identified with alcohol use in excess of National Institute on Alcohol Abuse and Alcoholism guidelines and/or any tobacco use should receive brief motivational counseling intervention by a healthcare worker trained in this technique. (NQF, 2007)

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# PQRS MEASURE 178

## Rheumatoid Arthritis (RA): Functional Status Assessment

It is anticipated that **clinicians who provide care for patients with a diagnosis of RA** will submit this measure.

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter with a diagnosis of RA

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

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

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry Only

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #178: Rheumatoid Arthritis (RA): Functional Status Assessment – National Quality Strategy Domain: Effective Clinical Care

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of patients aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) for whom a functional status assessment was performed at least once within 12 months

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for patients with RA seen during the reporting period. It is anticipated that **clinicians who provide care for patients with a diagnosis of RA** will submit this measure.

**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 years and older with a diagnosis of RA

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 18 years on date of encounter
**AND**
**Diagnosis for rheumatoid arthritis (RA) (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 714.0, 714.1, 714.2, 714.81
**Diagnosis for rheumatoid arthritis (RA) (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** M05.00, M05.011, M05.012, M05.019, M05.021, M05.022, M05.029, M05.031, M05.032, M05.039, M05.041, M05.042, M05.049, M05.051, M05.052, M05.059, M05.061, M05.062, M05.069, M05.071, M05.072, M05.079, M05.09, M05.10, M05.111, M05.112, M05.119, M05.121, M05.122, M05.129, M05.131, M05.132, M05.139, M05.141, M05.142, M05.149, M05.151, M05.152, M05.159, M05.161, M05.162, M05.169, M05.171, M05.172, M05.179, M05.19, M05.20, M05.211, M05.212, M05.219, M05.221, M05.222, M05.229, M05.231, M05.232, M05.239, M05.241, M05.242, M05.249, M05.251, M05.252, M05.259, M05.261, M05.262, M05.269, M05.271, M05.272, M05.279, M05.29, M05.30, M05.311, M05.312, M05.319, M05.321, M05.322, M05.329, M05.331, M05.332, M05.339, M05.341, M05.342, M05.349, M05.351, M05.352, M05.359, M05.361, M05.362, M05.369, M05.371, M05.372, M05.379, M05.39, M05.40, M05.411, M05.412, M05.419, M05.421, M05.422, M05.429, M05.431, M05.432, M05.439, M05.441, M05.442, M05.449, M05.451, M05.452, M05.459, M05.461, M05.462, M05.469, M05.471, M05.472, M05.479, M05.49, M05.50, M05.511, M05.512, M05.519, M05.521, M05.522, M05.529, M05.531, M05.532, M05.539, M05.541, M05.542, M05.549, M05.551, M05.552, M05.559, M05.561, M05.562, M05.569, M05.571, M05.572, M05.579, M05.59, M05.60, M05.611, M05.612, M05.619, M05.621, M05.622, M05.629, M05.631, M05.632, M05.639, M05.641, M05.642, M05.649, M05.651, M05.652, M05.659, M05.661, M05.662, M05.669, M05.671, M05.672, M05.679, M05.69, M05.70, M05.711, M05.712, M05.719, M05.721, M05.722, M05.729, M05.731, M05.732, M05.739, M05.741, M05.742, M05.749, M05.751, M05.752, M05.759, M05.761, M05.762, M05.769, M05.771, M05.772, M05.779, M05.79, M05.80, M05.811, M05.812, M05.819, M05.821,

M05.822, M05.829, M05.831, M05.832, M05.839, M05.841, M05.842, M05.849, M05.851, M05.852, M05.859, M05.861, M05.862, M05.869, M05.871, M05.872, M05.879, M05.89, M05.9, M06.00, M06.011, M06.012, M06.019, M06.021, M06.022, M06.029, M06.031, M06.032, M06.039, M06.041, M06.042, M06.049, M06.051, M06.052, M06.059, M06.061, M06.062, M06.069, M06.071, M06.072, M06.079, M06.08, M06.09, M06.1, M06.30, M06.311, M06.312, M06.319, M06.321, M06.322, M06.329, M06.331, M06.332, M06.339, M06.341, M06.342, M06.349, M06.351, M06.352, M06.359, M06.361, M06.362, M06.369, M06.371, M06.372, M06.379, M06.38, M06.39, M06.80, M06.811, M06.812, M06.819, M06.821, M06.822, M06.829, M06.831, M06.832, M06.839, M06.841, M06.842, M06.849, M06.851, M06.852, M06.859, M06.861, M06.862, M06.869, M06.871, M06.872, M06.879, M06.88, M06.89, M06.9

**AND**

**Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

**NUMERATOR:**

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

**Definitions:**

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

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

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

**Functional Status Assessed**

| | |
|---|---|
| ***Performance Met:*** | Functional status assessed(**1170F)** |

**OR**

| | |
|---|---|
| ***Performance Not Met:*** | Functional status **not** assessed, reason not otherwise specified (**1170F *with* 8P)** |

**RATIONALE:**

Functional limitations are a significant and disruptive complication for patients living with RA. Assessments of functional limitations are used to assess prognosis and guide treatment and therapy decisions. Functional status should be assessed at the baseline and each follow-up visit, using questionnaires such as the ACR's Classification of Functional Status in RA or the Health Assessment Questionnaire or an assessment of activities of daily living. Regardless of the assessment tool used, it should indicate whether a functional decline is due to inflammation, mechanical damage, or both, as treatment strategies will vary accordingly.

**CLINICAL RECOMMENDATION STATEMENTS:**

The management of RA is an iterative process, and patients should be periodically reassessed for evidence of disease or limitation of function with significant alteration of joint anatomy. Baseline evaluation of disease activity and damage in patients with rheumatoid arthritis through evaluation of functional status or quality of life assessments using standardized questionnaires, a physician's global assessment of disease activity, or patient's global assessment of disease activity. The initial evaluation of the patient with RA should document symptoms of active disease (ie, presence of joint pain, duration of morning stiffness, degree of fatigue), functional status, objective evidence of disease activity (ie, synovitis, as assessed by tender and swollen joint counts, and the ESR or CRP level), and mechanical joint problems.

At each follow up visit, the physician must assess whether the disease is active or inactive. Symptoms of inflammatory (as contrasted with mechanical) joint disease, which include prolonged morning stiffness, duration of fatigue, and active synovitis on joint examination, indicate active disease and necessitate consideration of changing the treatment program. Occasionally, findings of the joint examination alone may not adequately reflect disease activity and structural damage; therefore, periodic measurements of the ESR or CRP level and functional status, as well as radiographic examinations of involved joints should be performed. It is important to determine whether a decline in function is the result of inflammation, mechanical damage, or both; treatment strategies will differ accordingly. (ACR, 2002)

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# PQRS MEASURE 181

## Elder Maltreatment Screen and Follow-Up Plan

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 65 years on date of encounter

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of the encounter and follow-up plan documented on the date of the positive screen

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Patient Safety

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #181: Elder Maltreatment Screen and Follow-Up Plan – National Quality Strategy Domain: Patient Safety

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of patients aged 65 years and older with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of encounter AND a documented follow-up plan on the date of the positive screen

**INSTRUCTIONS:**
This measure is to be reported **once during the reporting period** for patients seen during the reporting period. 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 at the time of the qualifying visit. The documented follow up plan must be related to positive elder maltreatment screening, example: "Patient referred for protective services due to positive elder maltreatment screening". Cognitively impaired patients are included in the denominator of this measure and need to be screened using an elder maltreatment screening tool.

**Measure Reporting via Claims:**
CPT 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 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

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 65 years on date of encounter
**AND**
**Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 96116, 96150, 96151, 97003, 97802, 97803, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0270, G0402, G0438, G0439

**NUMERATOR:**
Patients with a documented elder maltreatment screen using an Elder Maltreatment Screening tool on the date of the encounter and follow-up plan documented on the date of the positive screen

**Definitions:**
**Screen for Elder Maltreatment** – An elder maltreatment screen should include assessment and documentation of one or more of the following components: (1) physical abuse, (2) emotional or

psychological abuse, (3) neglect (active or passive), (4) sexual abuse, (5) abandonment, (6) financial or material exploitation and (7) unwarranted control.
**Physical Abuse** – Infliction of physical injury by punching, beating, kicking, biting, burning, shaking, or other actions that result in harm.
**Emotional or Psychological Abuse** – Involves psychological abuse, verbal abuse, or mental injury and includes acts or omissions by loved ones or caregivers that have caused or could cause serious behavioral, cognitive, emotional, or mental disorders.
**Neglect** – Involves attitudes of others or actions caused by others-such as family members, friends, or institutional caregivers-that have an extremely detrimental effect upon well-being.

- **Active** – Behavior that is willful or when the caregiver intentionally withholds care or necessities. The neglect may be motivated by financial gain or reflect interpersonal conflicts.
- **Passive** – Situations where the caregiver is unable to fulfill his or her care giving responsibilities as a result of illness, disability, stress, ignorance, lack of maturity, or lack of resources.

**Sexual Abuse** –Forcing of undesired sexual behavior by one person upon another against their will who are either competent or unable to fully comprehend and/or give consent. This may also be called molestation.
**Elder Abandonment** – Desertion of an elderly person by an individual who has assumed responsibility for providing care for an elder, or by a person with physical custody of an elder.
**Financial or Material Exploitation** – Taking advantage of a person for monetary gain or profit.
**Unwarranted Control** – Controlling a person's ability to make choices about living situations, household finances, and medical care.

**Note:** *Self-neglect is a prevalent form of abuse in the elderly population. Screening for self-neglect is not included in this measure. Resources for suspected self-neglect are listed below.*

**Follow-Up Plan** – Must include a documented report to state or local Adult Protective Services (APS) agency. Note: **APS does not have jurisdiction in all states to investigate maltreatment of patients in long-term care facilities. In those states where APS does not have jurisdiction, APS may refer the provider to another state agency - such as the state facility licensure agency – for appropriate reporting.** *Federal reporting: In addition to state requirements, some types of providers are required by federal law to report suspected maltreatment. For example, nursing facilities certified by Medicare and/or Medicaid are required to report suspected maltreatment to the applicable State Survey and Certification Agency.*
For state-specific information to report suspected elder maltreatment, including self-neglect, the following resources are available:

1) National Adult Protective Services Association - http://www.napsa-now.org/get-help/help-in-your-area/
2) Eldercare Locater - 1-800-677-1116 http://www.eldercare.gov
3) National Center on Elder Abuse

http://www.ncea.aoa.gov/NCEAroot/Main_Site/Find_Help/State_Resources.aspx

**Disclaimer:** The follow-up plan recommendations set forth in this quality measure are not intended to supersede any mandatory state, local or federal reporting requirements.

**Not Eligible** – A patient is not eligible if one or more of the following reasons is documented:

- Patient refuses to participate and has reasonable decisional capacity for self-protection
- 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 NOTE:*** *Documentation of an elder maltreatment screening must include identification of the tool used. Examples of screening tools for elder maltreatment include, but are not limited to: Elder Abuse Suspicion Index (EASI), Vulnerability to Abuse Screening Scale (VASS) and Hwalek-Sengstock Elder*

*Abuse Screening Test (H-S/EAST). These tools are psychometrically sound instruments with demonstrated reliability and validity indices.*

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

**Elder Maltreatment Screen Documented as Positive AND Follow-Up Plan Documented**
*(One quality-data code [**G8733 or G8734**] is required on the claim form to submit this numerator option)*
***Performance Met:*** **G8733:** Elder maltreatment screen documented as positive AND a follow-up plan is documented

**OR**

**Elder Maltreatment Screen Documented as Negative, Follow-Up Plan not Required**
***Performance Met:*** **G8734:** Elder maltreatment screen documented as negative, follow-up is not required

**OR**

**Elder Maltreatment Screen not Documented, Patient not Eligible**
*(One quality-data code [**G8535 or G8941**] is required on the claim form to submit this numerator option)*
***Other Performance Exclusion:*** **G8535:** Elder maltreatment screen not documented; documentation that patient is not eligible for the elder maltreatment screen

**OR**

**Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Patient not Eligible for Follow-Up Plan**
***Other Performance Exclusion:*** **G8941:** Elder maltreatment screen documented as positive, follow-up plan not documented, documentation the patient is not eligible for follow-up plan

**OR**

**Elder Maltreatment Screen not Documented, Reason not Given**
*(One quality-data code [**G8536 or G8735**] is required on the claim form to submit this numerator option)*
***Performance Not Met:*** **G8536:** No documentation of an elder maltreatment screen, reason not given

**OR**

**Elder Maltreatment Screen Documented as Positive, Follow-Up Plan not Documented, Reason not Given**
***Performance Not Met:*** **G8735:** Elder maltreatment screen documented as positive, follow-up plan **not** documented, reason not given

**RATIONALE:**

The Institute of Medicine and the National Research Council of the National Academies: Elder abuse and its prevention: Workshop summary (2013) reports "The association of elder maltreatment with hospitalizations, hospital admissions, and mortality emphasizes the need to explore and expand appropriate measurement and assessment of maltreatment—across multiple settings and provider types" (Mosqueda & Dong, 2011; Dong et al., 2011d, 2012d; Dong, 2012). Research conducted by Bond and Butler (2013) reports "Elder abuse and neglect is estimated to affect approximately 700,000 to 1.2 million elderly people a year with an estimated annual cost of tens of billions of dollars".

"Most cases of elder abuse go unidentified and unreported (Cohen, 2011, p.261). Elder maltreatment is prevalent and occurs predominantly in the community, not in nursing care facilities. One in ten seniors reported being abused, neglected or exploited in the past twelve months; 5.2% for financial abuse, 4.6% for emotional, 1.6% for physical abuse and 0.6% for sexual abuse. Financial exploitation by family members and by strangers was increased among the more physically disabled adults (Aceirno et al., 2010). Elder Abuse and Neglect: In Search of Solutions (2013), reports that every year an estimated 4 million older Americans are victims of physical, psychological, or other forms of abuse and neglect, and for every reported case there may be as many as 23 unreported. Although less prevalent, patients in nursing homes do experience maltreatment.

There are many complex reasons for underreporting; minimal screening, a lack of knowledge and skills for interventions on the part of health care providers, (Cohen, 2011), a society's belief that family matters should not be discussed outside of the family and 'outsiders' should not interfere in a family matter, shame and embarrassment on the part of the victim, language barriers, and financial or emotional dependence on the abuser (APA, 2013). This lack of identifying victims of elder abuse leads to increased rates of emergency room use (Dong, 2013), hospitalization (Dong & Simon, 2013), morbidity (Cohen, 2011), mortality (Dong, et al., 2009) and admission into a nursing home (Lachs et al., 2011). These outcomes are costly. As cited in Dong and Simon (2011), the Government Accounting Office reported spending $11.9 million dollars in 2009 for all activities related to elder abuse and this amount was not enough to provide basic protection for older adults from abuse, neglect and exploitation. It is clear that additional screening, education of victims and health care providers and financial support is needed in order to unveil the depth of the problem and provide aid those who are being abused and neglected.

**CLINICAL RECOMMENDATION STATEMENTS:**

The United States Preventive Services Task Force (USPSTF) (2013) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect (I statement).

Though the USPSTF does not support elder maltreatment screening, it is important to remember that absence of hard evidence supporting screening is not evidence that it is not effective. There have been many qualitative reports that do support the benefits of screening. Expert consensus and public policy for mandatory reporting support the value of screening this vulnerable population.

Although there is a lack of evidence to support screening of all elderly, there is level I evidence (systematic review of the evidence) to support the use of screening tools for assessing the vulnerable elderly population for mistreatment. There is also a level I evidence for developing guidelines for responding to cases of elder maltreatment for the at risk or abuse population (Careces & Fulmer, 2013). Though this population is not harmonious with the denominator of this measure, those at risk are a subset of the total elder population, therefore these recommendations support the structure of this measure.

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# PQRS MEASURE 182

## Functional Outcome Assessment

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter

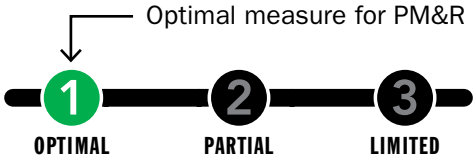
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99701, 99702, 99703, 99704

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Communication and Care Coordination

### TYPE OF MEASURE

Individual or Crosscutting Measure

### REPORTING METHOD(S)

Claims or Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #182: Functional Outcome Assessment – National Quality Strategy Domain: Communication and Care Coordination

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies

**INSTRUCTIONS:**
This measure is to be reported **each visit** for patients seen during the 12 month reporting period. The functional outcome assessment is required to be **current** as defined in the definition section. 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 codes and patient demographics are used to identify patients 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 listed CPT 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 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 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):** 97001, 97002, 97003, 97004, 98940, 98941, 98942

**NUMERATOR:**
Patients with a documented current functional outcome assessment using a standardized tool AND a documented care plan based on the identified functional outcome deficiencies

> **Numerator Instructions:** Documentation of a current functional outcome assessment must include identification of the standardized tool used.
>
> **Definitions:**
> **Standardized Tool** – A tool that has been normalized and validated. Examples of tools for functional outcome assessment include, but are not limited to: Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), Patient-Reported Outcomes

Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).

**Note:** *A functional outcome assessment is multi-dimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does* ***not*** *meet the criteria of a functional outcome assessment standardized tool.*

**Functional Outcome Assessment** – Patient completed questionnaires designed to measure a patient's physical limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.
**Current (Functional Outcome Assessment)** – A patient having a documented functional outcome assessment utilizing a standardized tool and a care plan if indicated within the previous 30 days.
**Functional Outcome Deficiencies** – Impairment or loss of physical function related to musculoskeletal/neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.
**Care Plan** – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient's health care problems. Care plans may also be known as a treatment plan.
**Not Eligible** – A patient is not eligible if one or more of the following reasons(s) is documented:

- Patient refuses to participate
- Patient unable to complete questionnaire
- 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 intent of this measure is for a functional outcome assessment tool to be utilized at a minimum of every 30 days but reporting is required at each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the numerator quality-data code* ***G8942*** *should be used for reporting purposes.*

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
**Functional Outcome Assessment Documented as Positive AND Care Plan Documented**
*(One quality-data code [**G8539 or G8542 or G8942**] is required on the claim form to submit this numerator option)*

| | |
|---|---|
| ***Performance Met:*** **G8539:** | Functional outcome assessment documented as positive using a standardized tool **AND** a care plan based, on identified deficiencies on the date of the functional outcome assessment, is documented |

**OR**
**Functional Outcome Assessment Documented, No Functional Deficiencies Identified, Care Plan not Required**

| | |
|---|---|
| ***Performance Met:*** **G8542:** | Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required |

**OR**
**Functional Outcome Assessment Documented AND Care Plan Documented, if Indicated, Within the Previous 30 Days**

| | |
|---|---|
| ***Performance Met:*** **G8942:** | Functional outcome assessment using a standardized tool is documented within the previous 30 days and |

care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented

**OR**

**Functional Outcome Assessment not Documented, Patient not Eligible**
*(One quality-data code [**G8540 or G9227**] is required on the claim form to submit this numerator option)*
***Other Performance Exclusion:*** **G8540:** Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool

**OR**

**Functional Outcome Assessment Documented, Care Plan not Documented, Patient not Eligible**
***Other Performance Exclusion:*** **G9227:** Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan

**OR**

**Functional Outcome Assessment not Documented, Reason not Given**
*(One quality-data code [**G8541 or G8543**] is required on the claim form to submit this numerator option)*
***Performance Not Met:*** **G8541:** Functional outcome assessment using a standardized tool not documented, reason not given

**OR**

**Functional Outcome Assessment Documented as Positive, Care Plan not Documented, Reason not Given**
***Performance Not Met:*** **G8543:** Documentation of a positive functional outcome assessment using a standardized tool; care plan **not** documented, reason not given

**RATIONALE:**
Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice. Despite the recognition of the importance of outcomes assessments, questionnaires and tools, recent evidence suggests their use in clinical practice is limited. Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by (1) identifying and quantifying body function and structure limitations; (2) formulating the evaluation, diagnosis, and prognosis; (3) informing the plan of care; and (4) helping to evaluate the success of physical therapy interventions (Potter et al., 2011). “The use of standardized tests and measures early in an episode of care establishes the baseline status of the patient/client, providing a means to quantify change in the patient's/client's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care, as part of periodic reexamination, provide information about whether predicted outcomes are being realized” (American Physical Therapy Association (APTA), 2011).

Early in the intervention process, occupational therapists should select outcomes that are valid, reliable, sensitive to change; congruent with client goals and based on their actual or purported ability to predict future outcomes. Outcomes are applied to measure progress and adjust goals and interventions. Results are used to make decisions about future direction of intervention (American Occupational Therapy Association (AOTA), 2014).

“Few outcome measures are routinely used to assess patients with neck pain other than a numeric pain rating scale. A comparison of practice patterns to current evidence suggests overutilization of some measures that have questionable reliability and underutilization of some with better supporting evidence. This practice analysis suggests that there is substantial need to implement more consistent outcome measurement” (MacDermid et al., 2013) (GRADE: Low).

Barriers to use of classification systems and outcome measures were lack of knowledge, too limiting and time. Classification systems are being used for decision-making in physical therapy practice for patients with lower back pain (LBP). Lack of knowledge and training seems to be the main barrier to the use of classification systems in

practice. The Oswestry Disability Index and Numerical Pain Scale were the most commonly used outcome measures. The main barrier to their use was lack of time. Continuing education and reading the literature were identified as important tools to teach evidence-based practice to physical therapists in practice (Davies et al., 2014) (GRADE: Low). Outcome use in occupational therapy indicated that some therapists used both biomechanical and self assessment of function measures in their practice to measure outcomes, but the majority use biomechanical outcomes (Bohnen, 2011).

Musculoskeletal disorders accounted for 6.8% of total Disability-adjusted life years (DALYs) as reported in the Global Burden of Disease Study 2010 (Hoy et al., 2014). Of this large total, low back pain accounted for nearly half, neck pain a fifth, and osteoarthritis about 10% (Murray, 2012). In 2010 the top 15 diseases and risk factors contributing to Disability-adjusted life years (DALYs) are a complex mix of cardiovascular diseases (ischemic heart disease and stroke), musculoskeletal disorder (low back pain, other musculoskeletal disorders, and neck pain), etc. (US Burden of Disease Collaborators, 2013).

In 2010, there were 777 million Years lived with disability (YLDs) from all causes, up from 583 million in 1990. The main contributors to global YLDs were mental and behavioral disorders, musculoskeletal disorders and diabetes or endocrine disorders (Vos et al., 2012). In 2010 the top 8 conditions were the same in 1990 and 2010 for Years lived with disability (YLDs) in the United States: low back pain, major depressive disorder, other musculoskeletal disorders, neck pain, anxiety disorders and diabetes (US Burden of Disease Collaborators, 2013).

One in two adults reports a musculoskeletal condition requiring medical attention. Annual direct and indirect costs for bone and joint health are 950 billion – 7.4% of the gross domestic product. Musculoskeletal disorders and diseases are the leading cause of disability in the United States. Between 1996-1998 and 2004-2006, the number of persons reporting a musculoskeletal disease increased nearly 14 million from 76 million reported in 1996. For the years 2004-2006 the sum of the direct expenditures in health care costs and indirect expenditures in lost wages has been estimated to be $950 billion dollars annually, or 7.4% of the national gross domestic product (Bone and Joint Initiative USA, 2011). Musculoskeletal disorder (MSD) cases (388,060) accounted for 34 percent of all injury and illness cases in 2012. Both the incidence rate and case count remained statistically unchanged from the previous year; however the median days away from work increased by 1 day to a median of 12 days (Bureau of Labor and Statistics, 2013).

Neck Pain is ranked as the 4th greatest contributor to global disability (Hoy et al., 2014). “The annual prevalence of nonspecific neck pain is estimated to range between 30% and 50%. Persistent or recurrent neck pain continues to be reported by 50% to 85% of patients 1 to 5 years after initial onset. Its course is usually episodic, and complete recovery is uncommon for most patients. Twenty-seven percent of patients seeking chiropractic treatment report neck or cervical problems (Bryans et al., 2014)”. “Neck disorders can cause pain and impairments in: joint motion, sensory function, proprioception, motor function, coordination, posture and balance. These can be associated with functional disability, loss of physical activity, loss of work capacity, psychological distress, and impaired quality of life” (MacDermid et al., 2013).

Low back pain is the leading cause of disability globally and was estimated to be responsible for 83 million years lived with a disability in 2010 (Buchbinder et al., 2013). “The majority of individuals with an episode of acute low back pain improve and return to work within the first two weeks. The probability of recurrence within the first year ranges from 30 to 60%. Most of these recurrences will recover in much the same pattern as the initial event. In as many as one-third of the cases, the initial episode of low back pain persists for the next year. Most of these individuals continue to function with only limited impairment” (ICSI, 2012). “ Low back pain symptoms peak between the ages of 40 and 69, are higher among females than males in all age groups, and are more common in affluent countries with high-income. Acute or chronic, LBP can lead to notable functional limitations and disability” (Learman et al., 2014).

“Most of the total cost for low back pain is dedicated to the small percentage of sufferers whose condition has progressed to the chronic disabling stage (pain for more than 12 weeks). The medical costs for low back pain in general were estimated at $26.3 billion in 1998 and now are one-third to one-fourth of the total cost of care. Lost production and disability account for other costs. Disability alone claims 80% of the total expense of this condition.

Expenditures for medical care and disability continue to increase. The human cost is equally significant; low back pain is currently the second most common cause of disability in the United States and is the most common cause of disability in those under age 45 *(Centers for Disease Control and Prevention, 2009)*" (ICSI, 2012).

"Visits to primary care clinicians for low back pain are equally split between chiropractors and allopathic clinicians, with low back pain the fifth most common reason for an office visit to all clinicians. The majority of these visits are not because of pain but rather due to the disability associated with the low back symptoms" (ICSI, 2012).

"Arthritis is considered the leading cause of disability among adults in the United States today and contributes substantially to the rising cost of health care. According to recent results from the 2007 to 2009 National Health Interview Survey, just over 20% of adults have been physician diagnosed with arthritis, and this estimate is projected to reach 25% of adults, or 67 million by 2030. Affected most is the growing aging population that currently represents about 13% of the total US population, with this figure expected to increase over the next 2 decades to 19%, or 72 million persons. In rural (nonmetropolitan) areas, the elderly, approximately 15% of the rural population or 7.5 million persons, are especially affected, with evidence suggesting that these individuals experience higher rates of arthritis and comorbid conditions, poorer health status, greater poverty, and less access to medical care. Total attributable costs for arthritis in 2003 were US $128 billion, with direct costs estimated at $81 billion and indirect costs at $47 billion. In addition, arthritis accounted for 3% of all hospitalizations and 5% of all ambulatory care visits in 2004 related to a primary diagnosis of arthritis. Costs related to pharmaceutical use for arthritis were estimated at more than $75 billion in 2003 compared with $33 billion in 1997" (Enyinnaya et al., 2012).

"Osteoarthritis (OA) is the most frequently diagnosed form of arthritis among the elderly and contributes substantially to their associated disability" (Enyinnaya et al., 2012). "Knee OA affects 28% of adults older than 45 years and 37% of adults older than 65 years in the United States. Osteoarthritis is a leading cause of disability among noninstitutionalized adults" (Wang et al., 2012).

Average expense per episode of ambulatory physical therapy was $1184 with an average of 9.6 visits (Machlin et al., 2011). Physical activity limitations are associated with worse economic outcomes across multiple economic metrics (Dall et al., 2013). Inflation-adjusted biennial expenditures on ambulatory services for chronic back pain increased by 129% over the same period, from $15.6 billion in 2000 to 2001 to $35.7 billion in 2006-2007 (Smith et al., 2013).

**CLINICAL RECOMMENDATION STATEMENTS:**

As a category, functional outcome assessments of everyday tasks are very suitable for evaluating treatment of dysfunctions of the neuromusculoskeletal system. Many questionnaires could be used; choice should depend upon the validity, reliability, responsiveness, and practicality demonstrated in the scientific literature. Functional questionnaires seek to directly quantify symptoms, function and behavior, rather than draw inferences from relevant physiological tests. Clinicians contemplating the use of functional instruments should be aware of differences between questionnaires and choose the most appropriate assessment tool for the specific purpose (Haldeman et al., 2005) (Evidence Class: I, II, III, Consensus Level: 1). Utilization of validated pain and function scales help to differentiate treatment approaches in order to improve the patient's ability to function (ICSI, 2012).

Outcome measures/standardized assessments are used by physical therapists to evaluate patient response to therapeutic interventions. In a 2006 Centers for Medicare & Medicaid Services report, *Uniform Patient Assessment for Post-Acute Care,* the Division of Health Care Policy and Research recommended there is a role for uniform outcome assessments to determine long term function for patients leaving the acute care hospital.

Clinicians should use validated functional outcome measures, such as the Disabilities of the Arm, Shoulder and Hand (DASH), the American Shoulder and Elbow Surgeons shoulder scale (ASES), or the Shoulder Pain and Disability Index (SPPADI). These should be utilized before and after interventions intended to alleviate the impairments of body function and structure, activity limitations, and participation restrictions associated with adhesive capsulitis (Kelley et al., 2013) (Guideline).

Clinicians should use validated self-report questionnaires, such as the Oswestry Disability Index and the Roland-Morris Disability Questionnaire. These tools are useful for identifying a patient's baseline status relative to pain, function, and disability and for monitoring a change in a patient's status throughout the course of treatment (Delitto et al., 2012) (Guideline).

"The Oswestry Disability Questionnaire is used to assess the patient's subjective rating of perceived disability related to his or her functional limitations, eg,work status, difficulty caring for oneself. The higher the score, the more perceived the disability. Using this test at the initial visit helps the examiner understand the patient's perception of how his or her back pain is affecting his or her life. There are two ways that this test aids in the treatment of back pain. A higher score is indicative of the need for more intensive treatment such as spinal manipulative therapy and education to help the patient understand the low likelihood of disability related to back pain. Understanding the low likelihood helps prevent the fear of disability from becoming a barrier to improvement. People with higher disability should be managed more aggressively, with a heightened sense of urgency to avoid the negative aspect of prolonged pain and disability. The use of anticipatory guidance and early return to work with appropriate restrictions are important aspects. By tracking these scores, improvement can be documented and monitored" (Goertz et al., 2012) (Guideline).

Tracking the outcomes of an implementation program is critical to evaluating its benefit to patients. (Kramer et al., 2013) Understanding the clinical course of a condition can help assessment of individual patient outcomes by providing a meaningful point of reference with which to compare an individual patient's progress (Leaver et al., 2013).

The Council on Chiropractic Education (2012) recommended keeping appropriate records of the patient's evaluation and case management needs to aptly respond to changes in patient status, or failure of the patient to respond to care. The Institute of Medicine's (2012) *Living Well with Chronic Illness: A Call for Public Health Action* stated the surveillance systems need to be improved to assess health-related quality of life and functional status of patients. Federal and state governments should expand surveillance systems which can be used to inform the planning, development, implementation, and evaluation of public health policies, programs and interventions relevant to individuals with chronic illness.

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# PQRS MEASURE 238 EMEASURE ID #156

## Use of High-Risk Medications in the Elderly

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 66 years on date of encounter who had a visit during the measurement period

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Percentage of patients who were ordered at least one high-risk medication during the measurement period

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Patient Safety

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Registry or Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #238 (NQF 0022): Use of High-Risk Medications in the Elderly – National Quality Strategy Domain: Patient Safety

**2015 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported.

1) Percentage of patients who were ordered at least one high-risk medication.
2) Percentage of patients who were ordered at least two different high-risk medications.

**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 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.

**This measure will be calculated with 2 performance rates:**

1) Percentage of patients who were ordered at least one high-risk medication
2) Percentage of patients who were ordered at least two different high-risk medications

Eligible professionals should continue to report the measure as specified, with no additional steps needed to account for multiple performance rates.

**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.

**There are two reporting criteria for this measure:**

1) **Percentage of patients who were ordered at least one high-risk medication**

**OR**

2) **Percentage of patients who were ordered at least two different high-risk medications**

**REPORTING CRITERIA 1: Percentage of patients who were ordered at least one high-risk medication**

**DENOMINATOR (REPORTING CRITERIA 1) :**
Patients 66 years and older who had a visit during the measurement period

**Denominator Criteria (Eligible Cases) 1:**
Patients aged ≥ 66 years on date of encounter
**AND**
**Patient encounter during reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439

**NUMERATOR (REPORTING CRITERIA 1):**

Percentage of patients who were ordered at least one high-risk medication during the measurement period

**Numerator Instructions:** A lower calculated performance rate for this measure indicates better clinical care or control.

A high-risk medication is identified by either of the following:

- A prescription for medications classified as high risk at any dose and for any duration listed in Table 1
- Prescriptions for medications classified as high risk at any dose with greater than a 90 day cumulative medication duration listed in Table 2

**Definition:**
**Cumulative Medication Duration** - an individual's total number of medication days over a specific period; the period counts multiple prescriptions with gaps in between, but does not count the gaps during which a medication was not dispensed.
To determine the cumulative medication duration, determine first the number of the Medication Days for each prescription in the period: the number of doses divided by the dose frequency per day. Then add the Medication Days for each prescription without counting any days between the prescriptions.
**High risk medication –**

**Table 1: High-Risk Medications at any dose or duration**

| Description | Prescription | |
|---|---|---|
| Anticholinergics (excludes TCAs), first-generation antihistamines | • Brompheniramine<br>• Carbinoxamine<br>• Chlorpheniramine<br>• Clemastine<br>• Cyproheptadine<br>• Dexbrompheniramine | • Dexchlorpheniramine<br>• Diphenhydramine (oral)<br>• Doxylamine<br>• Hydroxyzine<br>• Promethazine<br>• Triprolidine |
| Anticholinergics (excludes TCAs), anti-Parkinson agents | • Benztropine (oral) | • Trihexyphenidyl |
| Antithrombotics | • Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin) | • Ticlopidine |
| Cardiovascular, alpha agonists, central | • Guanabenz<br>• Guanfacine | • Methyldopa |
| Cardiovascular, other | • Disopyramide | • Nifedipine, immediate release |
| Central nervous system, tertiary TCAs | • Amitriptyline<br>• Clomipramine | • Imipramine<br>• Trimipramine |
| Central nervous system, barbiturates | • Amobarbital<br>• Butabarbital<br>• Butalbital<br>• Mephobarbital | • Pentobarbital<br>• Phenobarbital<br>• Secobarbital |
| Central nervous system, vasodilators | • Ergot mesylates | • Isoxsuprine |
| Central nervous system, other | • Thioridazine<br>• Chloral Hydrate | • Meprobamate |

| Description | Prescription | |
|---|---|---|
| Endocrine system, estrogens with or without progestins; include only oral and topical patch products | • Conjugated estrogen<br>• Esterified estrogen | • Estradiol<br>• Estropipate |
| Endocrine system, sulfonylureas, long-duration | • Chlorpropamide | • Glyburide |
| Endocrine system, other | • Desiccated thyroid | • Megestrol |
| Gastrointestinal system, other | • Trimethobenzamide | |
| Pain medications, skeletal muscle relaxants | • Carisoprodol<br>• Chlorzoxazone<br>• Cyclobenzaprine | • Metaxalone<br>• Methocarbamol<br>• Orphenadrine |
| Pain medications, other | • Indomethacin<br>• Ketorolac, includes parenteral | • Meperidine<br>• Pentazocine |

**Table 2: High-Risk Medications With Days Supply Criteria**

| Description | Prescription | | Days Supply Criteria |
|---|---|---|---|
| Anti-Infectives, other | • Nitrofurantoin<br>• Nitrofurantoin macrocrystals | • Nitrofurantoin macrocrystals-monohydrate | >90 days |
| Nonbenzodiazepine hypnotics | • Eszopiclone<br>• Zaleplon | • Zolpidem | >90 days |

***NUMERATOR NOTE:*** *Some high-risk medications are not included in this specific measure but should be avoided above a specified average daily dose. These medications are listed in table DAE-C. To calculate an average daily dose multiply the quantity of pills ordered by the dose of each pill and divide by the days supply. For example, a prescription for a 30-days supply of digoxin containing 15 pills, 0.250 mg each pill, has an average daily dose of 0.125 mg.*

**Table DAE-C: High-Risk Medications With Average Daily Dose Criteria**

| Description | Prescription | Average Daily Dose Criteria |
|---|---|---|
| Alpha agonists, central | • Reserpine | >0.1 mg/day |
| Cardiovascular, other | • Digoxin | >0.125 mg/day |
| Tertiary TCAs (as single agent or as part of combination products) | • Doexpin | >6 mg/day |

**Numerator Options:**

***Performance Met:*** One high-risk medication ordered **(G9365)**

**OR**

***Performance Not Met:*** One high-risk medication **not** ordered **(G9366)**

**OR**

**REPORTING CRITERIA 2: Percentage of patients who were ordered at least two different high-risk medications**

**DENOMINATOR (REPORTING CRITERIA 2):**
Patients 66 years and older who had a visit during the measurement period

**Denominator Criteria (Eligible Cases) 2:**
Patients aged ≥ 66 years on date of encounter
**AND**
**Patient encounter during reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439

**NUMERATOR (REPORTING CRITERIA 2):**
Percentage of patients who were ordered at least two different high-risk medications during the measurement period

**Numerator Instructions:** A lower calculated performance rate for this measure indicates better clinical care or control.

A high-risk medication is identified by either of the following:

- A prescription for medications classified as high risk at any dose and for any duration listed in Table 1
- Prescriptions for medications classified as high risk at any dose with greater than a 90 day cumulative medication duration listed in Table 2

**Definition:**
**Cumulative Medication Duration** – an individual's total number of medication days over a specific period; the period counts multiple prescriptions with gaps in between, but does not count the gaps during which a medication was not dispensed.
To determine the cumulative medication duration, determine first the number of the Medication Days for each prescription in the period: the number of doses divided by the dose frequency per day. Then add the Medication Days for each prescription without counting any days between the prescriptions.
**High risk medication –**

**Table 1: High-Risk Medications at any dose or duration**

| Description | Prescription | |
|---|---|---|
| Anticholinergics (excludes TCAs), first-generation antihistamines | • Brompheniramine<br>• Carbinoxamine<br>• Chlorpheniramine<br>• Clemastine<br>• Cyproheptadine<br>• Dexbrompheniramine | • Dexchlorpheniramine<br>• Diphenhydramine (oral)<br>• Doxylamine<br>• Hydroxyzine<br>• Promethazine<br>• Triprolidine |
| Anticholinergics (excludes TCAs), anti-Parkinson agents | • Benztropine (oral) | • Trihexyphenidyl |
| Antithrombotics | • Dipyridamole, oral short-acting (does not apply to the extended-release combination with aspirin) | • Ticlopidine |
| Cardiovascular, alpha agonists, central | • Guanabenz<br>• Guanfacine | • Methyldopa |

| Description | Prescription | |
|---|---|---|
| Cardiovascular, other | • Disopyramide | • Nifedipine, immediate release |
| Central nervous system, tertiary TCAs | • Amitriptyline<br>• Clomipramine | • Imipramine<br>• Trimipramine |
| Central nervous system, barbiturates | • Amobarbital<br>• Butabarbital<br>• Butalbital<br>• Mephobarbital | • Pentobarbital<br>• Phenobarbital<br>• Secobarbital |
| Central nervous system, vasodilators | • Ergot mesylates | • Isoxsuprine |
| Central nervous system, other | • Thioridazine<br>• Chloral Hydrate | • Meprobamate |
| Endocrine system, estrogens with or without progestins; include only oral and topical patch products | • Conjugated estrogen<br>• Esterified estrogen | • Estradiol<br>• Estropipate |
| Endocrine system, sulfonylureas, long-duration | • Chlorpropamide | • Glyburide |
| Endocrine system, other | • Desiccated thyroid | • Megestrol |
| Gastrointestinal system, other | • Trimethobenzamide | |
| Pain medications, skeletal muscle relaxants | • Carisoprodol<br>• Chlorzoxazone<br>• Cyclobenzaprine | • Metaxalone<br>• Methocarbamol<br>• Orphenadrine |
| Pain medications, other | • Indomethacin<br>• Ketorolac, includes parenteral | • Meperidine<br>• Pentazocine |

**Table 2: High-Risk Medications With Days Supply Criteria**

| Description | Prescription | | Days Supply Criteria |
|---|---|---|---|
| Anti-Infectives, other | • Nitrofurantoin<br>• Nitrofurantoin macrocrystals | • Nitrofurantoin macrocrystals-monohydrate | >90 days |
| Nonbenzodiazepine hypnotics | • Eszopiclone<br>• Zaleplon | • Zolpidem | >90 days |

***NUMERATOR NOTE:*** *Some high-risk medications are not included in this specific measure but should be avoided above a specified average daily dose. These medications are listed in table DAE-C. To calculate an average daily dose multiply the quantity of pills ordered by the dose of each pill and divide by the days supply. For example, a prescription for a 30-days supply of digoxin containing 15 pills, 0.250 mg each pill, has an average daily dose of 0.125 mg.*

**Table DAE-C: High-Risk Medications With Average Daily Dose Criteria**

| Description | Prescription | Average Daily Dose Criteria |
|---|---|---|
| Alpha agonists, central | • Reserpine | >0.1 mg/day |
| Cardiovascular, other | • Digoxin | >0.125 mg/day |
| Tertiary TCAs (as single agent or as part of combination products) | • Doxepin | >6 mg/day |

**Numerator Options:**

***Performance Met:*** At least two different high-risk medications ordered **(G9367)**

**OR**

***Performance Not Met:*** At least two different high-risk medications **not** ordered **(G9368)**

**RATIONALE:**

Seniors receiving inappropriate medications are more likely to report poorer health status at follow-up, compared to seniors who receive appropriate medications (Fu, Liu, and Christensen 2004). In 2005, rates of potentially inappropriate medication use in the elderly were as large or larger than in a 1996 national sample, highlighting the need for progress in this area (Simon et al. 2005). While some adverse drug events are not preventable, studies estimate that between 30 and 80 percent of adverse drug events in the elderly are preventable (MacKinnon and Hepler 2003).

Reducing the number of inappropriate prescriptions can lead to improved patient safety and significant cost savings. Conservative estimates of extra costs due to potentially inappropriate medications in the elderly average $7.2 billion a year (Fu, Liu, and Christensen 2004). Medication use by older adults will likely increase further as the U.S. population ages, new drugs are developed, and new therapeutic and preventive uses for medications are discovered (Rothberg et al. 2008). By the year 2030, nearly one in five U.S. residents is expected to be aged 65 years or older; this age group is projected to more than double in number from 38.7 million in 2008 to more than 88.5 million in 2050. Likewise, the population aged 85 years or older is expected to increase almost four-fold, from 5.4 million to 19 million between 2008 and 2050. As the elderly population continues to grow, the number of older adults who present with multiple medical conditions for which several medications are prescribed continues to increase, resulting in polypharmacy (Gray and Gardner 2009).

**CLINICAL RECOMMENDATION STATEMENTS:**

The measure is based on the literature and key clinical expert consensus processes by Beers in 1997, Zahn in 2001 and an updated process by Fick in 2003, which identified drugs of concern in the elderly based on various high-risk criteria. NCQA's Medication Management expert panel selected a subset of drugs that should be used with caution in the elderly for inclusion in the proposed measure based upon these two lists. NCQA analyzed the prevalence of drugs prescribed according to the Beers and Zhan classifications and determined that drugs identified by Zhan that are classified as never or rarely appropriate would form the basis for the list (Fick 2003).

Certain medications (MacKinnon 2003) are associated with increased risk of harms from drug side-effects and drug toxicity and pose a concern for patient safety. There is clinical consensus that these drugs pose increased risks in the elderly (Kaufman 2005). Studies link prescription drug use by the elderly with adverse drug events that contribute to hospitalization, increased length of hospital stay, increased duration of illness, nursing home placement and falls and fractures that are further associated with physical, functional and social decline in the elderly (AHRQ 2009).

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# PQRS MEASURE 239 EMEASURE ID #155

## Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents

### ELIGIBLE PATIENT POPULATION

Patients 3-17 years of age with at least one outpatient visit with a primary care physician (PCP) or an obstetrician/gynecologist (OB/GYN) during the measurement period

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who had a height, weight and body mass index (BMI) percentile recorded during the measurement period; Patients who had counseling for nutrition during a visit that occurs during the measurement period; Patients who had counseling for physical activity during a visit that occurs during the measurement period

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Community/Population Health

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

# PQRS MEASURE 240 EMEASURE ID #117

## Childhood Immunization Status

### ELIGIBLE PATIENT POPULATION

Children who turn 2 years of age during the measurement period and who have a visit during the measurement period

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Children who have evidence showing they received recommended vaccines, had documented history of the illness, had a seropositive test result, or had an allergic reaction to the vaccine by their second birthday

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Community/Population Health

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM) or Crosscutting

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 243

## Cardiac Rehabilitation Patient Referral from an Outpatient Setting

### ELIGIBLE PATIENT POPULATION

All patients aged ≥ 18 years on date of encounter evaluated in the outpatient setting during the reporting period who have a qualifying event/diagnosis [chronic stable angina (CSA), or who **within the previous 12 months** have had an acute myocardial infarction (AMI) or have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation] who do not meet any of the exclusion criteria (patient factors, medical factors, health care system factors) and who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who have had a qualifying event/diagnosis **within the previous 12 months**, who have been referred to an outpatient cardiac rehabilitation/ secondary prevention (CR) program.

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## [redacted]Measure #243 (NQF 0643): Cardiac Rehabilitation Patient Referral from an Outpatient Setting – National Quality Strategy Domain: Effective Clinical Care

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of patients evaluated in an outpatient setting who within the previous 12 months have experienced an acute myocardial infarction (MI), coronary artery bypass graft (CABG) surgery, a percutaneous coronary intervention (PCI), cardiac valve surgery, or cardiac transplantation, or who have chronic stable angina (CSA) and have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program for the qualifying event/diagnosis who were referred to a CR program

**Definition:**
**Referral** - A referral is defined as an official communication between the health care provider and the patient to recommend and carry out a referral order to an outpatient CR program. This includes the provision of all necessary information to the patient that will allow the patient to enroll in an outpatient CR program. This also includes a written or electronic communication between the healthcare provider or healthcare system and the cardiac rehabilitation program that includes the patient's enrollment information for the program. A hospital discharge summary or office note may potentially be formatted to include the necessary patient information to communicate to the CR program (the patient's cardiovascular history, testing, and treatments, for instance). According to standards of practice for cardiac rehabilitation programs, care coordination communications are sent to the referring provider, including any issues regarding treatment changes, adverse treatment responses, or new non-emergency condition (new symptoms, patient care questions, etc.) that need attention by the referring provider. These communications also include a progress report once the patient has completed the program. All communications must maintain an appropriate level of confidentiality as outlined by the 1996 Health Insurance Portability and Accountability Act (HIPAA).

**Note:** *A patient with a qualifying diagnosis should have a referral to CR within the subsequent 12 months. In the event that the patient has a second (recurrent) qualifying event before the original 12 month "referral" period has ended, a new 12 month "referral" period for CR referral starts at the time of the second qualifying event, since the patient again becomes eligible for CR at that time.*

**INSTRUCTIONS:**
This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period who had a qualifying diagnosis within the previous 12 months and who have not already participated in an outpatient CR program. 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 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:**
All patients age ≥ 18 years evaluated in the outpatient setting during the reporting period who have a qualifying event/diagnosis [chronic stable angina (CSA), or who **within the previous 12 months** have had an acute myocardial infarction (AMI) or have undergone coronary artery bypass graft (CABG) surgery, a percutaneous coronary

intervention (PCI), cardiac valve surgery, or cardiac transplantation] who do not meet any of the exclusion criteria (patient factors, medical factors, health care system factors) and who have not already participated in an early outpatient cardiac rehabilitation/secondary prevention (CR) program

**Denominator Instructions:** Coronary Artery Bypass Graft, Percutaneous Coronary Intervention, Cardiac Valve surgery, Cardiac Transplant or Acute Myocardial Infarction, in order to meet the criteria for inclusion of the measure, must have occurred or been performed within 12 months of date of encounter.

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 18 years on date of encounter
**AND**
**Patient encounter during the reporting period (CPT or HCPCS):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0438, G0439
**AND**
**Diagnosis of Chronic Stable Angina (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 413.0, 413.1, 413.9
**Diagnosis for Chronic Stable Angina (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** I20.1, I20.8, I20.9
**OR**
**Diagnosis of Acute Myocardial Infarction (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 412
**Diagnosis of Acute Myocardial Infarction (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I25.2
**OR**
**Coronary Artery Bypass Graft Surgery (CPT):** 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33572, 33999, 35500, 35600
**OR**
**Percutaneous Coronary Intervention (CPT):** 92920, 92924, 92928, 92933, 92937, 92941, 92943
**OR**
**Cardiac Valve Surgery (CPT):** 33361, 33362, 33363, 33364, 33365, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33412, 33413, 33414, 33415, 33416, 33417, 33420, 33422, 33425, 33426, 33427, 33430, 33463, 33464, 33465, 33468, 33470, 33471, 33475, 33476, 33478, 33496, 33600, 33602

**OR**
**Cardiac Transplantation (CPT):** 33935, 33945
**AND**
**Qualifying cardiac event/diagnosis in previous 12 months:**
1460F

**NUMERATOR:**
Patients who have had a qualifying event/diagnosis **within the previous 12 months,** who have been referred to an outpatient cardiac rehabilitation/secondary prevention (CR) program

**Numerator Instructions:** CR programs may include a traditional CR program based on face-to-face interactions and training sessions or other options that include home-based approaches. If alternative CR approaches are used, they should be designed to meet appropriate safety standards.

**Numerator Options:**
***Performance Met:*** Referral to an outpatient cardiac rehabilitation/secondary prevention program
Referred to an outpatient cardiac rehabilitation program **(4500F)**

**OR**

| | |
|---|---|
| ***Medical Performance Exclusion:*** | Documentation of medical reason(s) for not referring to an outpatient CR program **(4500F *with* 1P)** |
| **OR** | |
| ***Patient Performance Exclusion:*** | Documentation of patient reason(s) for not referring to an outpatient CR program **(4500F *with* 2P)** |
| **OR** | |
| ***System Performance Exclusion:*** | Documentation of system reason(s) for not referring to an outpatient CR program **(4500F *with* 3P)** |
| **OR** | |
| ***Other Performance Exclusion:*** | Previous cardiac rehabilitation for qualifying cardiac event completed **(4510F)** |
| **OR** | |
| ***Performance Not Met:*** | Patient **not** referred to outpatient CR/secondary prevention program, reason not otherwise specified **(4500F *with* 8P)** |

**RATIONALE:**

Cardiac rehabilitation services have been shown to help reduce morbidity and mortality in persons who have experienced a recent coronary artery disease event, but these services are used in less than 30% of eligible patients(1). A key component to CR utilization is the appropriate and timely referral of patients to an outpatient CR program. While referral takes place generally while the patient is hospitalized for a qualifying event (MI, CSA, CABG, PCI, cardiac valve surgery, or heart transplantation), there are many instances in which a patient can and should be referred from an outpatient clinical practice setting (eg, when a patient does not receive such a referral while in the hospital, or when the patient fails to follow through with the referral for whatever reason).

This performance measure has been developed to help health care systems implement effective steps in their systems of care that will optimize the appropriate referral of a patient to an outpatient CR program.

This measure is designed to serve as a stand-alone measure or, preferably, to be included within other performance measurement sets that involve disease states or other conditions for which CR services have been found to be appropriate and beneficial (eg, following MI, CABG surgery)(2, 3). This performance measure is provided in a format that is meant to allow easy and flexible inclusion into such performance measurement sets.

Referral of appropriate outpatients to a CR program is the responsibility of the health care provider within a health care system that is providing the primary cardiovascular care to the patient in the outpatient setting.

**CLINICAL RECOMMENDATION STATEMENTS:**

*2011 ACCF/AHA Guideline for Coronary Artery Bypass Graft Surgery(4)*

*Class I*

Cardiac rehabilitation is recommended for all eligible patients after CABG. (Level of Evidence: A)

*ACC/AHA 2007 Update of the Guidelines for the Management of Patients with ST-Elevation Myocardial Infarction(5)*

*Class I*

Advising medically supervised programs (cardiac rehabilitation) for high-risk patients (eg, recent acute coronary syndrome or revascularization, heart failure) is recommended. (Level of Evidence: B)

*ACC/AHA 2007 Guidelines for the Management of Patients with Unstable Angina and Non–ST-Segment Elevation Myocardial Infarction(6)*

*Class I*

Cardiac rehabilitation/secondary prevention programs are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and/or those moderate- to high-risk patients in whom supervised exercise training is particularly warranted. (Level of Evidence: B)

Cardiac rehabilitation/secondary prevention programs, when available, are recommended for patients with UA/NSTEMI, particularly those with multiple modifiable risk factors and those moderate- to high-risk patients in whom supervised or monitored exercise training is warranted. (Level of Evidence: B)

*ACC/AHA 2007 Chronic Angina Focused Update of the Guidelines for the Management of Patients With Chronic Stable Angina (7)*

*Class I*

Medically supervised programs (cardiac rehabilitation) are recommended for at-risk patients (eg, recent acute coronary syndrome or revascularization, heart failure). (Level of Evidence: B)

*2009 Focused update incorporated into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults (8)*

*Class I*

Exercise training is beneficial as an adjunctive approach to improve clinical status in ambulatory patients with current or prior symptoms of HF and reduced LVEF. (Level of Evidence: B)

*Effectiveness-based Guidelines for the Prevention of Cardiovascular Disease in Women—2011 update: A Guideline from the American Heart Association*(9)*Class I*

A comprehensive CVD risk-reduction regimen such as cardiovascular or stroke rehabilitation or a physician-guided home- or community-based exercise training program should be recommended to women with a recent acute coronary syndrome or coronary revascularization, new-onset or chronic angina, recent cerebrovascular event, peripheral arterial disease (Class I; Level of Evidence A) or current/prior symptoms of heart failure and an LVEF ≤35%. (Class I; Level of Evidence B)

*ACC/AHA/SCAI 2007 Focused Update of the Guidelines for Percutaneous Coronary Intervention(10)*

*Class I*

Medically supervised exercise programs (cardiac rehabilitation) should be recommended to patients after PCI, particularly for patients at moderate to high risk, for whom supervised exercise training is warranted. (Class I; Level of Evidence A)

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# PQRS Measures in Dementia Measures Group

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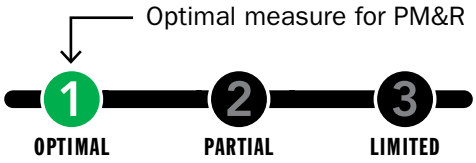
281 Cognitive Assessment
282 Functional Status Assessment
283 Neuropsychiatric Symptom Assessment
284 Management of Neuropsychiatric Symptoms
285 Screening for Depressive Symptoms
286 Counseling Regarding Safety Concerns
287 Counseling Regarding Risks of Driving
288 Caregiver Education and Support

## REPORTING REQUIREMENTS FOR MEASURES GROUP

Report on 20 unique patients (a majority of which must be Medicare Part B FFS patients) for all patients with two denominator eligible visits regardless of age, with a specific diagnosis of dementia accompanied by a specific patient encounter - – refer to measure specifications for diagnosis and patient encounter information.

To report satisfactorily the Dementia Measures Group it requires all applicable measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.

## AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




## REPORTING METHOD(S)

Registry Only

## MEASURES GROUP OVERVIEW

Click **here** to access the Dementia measures group overview.

## MEASURES GROUP RATIONALE

Click **here** to access the Dementia Measures Group Rationale and Clinical Recommendation Statements

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## DEMENTIA MEASURES GROUP OVERVIEW

**2015 PQRS OPTIONS FOR MEASURES GROUPS:**

**2015 PQRS MEASURES IN DEMENTIA MEASURES GROUP:**

#47 Care Plan
#280 Dementia: Staging of Dementia
#281 Dementia: Cognitive Assessment
#282 Dementia: Functional Status Assessment
#283 Dementia: Neuropsychiatric Symptom Assessment
#284 Dementia: Management of Neuropsychiatric Symptoms
#285 Dementia: Screening for Depressive Symptoms
#286 Dementia: Counseling Regarding Safety Concerns
#287 Dementia: Counseling Regarding Risks of Driving
#288 Dementia: Caregiver Education and Support

**INSTRUCTIONS FOR REPORTING:**

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

  **G8902:** I intend to report the Dementia Measures Group

- Report the patient sample method:
  **20 Patient Sample Method via registries:** 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2015).

- Patient sample criteria for the Dementia Measures Group are all patients with two denominator eligible visits regardless of age, with a specific diagnosis of dementia accompanied by a specific patient encounter:

  **One of the following diagnosis codes indicating Dementia:**
  **ICD-9-CM [for use 1/1/2015 – 9/30/2015]:** 094.1, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 294.10, 294.11, 294.20, 294.21, 294.8, 331.0, 331.11, 331.19, 331.82
  **ICD-10-CM [for use 10/1/2015 – 12/31/2015]:** A52.17, F01.50, F01.51, F02.80, F02.81, F03.90, F03.91, F05, F06.8, G30.0, G30.1, G30.8, G30.9, G31.01, G31.09, G31.83

  **Accompanied by:**

  **One of the following patient encounter codes**: 90791, 90792, 90832, 90834, 90837, 96116, 96118, 96119, 96120, 96150, 96151, 96152, 96154, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

- Report a numerator option on **all applicable** measures within the Dementia Measures Group for each patient within the eligible professional's patient sample.

- Measure #47 need only be reported on patients 65 years and older.

- Instructions for qualifying numerator option reporting for each of the measures within the Dementia Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

  **Composite QDC G8761:** All quality actions for the applicable measures in the Dementia Measures Group have been performed for this patient

- To report satisfactorily the Dementia Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.

- **NOTE**: The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures group option.

## Measure #47 (NQF 0326): Care Plan -- National Quality Strategy Domain: Communication and Care Coordination

**DESCRIPTION:**
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**NUMERATOR:**
Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**Numerator Instructions:** If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report **1124F**.

**Definition:**
**Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan** – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

**Numerator Options:**
***Performance Met:*** Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record **(1123F)**
**OR**
***Performance Met:*** Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan **(1124F)**

**OR**

***Performance Not Met*:** Advance care planning **not** documented, reason not otherwise specified **(1123F *with* 8P)**

## Measure #280: Dementia: Staging of Dementia -- National Quality Strategy Domain: Communication and Care Coordination

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period

**NUMERATOR:**
Patients whose severity of dementia was classified as mild, moderate or severe at least once within a 12 month period

**Numerator Instructions:** Dementia severity can be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Global Deterioration Scale (GDS)
- Functional Assessment Staging Tool (FAST)
- Clinical Dementia Rating (CDR)
- Dementia Severity Rating Scale
- Mini-Mental State Examination (MMSE) [Note: While simple and quick to administer, the MMSE is a blunt instrument for staging Alzheimer's disease. The MMSE has not been well validated for non-Alzheimer's dementias.]
- Formal Neuropsychological Evaluation

**Definitions:**
**Mild dementia -** Can be classified quantitatively as MMSE score of > 18, GDS or FAST stage 4, CDR of 1; qualitatively as being likely to have difficulty with balancing a checkbook, preparing a complex meal, or managing a complicated medication schedule. (APA, 2007)
**Moderate dementia -** Can be classified quantitatively as MMSE score of 10–18, GDS or FAST stages 5 and 6, CDR of 2; qualitatively as experiencing difficulties with simpler food preparation, household cleanup, and yard work and requiring assistance with some aspects of self-care (eg, picking out the proper clothing to wear). (APA, 2007)
**Severe dementia -** Can be classified quantitatively as MMSE score of < 10, GDS or FAST stages 6 and 7, CDR of 3; qualitatively as requiring considerable or total assistance with personal care, such as dressing, bathing, and toileting. (APA, 2007)

***NUMERATOR NOTE:*** *The proposed scoring cut-offs listed above are offered only as a guide and are quoted verbatim from the referenced clinical guideline. The scoring and appropriate severity cut-offs for any of these instruments must be interpreted in the context of the patient's age, education, and ethnicity.*

**Numerator Options:**
***Performance Met:*** Dementia severity classified, mild **(1490F)**
**OR**
***Performance Met:*** Dementia severity classified, moderate **(1491F)**
**OR**
***Performance Met:*** Dementia severity classified, severe **(1493F)**
**OR**
***Performance Not Met:*** Dementia severity **not** classified, reason not otherwise specified **(1490F *with* 8P)**

## Measure #281: Dementia: Cognitive Assessment -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

**NUMERATOR:**
Patients for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period

**Numerator Instructions:**
Cognition can be assessed by the clinician during the patient's clinical history. Cognition can also be assessed by direct examination of the patient using one of a number of instruments, including several originally developed and validated for screening purposes. This can also include, where appropriate, administration to a knowledgeable informant. Examples include, but are not limited to:

- Blessed Orientation-Memory-Concentration Test (BOMC)
- Montreal Cognitive Assessment (MoCA)
- St. Louis University Mental Status Examination (SLUMS)
- Mini-Mental State Examination (MMSE) *[Note: The MMSE has not been well validated for non-Alzheimer's dementias.]*
- Short Informant Questionnaire on Cognitive Decline in the Elderly (IQCODE)
- Ascertain Dementia 8 (AD8) Questionnaire
- Minimum Data Set (MDS) Brief Interview for Mental Status (BIMS) *[Note: Validated for use with nursing home patients only]*
- Formal neuropsychological evaluation

**Numerator Options:**
***Performance Met:*** Cognition assessed and reviewed **(1494F)**

**OR**

***Medical Performance Exclusion:*** Documentation of medical reason(s) for not assessing cognition (eg, patient with very advanced stage dementia, other medical reason) **(1494F *with* 1P)**

**OR**

***Patient Performance Exclusion:*** Documentation of patient reason(s) for not assessing cognition **(1494F *with* 2P)**

**OR**

***Performance Not Met:*** Cognition **not** assessed and reviewed, reason not otherwise specified **(1494F *with* 8P)**

## Measure #282: Dementia: Functional Status Assessment -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period

**NUMERATOR:**
Patients for whom an assessment of functional status is performed and the results reviewed at least once within a 12 month period

**Numerator Instructions:** Functional status can be assessed by direct examination of the patient or knowledgeable informant. An assessment of functional status should include, at a minimum, an evaluation of the patient's ability to perform instrumental activities of daily living (IADL) and basic activities of daily living (ADL). Functional status can also be assessed using one of a number of available valid and reliable instruments available from the medical literature. Examples include, but are not limited to:

- Lawton IADL Scale
- Barthel ADL Index
- Katz Index of Independence in ADL

**Numerator Options:**

***Performance Met:*** Functional status for dementia assessed and results reviewed **(1175F)**

**OR**

***Medical Performance Exclusion:*** Documentation of medical reason(s) for not assessing and reviewing functional status for dementia (eg, patient is severely impaired and caregiver knowledge is limited, other medical reason) **(1175F *with* 1P)**

**OR**

***Performance Not Met:*** Functional status for dementia **not** assessed and results **not** reviewed, reason not otherwise specified **(1175F *with* 8P)**

## Measure #283: Dementia: Neuropsychiatric Symptom Assessment -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia and for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period

**NUMERATOR:**
Patients for whom an assessment of neuropsychiatric symptoms is performed and results reviewed at least once in a 12 month period

**Numerator Instructions:** Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant.

Examples of reliable and valid instruments that are commonly used in research settings and that can be used to assess behavior include, but are not limited to:

- Dementia Signs and Symptoms (DSS) Scale
- Neuropsychiatric Inventory (NPI)

The assessment of behavioral status may include the assessment of Behavioral and Psychological Symptoms of Dementia (BPSD). For patients residing in nursing homes, it may include an assessment of the behavioral symptom items from the Minimum Data Set (MDS).
The following is a non-exhaustive list of dimensions (based on items included in available validated instruments) that may be evaluated during an assessment of neuropsychiatric symptoms:

*Activity disturbances:*

- agitation
- wandering
- purposeless hyperactivity
- verbal or physical aggressiveness
- resistiveness with care
- apathy
- impulsiveness
- socially inappropriate behaviors
- appetite
- eating disturbances
- sleep problems
- diurnal/sleep-wake cycle disturbances
- repetitive behavior

*Mood disturbances:*

- anxiety
- dysphoria
- euphoria
- irritability
- mood lability/fluctuations

*Thought and perceptual disturbances:*

- having fixed false beliefs (delusions)
- hearing or seeing non-present entities (hallucinations)
- paranoia

**Numerator Options:**

***Performance Met:*** Neuropsychiatric symptoms assessed and results reviewed **(1181F)**

**OR**

***Performance Not Met:*** Neuropsychiatric symptoms **not** assessed and results **not** reviewed, reason not otherwise specified **(1181F *with* 8P)**

## Measure #284: Dementia: Management of Neuropsychiatric Symptoms -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

**NUMERATOR:**
Patients who received or were recommended to receive an intervention for neuropsychiatric symptoms within a 12 month period

**Numerator Options:**
***Performance Met:***
One or more neuropsychiatric symptoms **(G8947)**
**AND**
Neuropsychiatric intervention ordered **(4525F)**
**OR**
***Performance Met:*** Neuropsychiatric intervention received **(4526F)**

**OR**

***Other Performance Exclusion:*** No neuropsychiatric symptoms **(G8948)**

**OR**

***Performance Not Met:***
One or more neuropsychiatric symptoms **(G8947)**
**AND**
Neuropsychiatric intervention **not** ordered, reason not otherwise specified **(4525F *with* 8P)**

## Measure #285: Dementia: Screening for Depressive Symptoms -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia who were screened for depressive symptoms within a 12 month period

**NUMERATOR:**
Patients who were screened for depressive symptoms within a 12 month period

**Numerator Instructions:**
In addition to clinical qualitative approaches, dementia patients can be screened for depressive symptoms using one of a number of valid, reliable instruments available from the medical literature. Examples include, but are not limited to:

- Cornell Scale for Depression in Dementia
- Geriatric Depression Scale
- PHQ-9

**Definition:**
**Depressive Symptoms** - Depressive symptoms in a patient with dementia can include: anxiety, sadness, lack of reactivity to pleasant events, irritability, agitation, retardation, multiple physical complaints, acute loss of interest, appetite loss, lack of energy, diurnal variation of mood, difficulty falling asleep, multiple awakenings, during sleep, early morning awakenings, suicide, self-depreciation, pessimism, and mood congruent delusions. Since patients may be unable to describe their symptoms, caregiver report of depressive symptoms should be reviewed and included in the screen for depressive symptoms.

**Numerator Options:**
***Performance Met:*** Screening for depression performed **(3725F)**

**OR**

***Performance Not Met:*** Screening for depression **not** performed, reason not otherwise specified **(3725F *with* 8P)**

## Measure #286: Dementia: Counseling Regarding Safety Concerns -- National Quality Strategy Domain: Patient Safety

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period

**NUMERATOR:**
Patients or their caregiver(s) who were counseled or referred for counseling regarding safety concerns within a 12 month period

**Numerator Instructions:** Counseling should include a discussion with the patient and their caregiver(s) regarding one or more of the following common safety concerns and potential risks to the patient. When appropriate, it should also include a recommendation or referral for a home safety evaluation.
*Note: For nursing home patients, different safety concerns might apply.*

A number of organizations have developed educational materials that are recommended to aid implementation of the measure. These materials/tools include:

- Alzheimer's Association Safety Topics. Available on the Alzheimer's Association website.
- Alzheimer's Disease Education and Referral Center's Home Safety for the Alzheimer's Patient. Available on the National Institute on Aging website.

**Definition:**
**Caregiver(s) -** Person(s) who provide care to those who need supervision or assistance in illness or disability. They may provide the care in the home, in a hospital, or in an institution. Although caregiver(s) include trained medical, nursing, and other health personnel, the concept also refers to parents, spouses, or other family members, friends, members of the clergy, teachers, social workers, fellow patients.

**Safety Concerns** - Safety concerns include, but are not limited to:

- Fall risk
- Gait/balance
- Medication management
- Financial management
- Home safety risks that could arise from cooking or smoking
- Physical aggression posing threat to self, family caregiver, or others
- Wandering
- Access to firearms or other weapons
- Access to potentially dangerous materials
- Being left alone in home or locked in room
- Inability to respond rapidly to crisis/household emergencies
- Driving
- Operation of hazardous equipment
- Suicidality
- Abuse or neglect

**Numerator Options:**
***Performance Met:*** Safety counseling for dementia provided **(6101F)**

**OR**

***Performance Met:*** Safety counseling for dementia ordered **(6102F)**

**OR**

***Medical Performance Exclusion:*** Documentation of medical reason(s) for not providing counseling regarding safety concerns (eg, patient in palliative care, other medical reason) **(6101F *with* 1P)**

**OR**

***Medical Performance Exclusion:*** Documentation of medical reason(s) for not ordering safety counseling (eg, patient in palliative care, other medical reason) **(6102F *with* 1P)**

**OR**

***Performance Not Met:*** Safety counseling for dementia **not** provided, reason not otherwise specified **(6101F *with* 8P)**

**OR**

***Performance Not Met:*** Safety counseling for dementia **not** ordered, reason not otherwise specified **(6102F *with* 8P)**

## Measure #287: Dementia: Counseling Regarding Risks of Driving -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

**NUMERATOR:**
Patients or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving at least once within a 12 month period

**Numerator Instructions:**
One resource that includes patient and caregiver educational materials that can be used to aid implementation of the measure is the *Physician's Guide to Assessing and Counseling Older Drivers,* developed by the American Medical Association in cooperation with the National Highway Traffic Safety Administration. This document is available on the AMA website.

**Definition:**
**Caregiver(s) -** Person(s) who provide care to those who need supervision or assistance in illness or disability. They may provide the care in the home, in a hospital, or in an institution. Although caregiver(s) include trained medical, nursing, and other health personnel, the concept also refers to parents, spouses, or other family members, friends, members of the clergy, teachers, social workers, fellow patients.

**Numerator Options:**
***Performance Met:*** Counseling provided regarding risks of driving and the alternatives to driving **(6110F)**

**OR**

***Medical Performance Exclusion:*** Documentation of medical reason(s) for not counseling regarding the risks of driving (eg, patient is no longer driving, other medical reason) **(6110F *with* 1P)**

**OR**

***Performance Not Met:*** Counseling regarding risks of driving and alternatives to driving **not** performed, reason not otherwise specified **(6110F *with* 8P)**

## Measure #288: Dementia: Caregiver Education and Support -- National Quality Strategy Domain: Communication and Care Coordination

**DESCRIPTION:**
Percentage of patients, regardless of age, with a diagnosis of dementia whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

**NUMERATOR:**
Patients whose caregiver(s) were provided with education on dementia disease management and health behavior changes AND referred to additional resources for support within a 12 month period

**Numerator Instructions:**
There are a number of assessment tools available for the caregiver. These should be considered as an integral component of comprehensive caregiver education and support. The American Medical Association has developed a Caregiver Health Self-assessment Questionnaire to help caregivers analyze their own behavior and health risks and, with their physician's help, make decisions that will benefit both the caregiver and the patient. This questionnaire is available on the AMA website.

**Definitions:**
**Caregiver(s) -** Person(s) who provide care to those who need supervision or assistance in illness or disability. They may provide the care in the home, in a hospital, or in an institution. Although caregiver(s) include trained medical, nursing, and other health personnel, the concept also refers to parents, spouses, or other family members, friends, members of the clergy, teachers, social workers, fellow patients.
**Education –** Education should also include advising the caregiver that he or she is at "increased risk of serious illness (including circulatory and heart conditions and respiratory disease and hypertension), increased physician visits and use of prescription medications, emotional strain, anxiety, and depression."

**Numerator Options:**
***Performance Met:*** Caregiver provided with education and referred to additional resources for support **(4322F)**

**OR**

***Medical Performance Exclusion:*** Documentation of medical reason(s) for not providing the caregiver with education on disease management and health behavior changes or referring to additional sources for support (eg, patient does not have a caregiver, other medical reason) **(4322F *with* 1P)**

**OR**

***Performance Not Met:*** Caregiver **not** provided with education and **not** referred to additional resources for support, reason not otherwise specified **(4322F *with* 8P)**

## DEMENTIA MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

**Measure #47 - Care Plan**
**RATIONALE:**
It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno, 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

**CLINICAL RECOMMENDATION STATEMENTS:**
Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.
Oral statements

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

**Measure #280 Dementia:Staging of Dementia**
**RATIONALE:**
Dementia is characterized by continued and progressive impairment in cognition and function including the evolution of symptoms over time. (APA, 2007)

The treatment varies throughout the disease course. (APA, 2007)

Patients with dementia, therefore, require assessment of disease severity and subsequent treatment specific and appropriate to their current stage of disease. (APA, 2007)

Early stage patients, for example, have special needs and can and should be involved in care planning and referred to community resources. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

Care for late stage patients may focus on improving the quality of life for patients and caregivers, maintaining optimal function and providing maximum comfort. (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

**CLINICAL RECOMMENDATION STATEMENTS:**

Progressive dementias are generally staged globally according to the level of cognitive and functional impairment, and the same categories may be used to describe the degree of severity of any dementia. However, the staging criteria have not been well validated for non-Alzheimer's dementias. Specific functional staging (FAST staging) has also been developed, is widely used, and can be very useful in tracking the course of Alzheimer's disease and other dementias. The CDR is a commonly used scale to stage dementia severity. The Global Deterioration Scale (GDS) distinguishes three stages in this range. (APA, 2007)

Individuals with "mild" dementia (MMSE score of >18, GDS or FAST stage 4, CDR of 1) are likely to have difficulties with balancing a checkbook, preparing a complex meal, or managing a difficult medication schedule. Those with "moderate" impairment (MMSE score of 10–18, GDS or FAST stages 5 and 6, CDR of 2) also have difficulties with simpler food preparation, household cleanup, and yard work and may require assistance with some aspects of self-care (eg, picking out the proper clothing to wear). Those whose dementia is "severe" (MMSE score of <10, GDS or FAST stages 6 and 7, CDR of 3) require considerable or total assistance with personal care, such as dressing, bathing, and toileting. Research has shown that measurable cognitive abilities remain throughout the course of severe dementia. In the terminal phase, patients become bed bound, develop contractures, require constant care, and may be susceptible to accidents and infectious diseases, which ultimately prove fatal. (APA, 2007)

**Measure #281 – Dementia:Cognitive Assessment**

**RATIONALE:**

Dementia is often characterized by the gradual onset and continuing cognitive decline in one or more domains including memory, executive function, language, judgment, and spatial abilities. (APA, 2007) Cognitive deterioration represents a major source of morbidity and mortality and poses a significant burden on affected individuals and their caregivers. (NIH, 2010) Although cognitive deterioration follows a different course depending on the type of dementia, significant rates of decline have been reported. For example, one study found that the annual rate of decline for Alzheimer's disease patients was more than four times that of older adults with no cognitive impairment. (Wilson et al., 2010) Nevertheless, measurable cognitive abilities remain throughout the course of dementia. (APA, 2007) Initial and ongoing assessments of cognition are fundamental to the proper management of patients with dementia. These assessments serve as the basis for identifying treatment goals, developing a treatment plan, monitoring the effects of treatment, and modifying treatment as appropriate.

**CLINICAL RECOMMENDATION STATEMENTS:**

Ongoing assessment includes periodic monitoring of the development and evolution of cognitive and noncognitive psychiatric symptoms and their response to intervention (Category I). Both cognitive and noncognitive neuropsychiatric and behavioral symptoms of dementia tend to evolve over time, so regular monitoring allows detection of new symptoms and adaptation of treatment strategies to current needs…Cognitive symptoms that almost always require assessment include impairments in memory, executive function, language, judgment, and spatial abilities. It is often helpful to track cognitive status with a structured simple examination. (APA, 2007)

Conduct and document an assessment and monitor changes in cognitive status using a reliable and valid instrument. Cognitive status should be reassessed periodically to identify sudden changes, as well as to monitor the potential beneficial or harmful effects of environmental changes, specific medications, or other interventions. Proper assessment requires the use of a standardized, objective instrument that is relatively easy to use, reliable (with less variability between different assessors), and valid (results that would be similar to gold-standard evaluations). (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

**Measure #282 – Dementia:Functional Status Assessment**
**RATIONALE:**
Dementia is characterized by cognitive deficits that cause functional impairment compromising basic and instrumental activities of daily living. Functional decline for dementia patients is progressive and continuous and typically marked by decline in instrumental activities of daily living followed by a slower decline in basic activities of daily living. (Lechowski L et al. *Dement Geriatr Cogn Disord*. 2010;29(1):46-54.) Functional impairment is the main factor negatively impacting quality of life in patients with dementia including reported links to the development of apathy and depression. (Andersen CK, et al. *Health Qual Life Outcomes.* 2004, 2:52., Starkstein SE et al. *Am J Psychiatry.* 2005;162:2086-2093., Boyle PA, et al. *Am J Geriatr Psychiatry.* 2003 Mar-Apr;11(2):214-21.) In addition, decline in basic activities of daily living is an important risk factor for institutionalization and a strong predictor of decreased survival in dementia patients. (Steeman E, et al. *Arch Psychiatr Nurs.* 1997;11, 295-303., Bracco L, et al. *Arch Neurol.* 1994 Dec;51(12):1213-9.) Initial and ongoing assessments of functional status should be conducted to determine baseline level of functioning, monitor changes over time, and to identify strategies to maximize patient's independence.

**CLINICAL RECOMMENDATION STATEMENTS:**
A detailed assessment of functional status may also aid the clinician in documenting and tracking changes over time as well as providing guidance to the patient and caregivers. Functional status is typically described in terms of the patient's ability to perform instrumental activities of daily living such as shopping, writing checks, basic housework, and activities of daily living such as dressing, bathing, feeding, transferring, and maintaining continence. These regular assessments of recent cognitive and functional status provide a baseline for assessing the effect of any intervention, and they improve the recognition and treatment of acute problems, such as delirium. (APA, 2007)

Conduct and document an assessment and monitor changes in daily functioning, including feeding, bathing, dressing, mobility, toileting, continence, and ability to manage finances and medications…Functional assessment includes evaluation of physical, psychological, and socioeconomic domains. Physical functioning may focus on basic activities of daily living (ADLs) that include feeding, bathing, dressing, mobility, and toileting. Assessment of instrumental (or intermediate) activities of daily living (IADLs) addresses more advanced self-care activities, such as shopping, cooking, and managing finances and medications. Standardized assessment instruments such as the Barthel or Katz indices can provide information on the patient's capacity for self-care and independent living. Proxies or patient surrogates can complete a number of these instruments when necessary. The initial assessment of functional abilities is important to determine a baseline to which future functional deficits may be compared. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

**Measure #283 – Dementia: Neuropsychiatric Symptom Assessment**
**RATIONALE:**
Neuropsychiatric symptoms appear to be common for patients with dementia. In community samples of dementia patients, the prevalence of neuropsychiatric symptoms range from 40-88%. (Lyketsos CG et al. *JAMA*. 2002; 288:1475-1483., Ikeda M et al. *J Neurol Neurosurg Psychiatry.*

2004; 75:146-148., Liu CY et al. *Int Psychogeriatr.* 2007; 19:605-613.) Neuropsychiatric symptoms are also common in long-term care facilities, with prevalence ranges from 80-85%. (Zuidema SU et al. *Int J Geriatr Psychiatry*. 2007; 22:632-638., Kverno KS et al. *J Am Med Dir Assoc*. 2008; 7:509-15.) Neuropsychiatric symptoms of dementia have been associated with accelerated cognitive decline; increased functional impairment; decreased mean survival time; increased co-morbid conditions; increased danger to self; increased danger to others; increased health care service utilization; higher risk for institutionalization; and greater caregiver stress and burden. (Chui HC et al. *Arch Neurol.* 1994; 51:676–681., Weiner MF et al. *Acta Psychiatr Scand.* 2005; 111:367-371., Cummings JL et al. *Neurology.* 1994, 44(12):2308-14. Leger JM et al. *Int Psychogeriatr.* 2002; 14:405-416., Malone ML et al. *J Am Geriatr Soc.* 1993; 41:853-856.,Kunik ME et al. *Gerontologist.* 2003; 43:86-91., Kunik ME et al. *Psychiatr Serv*. 2005; 56:70-75., Steele C et al. *Am J Psychiatry.* 1990; 147:1049-1051., Knopman DS et al. *Neurology*. 1999; 52:718-718., Donaldson C et al. *Int J Geriatr Psychiatr.* 1998; 13:248-256., Miyamoto Y et al. *Int J Geriatr Psychiatry*. 2002; 17:765-773., Snyder L et al. *Am J Alzheimers Dis Other Demen.* 2007; 22:14-19.) An assessment of neuropsychiatric symptoms, therefore, is an important step in the development of a management plan for those with dementia.

**CLINICAL RECOMMENDATION STATEMENTS:**

It is important for the [clinician] treating a patient with dementia to regularly assess cognitive deficits or behavioral difficulties that potentially pose a danger to the patient or others. (APA, 2007)

Conduct and document an assessment and monitor changes in behavioral symptoms, psychotic symptoms, or depression. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

**For mild to moderate Alzheimer's disease**

Assessment of patients with mild to moderate AD [Alzheimer's Disease] should include measures of behavior and other neuropsychiatric symptoms. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

**For severe Alzheimer's disease**

Assessment should include cognition (eg, MMSE), function, behaviour, medical status, nutrition, safety and caregiver health. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

**Measure #284 – Dementia: Management of Neuropsychiatric Symptoms**

**RATIONALE:**

Neuropsychiatric symptoms appear to be common for patients with dementia. In community samples of dementia patients, the prevalence of neuropsychiatric symptoms range from 40-88%. (Lyketsos CG et al. *JAMA*. 2002; 288:1475-1483., Ikeda M et al. *J Neurol Neurosurg Psychiatry.* 2004; 75:146-148., Liu CY et al. *Int Psychogeriatr.* 2007; 19:605-613.) Neuropsychiatric symptoms are also common in long-term care facilities, with prevalence ranges from 80-85%.(Zuidema SU et al. *Int J Geriatr Psychiatry*. 2007; 22:632-638., Kverno KS et al. *J Am Med Dir Assoc*. 2008; 7:509-15.) Neuropsychiatric symptoms of dementia have been associated with accelerated cognitive decline; increased functional impairment; decreased mean survival time; increased co-morbid conditions; increased danger to self; increased danger to others; increased health care service utilization; higher risk for institutionalization; and greater caregiver stress and burden. ( Chui HC et al. *Arch Neurol.* 1994; 51:676–681., Weiner MF et al. *Acta Psychiatr Scand.* 2005; 111:367-371., Cummings JL et al. *Neurology.* 1994, 44(12):2308-14. Leger JM et al. *Int Psychogeriatr.* 2002; 14:405-416., Malone ML et al. *J Am Geriatr Soc.* 1993; 41:853-856.,Kunik ME et al. *Gerontologist.* 2003; 43:86-91., Kunik ME et al. *Psychiatr Serv*. 2005; 56:70-75., Steele C et al. *Am J Psychiatry.* 1990; 147:1049-1051., Knopman DS et al. *Neurology.* 1999; 52:718-718., Donaldson C et al. *Int J Geriatr Psychiatr.* 1998; 13:248-256., Miyamoto Y et al. *Int J Geriatr Psychiatry*. 2002; 17:765-773.,

Snyder L et al. *Am J Alzheimers Dis Other Demen.* 2007; 22:14-19.) Nonpharmacologic interventions should be considered in all cases and in some will be the mainstay of management. Examples of approaches that may be useful include behavioural management for depression, education programs for caregivers and staff to teach them how to recognize, manage, and sometimes prevent behavioral problems, stress reduction for caregivers, and, for patients living at home, enrollment in adult day programs offering structured activities and social stimulation. The evidence evaluating non-pharmacological interventions varies considerably in quality and amount, but broadly supports an individualized approach that includes one or more such interventions. A management plan that assesses the severity and intrusiveness of problematic behaviors can assist clinicians in determining what pharmacologic or non-pharmacologic interventions might be appropriate. (Lawlor B. *J Clin Psychiatry.* 2004;65(Suppl 11):5–10.) Mild forms of neuropsychiatric symptoms may be alleviated with psychosocial or environmental interventions. For aggressiveness, presentations of psychosis, or agitation, pharmacologic approaches may be more appropriate. (Sink K et al. *JAMA.* 2005;293:596–608.) If pharmacologic approaches are necessary, they should be administered at the lowest effective dose and their use should be reevaluated and their benefit documented on an ongoing basis.

**CLINICAL RECOMMENDATION STATEMENTS:**

**For mild to moderate Alzheimer's disease**

The management of BPSD [Behavioral and Psychological Symptoms of Dementia] should include a careful documentation of behaviours and identification of target symptoms, a search for potential triggers or precipitants, recording of the consequences of the behaviour, an evaluation to rule out treatable or contributory causes, and consideration of the safety of the patient, their caregiver, and others in their environment. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

**For severe Alzheimer's disease**

The management of BPSD should begin with appropriate assessments, diagnosis, and identification of target symptoms and consideration of safety of the patient, their caregiver and others in their environment. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

There are no fully comprehensive consensus guidelines for use of specific non-pharmacological approaches to neuropsychiatric symptoms. Patient heterogeneity, variations in care settings, and the broad range of non-pharmacological interventions having some empirical support impede uniform generalization. However, the following evidence statements serve as the evidence to support the measure and are quoted verbatim from the referenced clinical guidelines.

Nonpharmacologic interventions should be initiated first. Approaches that may be useful for severe Alzheimer disease include behavioural management for depression, and education programs for caregivers and staff to teach them how to recognize behavioural problems and to teach them behaviour-modification techniques. Music therapy and controlled multisensory stimulation (Snoezelen) are useful during treatment sessions, but longer-term benefits have not been demonstrated. (Grade B, Level 1) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

Except for emergency situations, non-pharmacological strategies are the preferred first-line treatment approach for behavioral problems. Medications should be used only as a last resort, if non-pharmacological approaches prove unsuccessful and they are clinically indicated. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

Pharmacologic therapies should be initiated concurrently with nonpharmacologic interventions in the presence of severe depression, psychosis or aggression that puts the patient or others at risk

of harm. (Grade B, Level 3) (Third Canadian Consensus Conference on the Diagnosis and Treatment of Dementia, 2008)

**Measure #285 – Dementia: Screening for Depressive Symptoms**
**RATIONALE:**
Depression is one of the most common co-occurring psychiatric conditions in dementia patients, affecting over 50% of patients with Alzheimer's disease. (Starkstein SE et al. *Am J Psychiatry.* 2005;162:2086-2093.) Depression can be reliably detected and quantified, and can be differentiated from the other neuropsychiatric symptoms of dementia. (Lyketsos CG et al. *Dement Geriatr Cogn Disord.* 2004;17:55-64.) The impact of depression is significant with even mild levels of depression in dementia patients associated with higher rates of disability, impaired quality of life, and greater mortality. (APA, 2007) In particular, Alzheimer's disease patients with depression have demonstrated "significantly more severe apathy, delusions, anxiety, pathological affective crying, irritability, deficits in activities of daily living, impairments in social functioning, and parkinsonism than Alzheimer's disease patients without depression." (Starkstein SE et al. *Am J Psychiatry.* 2005;162:2086-2093.) Furthermore, with increasing severity of depression, the severity of psychopathological and neurological impairments in dementia patients increases. (Starkstein SE et al. *Am J Psychiatry.* 2005;162:2086-2093.) Identifying depression in patients with dementia is therefore essential for early intervention and proper management.

**CLINICAL RECOMMENDATION STATEMENTS:**
Depression is a common, treatable comorbidity in patients with dementia and should be screened for (Guideline). (AAN, 2001)

Ongoing assessment includes periodic monitoring of the development and evolution of cognitive and noncognitive psychiatric symptoms and their response to intervention (Category I)…Among the neuropsychiatric symptoms that require ongoing assessment are depression (including major depression and other depressive syndromes), suicidal ideation or behavior, hallucinations, delusions, agitation, aggressive behavior, disinhibition, sexually inappropriate behavior, anxiety, apathy, and disturbances of appetite and sleep. (APA, 2007)

Conduct and document an assessment and monitor changes in behavioral symptoms, psychotic symptoms, or depression…It is important for health care professionals to be sensitive to symptoms of affective disorders associated with Alzheimer's Disease and to facilitate early intervention. Since administering assessment tests for depression to Alzheimer's Disease patients is often challenging and patients may be unable to describe their symptoms to the [primary care practitioner], gathering data from family members becomes especially important. The Cornell Scale for Depression in Dementia is a useful tool for providers because it captures both patient and caregiver input. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

In patients with serious illness at the end of life, clinicians should regularly assess patients for pain, dyspnea, and depression. (Grade: strong recommendation, moderate quality of evidence.) (ACP, 2008)

**Measure #286 – Dementia: Counseling Regarding Safety Concerns**
**RATIONALE:**
The vast majority (87%) of individuals with Alzheimer's disease are cared for at home by family members.(Alz Assoc, 2009) "As the disease progresses however, physical features of the home environment may present as a safety hazard or barrier to performing activities of daily living, particularly at the moderate stage of the disease process."(Gitlin LN et al. *Disabil Rehabil.* 2002, Vol. 24 , No. 1-3, Pages 59-71.) Safety concerns should be addressed with patients and their caregivers throughout the course of the disease.

**CLINICAL RECOMMENDATION STATEMENTS:**

Recommended assessments include evaluation of suicidality, dangerousness to self and others, and the potential for aggression, as well as evaluation of living conditions, safety of the environment, adequacy of supervision, and evidence of neglect or abuse (Category I). [I]Important safety issues in the management of patients with dementia include interventions to decrease the hazards of wandering and recommendations concerning activities such as cooking, driving, hunting, and the operation of hazardous equipment. Caregivers should be referred to available books [and other materials] that provide advice and guidance about maximizing the safety of the environment for patients with dementia…As patients become more impaired, they are likely to require more supervision to remain safe, and safety issues should be addressed as part of every evaluation. Families should be advised about the possibility of accidents due to forgetfulness (eg, fires while cooking), of difficulties coping with household emergencies, and of the possibility of wandering. Family members should also be advised to determine whether the patient is handling finances appropriately and to consider taking over the paying of bills and other responsibilities. At this stage of the disease [ie, moderately impaired patients], nearly all patients should not drive. (APA, 2007)

Safety issues such as driving, fall risk, medication management, environmental hazards, wandering, and access to firearms need to be discussed periodically with the patient and caregiver. Safety concerns typically focus on three risks in particular: falling, wandering, and driving. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

**For mild to moderate Alzheimer's disease**

Assess for safety risks (eg, driving, financial management, medication management, home safety risks that could arise from cooking or smoking, potentially dangerous behaviours such as wandering). (Canadian Consensus Conference on Diagnosis and Treatment of Dementia, 2008)

**Measure #287 – Dementia: Counseling Regarding Risks of Driving**

**RATIONALE:**

Motor vehicle-related injuries are a leading cause of injury deaths in adults over 65. (AMA Physician's Guide to Assessing and Counseling Older Drivers, 2010) Per mile driven, drivers age 75 and older are involved in significantly more motor vehicle crashes than middle-aged drivers. (AMA Physician's Guide to Assessing and Counseling Older Drivers, 2010) Dementia has a negative impact on driving skills which deteriorate with increasing dementia severity. (AAN, 2010)

Compared with cognitively intact older adults drivers, studies suggest that drivers with dementia have at least a 2-fold greater risk of crashes. (Carr DB et al. *JAMA.* 2010;303(16):1632-1641.) "Physicians can influence their patients' decisions to modify or stop driving. They can also help their patients maintain safe driving skills." (AMA Physician's Guide to Assessing and Counseling Older Drivers, 2010) Clinicians should address the risks of driving in patients with dementia for the safety of the patient and everyone on the road.

**CLINICAL RECOMMENDATION STATEMENTS:**

A diagnosis of Alzheimer's disease is not, on its own, a sufficient reason to withdraw driving privileges. The determining factor in withdrawing driving privileges should be an individual's driving ability. (Alzheimer's Association, 2001)

All patients and families should be informed that even mild dementia increases the risk of vehicular accidents (Category I). Mildly impaired patients should be advised to limit their driving to safer situations or to stop driving (Category I), and moderately impaired patients should be instructed not to drive (Category I). Advice about driving cessation should also be communicated to family members, as the implementation of the recommendation often falls on them (Category I). Relevant state laws regarding notification should be followed (Category I). (APA, 2007)

For patients with dementia, consider the following characteristics useful for identifying patients at increased risk for unsafe driving: the Clinical Dementia Rating scale (Level A), a caregiver's rating of a patient's driving ability as marginal or unsafe (Level B), a history of crashes or traffic citations (Level C), reduced driving mileage or self-reported situational avoidance (Level C), Mini-Mental State Examination scores of (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008) or less (Level C), and aggressive or impulsive personality characteristics (Level C). Consider the following characteristics not useful for identifying patients at increased risk for unsafe driving: a patient's self-rating of safe driving ability (Level A) and lack of situational avoidance (Level C). There is insufficient evidence to support or refute the benefit of neuropsychological testing, after controlling for the presence and severity of dementia, or interventional strategies for drivers with dementia (Level U). Clinicians may present patients and their caregivers with the data showing that, as a group, patients with mild dementia (CDR of 1) are at a substantially higher risk for unsafe driving and thus should strongly consider discontinuing driving. At the very least, patients and their caregivers should prepare for the eventuality of driving cessation as dementia severity increases. (AAN, 2010)

**Measure #288 – Dementia: Caregiver Education and Support**
**RATIONALE:**
The vast majority (87%) of individuals with Alzheimer's disease are cared for at home by family members. (Alz Assoc, 2009) Chodosh et al. found that greater caregiver knowledge of dementia management was associated with higher care quality. (Chodosh J et al. *J Am Geriatr Soc.* 2007 Aug;55(8):1260-8.) Other studies have indicated that intensive caregiver support in the form of individual and family counseling and on-going telephone counseling results in improved patient health outcomes. (Gaugler JE et al. *J Am Geriatr Soc.* 2005;53:2098–2105., Mittelman MS et al. *Neurology.* 2006;67:1592–1599.) Providing education to caregivers and referring them to additional sources for support is a critically important piece of comprehensive care for patients with dementia.

**CLINICAL RECOMMENDATION STATEMENTS:**

Important aspects of psychiatric management include educating patients and families about the illness, its treatment, and sources of additional care and support (eg, support groups, respite care, nursing homes, and other long-term-care facilities) and advising patients and their families of the need for financial and legal planning due to the patient's eventual incapacity (eg, power of attorney for medical and financial decisions, an up-to-date will, and the cost of long-term care) (Category I)… The family should be educated regarding basic principles of care, including 1) recognizing declines in capacity and adjusting expectations appropriately, 2) bringing sudden declines in function and the emergence of new symptoms to professional attention, 3) keeping requests and demands relatively simple, 4) deferring requests if the patient becomes overly upset or angered, 5) avoiding overly complex tasks that may lead to frustration, 6) not confronting patients about their deficits, 7) remaining calm, firm, and supportive and providing redirection if the patient becomes upset, 8) being consistent and avoiding unnecessary change, and 9) providing frequent reminders, explanations, and orientation cues… In addition to providing families with information on support groups, there are a number of benefits of referral to the local chapter or national office of the Alzheimer's Association (1-800-272-3900; http://www.alz.org), the Alzheimer's Disease Education and Referral Center (ADEAR) (1-800-438-4380; http://www.nia.nih.gov/Alzheimers/), and other support organizations. (APA, 2007).

Studies have shown that education and support for caregivers increases the chances of adherence to treatment recommendations for patients. The PCP should provide information and education about the current stage of the disease process and talk with the patient and family to establish treatment goals. Based on the agreed-upon goals, a discussion regarding the expected effects (positive and negative) of interventions on cognition, mood, and behavior will ensure that the prescribed treatment strategy is appropriate to family values and culture. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008)

Seamless resource referral and access to critical services for both patients and caregivers are considered essential. The PCP should encourage the caregiver to participate in educational programs, support groups, respite services, and adult day service programs. The local Alzheimer's Association chapter or other local agency support groups and community resources such as the Caregiver Resources Centers should be recommended. (California Workgroup on Guidelines for Alzheimer's Disease Management, 2008).

# PQRS Measures in Parkinson's Disease Measures Group

47 Care Plan

289 Annual Parkinson's Disease Diagnosis Review

290 Psychiatric Disorders or Disturbances Assessment

291 Cognitive Impairment or Dysfunction Assessment

292 Querying about Sleep Disturbances

293 Rehabilitative Therapy Options

294 Parkinson's Disease Medical and Surgical Treatment Options Reviewed

## REPORTING REQUIREMENTS FOR MEASURES GROUP

Report on 20 unique patients (a majority of which must be Medicare Part B FFS patients) aged 18 years or older with a specific diagnosis of Parkinson's Disease accompanied by a specific patient encounter – **refer to measure specifications for diagnosis and patient encounter information.**

To report satisfactorily the Parkinson's Disease Measures Group it requires all applicable measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.

## AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


## REPORTING METHOD(S)

Registry Only

## MEASURES GROUP OVERVIEW

Click **here** to access the Parkinson's Disease measures group overview.

## MEASURES GROUP RATIONALE

Click **here** to access the Parkinson's Disease Measures Group Rationale and Clinical Recommendation Statements.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

# PARKINSON'S DISEASE MEASURES GROUP OVERVIEW

## 2015 PQRS OPTIONS FOR MEASURES GROUPS:

### 2015 PQRS MEASURES IN PARKINSON'S DISEASE MEASURES GROUP:

#47 Care Plan
#289 Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review
#290 Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment
#291 Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment
#292 Parkinson's Disease: Querying about Sleep Disturbances
#293 Parkinson's Disease: Rehabilitative Therapy Options
#294 Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed

### INSTRUCTIONS FOR REPORTING:

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

  **G8903:** I intend to report the Parkinson's Disease Measures Group

- Report the patient sample method:
  **20 Patient Sample Method via registries:** 20 unique patients (a majority of which must be Medicare Part B FFS patients) meeting patient sample criteria for the measures group during the reporting period (January 1 through December 31, 2015).

- Patient sample criteria for the Parkinson's Disease Measures Group are patients aged 18 years and older with a specific diagnosis of Parkinson's Disease accompanied by a specific patient encounter:

  **The following diagnosis code indicating Parkinson's disease:**
  **ICD-9-CM [for use 1/1/2015 – 9/30/2015]:** 332.0
  **ICD-10-CM [for use 10/1/2015 - 12/31/2015]:** G20

  **Accompanied by:**

  **One of the following patient encounter codes:** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, or 99350

- Report a numerator option on **all applicable** measures within the Parkinson's Disease Measures Group for each patient within the eligible professional's patient sample.

- Measure #47 need only be reported on patients 65 years and older.

- Instructions for qualifying numerator option reporting for each of the measures within the Parkinson's Measures Group are displayed on the next several pages. The following composite Quality Data Code (QDC) has been created for registries that utilize claims data. This QDC may be reported in lieu of individual QDCs when all quality clinical actions for all applicable measures within the group have been performed.

  **Composite QDC G8762:** All quality actions for the applicable measures in the Parkinson's Disease Measures Group have been performed for this patient

- To report satisfactorily the Parkinson's Disease Measures Group it requires **all applicable** measures for each patient within the eligible professional's patient sample to be reported a minimum of once during the reporting period.

- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group. The recommended clinical quality action must be performed on at least one patient for each measure within the measures group reported by the eligible professional. Performance exclusion quality-data codes are not counted in the performance denominator. If the eligible professional submits all performance exclusion quality-data codes, the performance rate would be 0/0 and would be considered satisfactorily reporting. If a measure within a measures group is not applicable to a patient, the patient would not be counted in the performance denominator for that measure (e.g., Preventive Care Measures Group - Measure #39: Screening or Therapy for Osteoporosis for Women would not be applicable to male patients according to the patient sample criteria). If the measure is not applicable for all patients within the sample, the performance rate would be 0/0 and would be considered satisfactorily reporting.

- **NOTE:** The detailed instructions in this specification apply exclusively to the reporting and analysis of the included measures under the measures group option.

## Measure #47 (NQF 0326): Care Plan -- National Quality Strategy Domain: Communication and Care Coordination

**DESCRIPTION:**
Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**NUMERATOR:**
Patients who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

**Numerator Instructions:** If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report **1124F**.

**Definition:**
**Documentation that Patient did not Wish or was not able to Name a Surrogate Decision Maker or Provide an Advance Care Plan** – May also include, as appropriate, the following:

- That the patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, as it would be viewed as harmful to the patient's beliefs and thus harmful to the physician-patient relationship.

**Numerator Options:**
***Performance Met:*** Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record **(1123F)**
**OR**
***Performance Met:*** Advance Care Planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan **(1124F)**

**OR**

***Performance Not Met*:** Advance care planning **not** documented, reason not otherwise specified **(1123F *with* 8P)**

## Measure #289: Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
All patients with a diagnosis of Parkinson's disease who had an annual assessment including a review of current medications (e.g., medications that can produce Parkinson-like signs or symptoms) and a review for the presence of atypical features (e.g., falls at presentation and early in the disease course, poor response to levodopa, symmetry at onset, rapid progression [to Hoehn and Yahr stage 3 in 3 years], lack of tremor or dysautonomia) at least annually

**NUMERATOR:**
All patients who had an annual assessment including a review of current medications and for the presence of atypical features

**Numerator Options:**
***Performance Met:*** Parkinson's disease diagnosis reviewed **(1400F)**

**OR**

***Performance Not Met:*** Parkinson's disease diagnosis was **not** reviewed, reason not otherwise specified **(1400F *with* 8P)**

## Measure #290: Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
All patients with a diagnosis of Parkinson's disease who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually

**NUMERATOR:**
Patients who were assessed for psychiatric disorders or disturbances (e.g., psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually

**Numerator Options:**
***Performance Met:*** Psychiatric disorders or disturbances assessed **(3700F)**

**OR**

***Performance Not Met:*** Psychiatric disorders or disturbances **not** assessed, reason not otherwise specified **(3700F *with* 8P)**

## Measure #291: Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
All patients with a diagnosis of Parkinson's disease who were assessed for cognitive impairment or dysfunction at least annually

**NUMERATOR:**
Patients who were assessed for cognitive impairment or dysfunction at least annually

**Numerator Options:**
***Performance Met:*** Cognitive impairment or dysfunction assessed **(3720F)**

**OR**

***Performance Not Met:*** Cognitive impairment or dysfunction was **not** assessed, reason not otherwise specified **(3720F *with* 8P)**

## Measure #292: Parkinson's Disease: Querying about Sleep Disturbances -- National Quality Strategy Domain: Effective Clinical Care

**DESCRIPTION:**
All patients with a diagnosis of Parkinson's disease (or caregivers, as appropriate) who were queried about sleep disturbances at least annually

**NUMERATOR:**
Patients (or caregiver(s), as appropriate) who were queried about sleep disturbances at least annually

**Numerator Options:**
***Performance Met:*** Patient (or caregiver) queried about sleep disturbances **(4328F)**

**OR**

*Medical Performance Exclusion:* Documentation of medical reason(s) for not querying about sleep disturbances **(4328F *with* 1P)**

**OR**

***Performance Not Met:*** Patient (or caregiver) **not** queried about sleep disturbances, reason not otherwise specified **(4328F *with* 8P)**

## Measure #293: Parkinson's Disease: Rehabilitative Therapy Options -- National Quality Strategy Domain: Communication and Care Coordination

**DESCRIPTION:**
All patients with a diagnosis of Parkinson's Disease (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually

**NUMERATOR:**
Patients (or caregiver(s), as appropriate) who had rehabilitative therapy options (e.g., physical, occupational, or speech therapy) discussed at least annually

**Numerator Options:**

***Performance Met:*** Rehabilitative therapy options discussed with patient (or caregiver) **(4400F)**

**OR**

***Medical Performance Exclusion:*** Documentation of medical reason(s) for not discussing rehabilitative therapy options with patient (or caregiver) **(4400F *with* 1P)**

**OR**

***Performance Not Met:*** Rehabilitative therapy options **not** discussed with patient (or caregiver), reason not otherwise specified **(4400F *with* 8P)**

**Measure #294: Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed -- National Quality Strategy Domain: Communication and Care Coordination**

**DESCRIPTION:**
All patients with a diagnosis of Parkinson's disease (or caregiver(s), as appropriate) who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually

**NUMERATOR:**
Patients (or caregiver(s), as appropriate) who had the Parkinson's disease treatment options (e.g., non-pharmacological treatment, pharmacological treatment, or surgical treatment) reviewed at least once annually

**Numerator Options:**

***Performance Met:*** Medical and surgical treatment options reviewed with patient (or caregiver) **(4325F)**

**OR**

***Medical Performance Exclusion:*** Medical and surgical treatment options not reviewed with patient (or caregiver) for medical reasons (eg, patient is unable to respond and no informant is available) **(4325F *with* 1P)**

**OR**

***Performance Not Met:*** Medical and surgical treatment options **not** reviewed with patient (or caregiver), reasons not specified **(4325F *with* 8P)**

## PARKINSON'S DISEASE MEASURES GROUP RATIONALE AND CLINICAL RECOMMENDATION STATEMENTS

**Measure #47 – Care Plan**
**RATIONALE:**
It is essential that the patient's wishes regarding medical treatment be established as much as possible prior to incapacity. The Work Group has determined that the measure should remain as specified with no required timeframe based on a review of the literature. Studies have shown that people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval. It was felt by the Work Group that the error rate in simply not having addressed the issue at all is so much more substantial (Teno, 1997) than the risk that an established plan has become outdated that we should not define a specific timeframe at this time. As this measure is tested and reviewed, we will continue to evaluate if and when a specific timeframe should be included.

**CLINICAL RECOMMENDATION STATEMENTS:**
Advance directives are designed to respect patient's autonomy and determine his/her wishes about future life-sustaining medical treatment if unable to indicate wishes. Key interventions and treatment decisions to include in advance directives are: resuscitation procedures, mechanical respiration, chemotherapy, radiation therapy, dialysis, simple diagnostic tests, pain control, blood products, transfusions, and intentional deep sedation.

Oral statements

- Conversations with relatives, friends, and clinicians are most common form; should be thoroughly documented in medical record for later reference.
- Properly verified oral statements carry same ethical and legal weight as those recorded in writing.

Instructional advance directives (DNR orders, living wills)

- Written instructions regarding the initiation, continuation, withholding, or withdrawal of particular forms of life-sustaining medical treatment.
- May be revoked or altered at any time by the patient.
- Clinicians who comply with such directives are provided legal immunity for such actions.

Durable power of attorney for health care or health care proxy

- A written document that enables a capable person to appoint someone else to make future medical treatment choices for him or her in the event of decisional incapacity. (AGS)

The National Hospice and Palliative Care Organization provides the Caring Connection web site, which provides resources and information on end-of-life care, including a national repository of state-by-state advance directives.

**Measure #289 - Parkinson's Disease: Annual Parkinson's Disease Diagnosis Review**
**RATIONALE:**
Because the diagnosis of Parkinson's disease is clinical with no confirmatory laboratory or imaging study, it is important to review the diagnosis periodically in order to ensure that no atypical features emerge. The emergence of atypical features in a patient previously thought to have Parkinson's disease will influence prognosis and medical treatment. It has been demonstrated that in the course of caring for patients with suspected Parkinson's disease, 10-15% will ultimately have a different pathologic diagnosis. This measure will alert the clinician to the emergence of atypical features in Parkinson's disease and suggest alternate diagnostic possibilities.

Hughes AJ, Daniel SE, Kilford L, Lees AJ. Accuracy of clinical diagnosis of idiopathic Parkinson's disease: a clinico-pathological study of 100 cases. J Neurol Neurosurg Psychiatry. 1992 Mar; 55(3):181-4

Hughes AJ, Ben-Shlomo Y, Daniel SE, Lees AJ. What features improve the accuracy of clinical diagnosis in
Parkinson's disease: a clinicopathologic study. Neurology. 1992 Jun;42(6):1142-6

**CLINICAL RECOMMENDATION STATEMENTS:**

The diagnosis of PD should be reviewed regularly (6-12 month intervals seen to review diagnosis) and re- considered if atypical clinical features develop. (Level D (DS)) NICE GL35 (June 2006)

Determining the presence of the following clinical features in early stages of disease should be considered to distinguish PD from other parkinsonian syndromes: 1) falls at presentation and early in the disease course, 2) poor response to levodopa, 3) symmetry at onset, 4) rapid progression (to Hoehn and Yahr stage 3 in 3 years),5) lack of tremor, and 6) dysautonomia (urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, persistent erectile failure, or symptomatic orthostatic hypotension) (Level B). AAN QSS PD (April 2006)

All veterans with the suspected diagnosis of PD who are also receiving medications known to cause parkinsonism (e.g., neuroleptics) should have a trial of withdrawal of these medications, a trial of low-potency neuroleptic, or documentation in the medical record that the medication could not be withdrawn before making the diagnosis of PD. Cheng #1 (Assessment of medication-induced PD) 2004

AAN QSS PD Diag. (April 2006) Suchowersky O, Reich S, Perlmutter J, Zesiewicz T, Gronseth G, Weiner WJ, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: diagnosis and prognosis of new onset Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11; 66(7):968-75

NICE National Collaborating Centre for Primary Care. National Collaborating Centre for Chronic Conditions. Parkinson's Disease: National Clinical Guideline for Management in Primary and Secondary Care (2006) London: Royal College of Physicians

Cheng Eric, Siderowf Andrew, Swarztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson’s disease

**Measure #290 - Parkinson’s Disease: Psychiatric Disorders or Disturbances Assessment**

**RATIONALE:**

Parkinson’s disease is associated with a wide range of psychiatric disorders. Some of these problems are related to the disease itself and some are related to the medications used to treat the disease. These disorders range from anxiety and depression to psychosis and impulse control disorder. It has been demonstrated that depression, in particular, has been often overlooked as a diagnostic possibility in patients with Parkinson’s disease. In fact, it has been demonstrated that depression and other psychiatric disorders are often overlooked in the general medical population. This measure will ensure that the clinician remembers to evaluate the patient for the basis of these psychiatric disorders on a yearly basis.

Marsh L. Neuropsychiatric aspects of Parkinson's disease. Psychosomatics. 2000 Jan-Feb; 41(1):15-23

Ravina B, Marder K, Fernandez HH, Friedman JH, McDonald W, Murphy D, Aarsland D, Babcock D, Cummings J, Endicott J, Factor S, Galpern W, Lees A, Marsh L, Stacy M, Gwinn-Hardy K, Voon V, Goetz C. Diagnostic criteria for psychosis in Parkinson's disease: report of an NINDS, NIMH work group. Mov Disord. 2007 Jun 15;22(8):1061-8

Galpern WR, Stacy M. Management of impulse control disorders in Parkinson's disease. Curr Treat Options Neurol. 2007 May;9(3):189-97

Shulman LM, Taback RL, Rabinstein AA, Weiner WJ. Non-recognition of depression and other non-motor symptoms in Parkinson's disease. Parkinsonism Relat Disord. 2002 Jan;8(3):193-7

**CLINICAL RECOMMENDATION STATEMENTS:**

Clinicians should be aware of dopamine dysregulation syndrome, an uncommon disorder in which dopaminergic medication misuse is associated with abnormal behaviors, including hypersexuality, pathological gambling and stereotypic motor acts. This syndrome may be difficult to manage. (Level D) NICE GL35 (Jun 2006).

If a veteran with PD presents with new onset of one of the following symptoms: sad mood, feeling down; insomnia or difficulties with sleep; apathy or loss of interest in pleasurable activities; complains of memory loss; unexplained weight loss of greater than 5% in the past month or 10% over one year; or unexplained fatigue or low energy, then the patient should be asked about or treated for depression, or referred to a mental health professional within two weeks of presentation. (Outcomes Impact 5; Room for Improvement 4; Overall utility rating 4) Cheng 2004

Clinicians should have a low threshold for diagnosing depression in PD. (Level D) NICE GL35 (Jun 2006) All veterans with PD should be reassessed for complications of PD (including, but not limited to functional status, excessive daytime somnolence, speech and swallowing difficulties, dementia, depression, and psychosis) at least on an annual basis. Cheng #10 (Reassessment for complications for PD) 2004

All people with PD and psychosis should receive a general medical evaluation and treatment for any precipitating condition. (Level D) NICE GL35 (Jun 2006)

NICE National Collaborating Centre for Primary Care. National Collaborating Centre for Chronic Conditions. Parkinson's Disease: National Clinical Guideline for Management in Primary and Secondary Care (2006) London: Royal College of Physicians

Cheng Eric, Siderowf Andrew, Swarztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)

**Measure #291 - Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment**

**RATIONALE:**

Parkinson's disease is associated with cognitive impairment. It is important to assess patients with Parkinson's disease on an annual basis with regard to their cognitive abilities. Clinically significant cognitive difficulties may be present early on in the disease course, but dementia may emerge and be diagnosed later in the course of the disease. However, the insidious onset of cognitive impairment/dementia often occurs over a prolonged period of time. Emerging cognitive impairment has limited treatment, but is important to identify in terms of the patient's care and responsibilities within the home, socially, or in the work place.

Factor, S. Weiner, W. Parkinson's Disease: Diagnosis and Clinical Management . 2002

**CLINICAL RECOMMENDATION STATEMENTS:**
The Mini-Mental State Examination (MMSE) and the Cambridge Cognitive Examination (CAM Cog) should be considered as screening tools for dementia in patients with PD (Level B). AAN QSS (April 2006)

All veterans with PD should be reassessed for complications of PD (including, but not limited to functional status, excessive daytime somnolence, speech and swallowing difficulties, dementia, depression, and psychosis) at least on an annual basis. Cheng #10 (Reassessment for complications for PD) 2004

AAN QSS Mental (April 2006) Miyasaki JM, Shannon K, Voon V, Ravina B, Kleiner-Fisman G, Anderson K, Shulman LM, Gronseth G, Weiner WJ, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: evaluation and treatment of depression, psychosis, and dementia in Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11;66(7):996-1002

Cheng Eric, Siderowf Andrew, Swarztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)This measure may be used as an accountability measure.

**Measure #292 - Parkinson's Disease: Querying about Sleep Disturbances**
**RATIONALE:**
Sleep disorders are common in Parkinson's disease and most commonly include sleep fragmentation (80%), restless legs syndrome (20%), REM behavior sleep disorder (>40%), and excessive daytime sleepiness (~50%). Sleep fragmentation could relate to motor symptoms such as tremor and dystonia, restless legs syndrome, depression, anxiety, agitation, urinary frequency, or medication (most notably selegiline but also dopamine agonists). Several approaches to effective therapy are available. Excessive daytime sleepiness could result in sleep attacks or unintended sleep episodes. Such episodes have been described in various situations, including while driving a car. Excessive daytime sleepiness may result from medication (dopamine agonists), dementia, psychosis, or poor nocturnal sleep hygiene and is generally more common in advanced Parkinson's disease.

Medication adjustment and the use of stimulants may be warranted. REM behavior disorder is defined by the patient acting out dreams. The result could be either the patient or spouse moving to a different bedroom. This syndrome is treated with benzodiazepines and other medications. Assessing sleep would be expected to lead to improved morbidity and function.

Comella, C. Sleep disorders in Parkinson's disease. Curr Treat Options Neurol. 2008 May; 10(3):215-21.
Adler CH, Thorpy MJ. Sleep issues in Parkinson's disease. Neurology. 2005 Jun 28;64(12 Suppl 3):S12-20. Iranzo A, Santamaría J, Rye DB, Valldeoriola F, Martí MJ, Muñoz E, Vilaseca I, Tolosa E. Characteristics of idiopathic REM sleep behavior disorder and that associated with MSA and PD. Neurology. 2005 Jul 26;65(2):247-52

**CLINICAL RECOMMENDATION STATEMENTS:**
A full sleep history should be taken from people with PD who report sleep disturbance (Level D) NICE GL35 (Jun 2006)

Good sleep hygiene should be advised in people with PD with any sleep disturbance and includes: avoidance of stimulants (for example, coffee, tea, caffeine) in the evening; establishment of a regular pattern of sleep; comfortable bedding and temperature; provision of assistive devices, such

as a bed lever or rails to aid with moving and turning, allowing the person to get more comfortable; restriction of daytime siestas; advice about taking regular and appropriate exercise to induce better sleep; a review of all medication and avoidance of any drugs that may affect sleep or alertness, or may interact with other medication (for example, selegiline, antihistamines, H2 antagonists, antipsychotics and sedatives). NICE GL35 (June 2006)

All veterans with PD should be reassessed for complications of PD (including, but not limited to functional status, excessive daytime somnolence, speech and swallowing difficulties, dementia, depression, and psychosis) at least on an annual basis. Cheng #10 (Reassessment for complications for PD) 2004

NICE National Collaborating Centre for Primary Care. National Collaborating Centre for Chronic Conditions. Parkinson's Disease: National Clinical Guideline for Management in Primary and Secondary Care (2006) London: Royal College of Physicians

Cheng Eric, Siderowf Andrew, Swarztrauber Kari, Eisa Mahmood, Lee Martin and Vickrey Barbara. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)

**Measure #293 - Parkinson's Disease: Rehabilitative Therapy Options**
**RATIONALE:**
For those patients with Parkinson's disease who have impaired activities of daily living, therapy options such as physical, occupational, and speech therapy should be offered. Rehabilitative therapies play an important role in improving function and quality of life for these patients. Symptomatic therapy can provide benefit for many years. Patients with Parkinson's disease commonly develop dysarthria.

AAN QSS Neuro Alt (April 2006) Suchowersky O, Gronseth G, Perlmutter J, Reich S, Zesiewicz T, Weiner
WJ, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: neuroprotective strategies and alternative therapies for Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11;66(7):976-82.

Factor, S. Weiner, W. Parkinson's Disease: Diagnosis and Clinical Management. 2002

**CLINICAL RECOMMENDATION STATEMENTS:**
Physiotherapy should be available for people with PD. Particular consideration should be given to: gait re-education, improvement of balance and flexibility; enhancement of aerobic capacity; improvement of movement initiation; improvement of functional independence, including mobility and activities of daily living; provision of advice regarding safety in the home environment. (Level B) NICE GL35 (Jun 2006)

Occupational therapy should be available for people with PD. Particular consideration should be given to: maintenance of work and family roles, home care and leisure activities; improvement and maintenance of transfers and mobility; improvement of personal self-care activities, such as eating, drinking, washing, and dressing; cognitive assessment and appropriate intervention. (Level D) NICE GL35 (Jun 2006)

Speech and language therapy should be available for people with PD. Particular consideration should be given to: Improvement of vocal loudness and pitch range, including speech therapy programs such as Lee Silverman Voice Treatment (LSVT) (Level B) NICE GL35 (Jun 2006)

All veterans with PD who have impairment of ADLs or in walking ability should be referred for physical therapy. Cheng et al. #9 (Referral for physical therapy) 2004

For patients with Parkinson's disease complicated by dysarthria, speech therapy may be considered to improve speech volume (Level C). Different exercise modalities, including multidisciplinary rehabilitation, active music therapy, treadmill training, balance training, and "cued" exercise training are probably effective in improving functional outcomes for patients with Parkinson's disease. For patients with Parkinson's disease, exercise therapy may be considered to improve function (Level C). AAN QSS Neuro Alt (April 2006)

NICE National Collaborating Centre for Primary Care. National Collaborating Centre for Chronic Conditions. Parkinson's Disease: National Clinical Guideline for Management in Primary and Secondary Care (2006) London: Royal College of Physicians

Cheng E, Siderowf A, Swarztrauber K, Eisa M, Lee M and Vickrey B. Development of Quality of Care Indicators for Parkinson's disease Movement Disorders Vol. 19, No.2, 2004 (P136-150)

AAN QSS Neuro Alt (April 2006) Suchowersky O, Gronseth G, Perlmutter J, Reich S, Zesiewicz T, Weiner WJ, Quality Standards Subcommittee of the American Academy of Neurology. Practice parameter: neuroprotective strategies and alternative therapies for Parkinson disease (an evidence-based review): report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2006 Apr 11; 66(7):976-82.

**Measure #294 - Parkinson's Disease: Parkinson's Disease Medical and Surgical Treatment Options Reviewed**

**RATIONALE:**

There are many different pharmacological, non-pharmacological, and surgical treatment options available for patients diagnosed with Parkinson's disease. Within each type of treatment, there are also multiple factors to be considered when deciding whether a patient with Parkinson's disease is a candidate for the treatment option.

With the advent of newly available pharmacological treatments from many different ongoing clinical trials and studies, the patient's current medication treatment should be reviewed as therapy-based reviews are updated.

AAN QSS Init. Treatment of Parkinson's Disease (Jan 2002) Miyasaki JM, Martin W, Suchowersky O, Weiner WJ, Lang AE. Practice parameter: initiation of treatment for Parkinson's disease: an evidence-based review: Report of the Quality Standards Subcommittee of the American Academy of Neurology. Neurology 2002 Jan 8;58(1):11-7

Anthony E. Lang, Jean-Luc Houeto, Paul Krack, et al. Deep brain stimulation: Preoperative issues Movement Disorders 2006 June; 21(S14): S171-S196

**CLINICAL RECOMMENDATION STATEMENTS:**

People with PD should have regular access to the following: clinical monitoring and medication adjustment; a continuing point of contact for support, including home visits when appropriate; a reliable source of information about clinical and social matters of concern to people with PD and their careers which may be provided by a Parkinson's disease nurse specialist. NICE GL35. (June 2006)

With the current evidence it is not possible to decide if the subthalamic nucleus or globus pallidus interna is the preferred target for deep brain stimulation for people with PD, or whether one form of surgery is more effective or safer than the other. In considering the type of surgery, account should

be taken of: clinical and lifestyle characteristics of the person with PD; patient preference, after the patient has been informed of the potential benefits and; drawbacks of the different surgical procedures. (Level D) NICE GL35 (June 2006)

NICE National Collaborating Centre for Primary Care. National Collaborating Centre for Chronic Conditions. Parkinson's Disease: National Clinical Guideline for Management in Primary and Secondary Care (2006) London: Royal College of Physicians.

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# PQRS MEASURE 312 EMEASURE ID #166

## Use of Imaging Studies for Low Back Pain

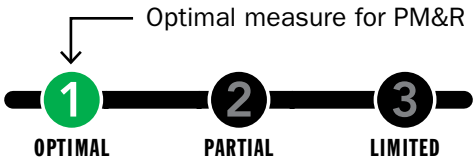
### ELIGIBLE PATIENT POPULATION

Patients 18-50 years of age with a diagnosis of low back pain during an outpatient or emergency department visit

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients without an imaging study conducted on the date of the outpatient or emergency department visit or in the 28 days following the outpatient or emergency department visit.

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Efficiency and Cost Reduction

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

# PQRS MEASURE 317 EMEASURE ID #22

## Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

### ELIGIBLE PATIENT POPULATION

All Patients aged ≥ 18 years

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is pre-hypertensive or hypertensive

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, *99218,*99219, *99220, *99224, *99225, *99226, *99234,*99235, *99236, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350

*Physician Facility Based Code

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Community/Population Health

### TYPE OF MEASURE

Individual, Crosscutting or Clinical Quality

### REPORTING METHOD(S)

Claims, Registry, Direct EHR Vendor / Data Submission Vendor or GPRO Web Interface

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS Resources:

- **2015 EHR-Based Reporting Made Simple**
- **2015 Registry Reporting Made Simple**
- **2015 Claims Reporting Made Simple**
- **2015 GPRO Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented – National Quality Strategy Domain: Community / Population Health

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**CLAIMS, REGISTRY**

**DESCRIPTION:**
Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. Eligible professionals who report the measure must perform the blood pressure screening at the time of a qualifying visit and may not obtain measurements from external sources.

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 current BP reading as indicated, example: "Patient referred to primary care provider for BP management".

**Measure Reporting via Claims:**
CPT 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 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 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
> **AND**
> **Patient encounter during the reporting period (CPT or HCPCS):** 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90880, 92002, 92004, 92012, 92014, 96118, 97532, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99340, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0402, G0438, G0439

**NUMERATOR:**
Patients who were screened for high blood pressure AND have a recommended follow-up plan documented, as indicated, if the blood pressure is pre-hypertensive or hypertensive

***NUMERATOR NOTE:*** *Although the recommended screening interval for a normal BP reading is every 2 years, to meet the intent of this measure, BP screening and follow-up must be performed once per measurement period. The intent of this measure is to screen patients for high blood pressure and provide recommended follow-up as indicated. Normal blood pressure follow-up is not recommended for patients with clinical or symptomatic hypotension.*

**Definitions:**

**Blood Pressure (BP) Classification:**

BP is defined by four (4) BP reading classifications: Normal, Pre-Hypertensive, First Hypertensive, and Second Hypertensive Readings.

**Recommended BP Follow-Up:**

The current *Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* (JNC) recommends BP screening intervals, lifestyle modifications and interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow-Up Interventions" listed below.

**Recommended Lifestyle Modifications:**

The current JNC report outlines lifestyle modifications which must include one or more of the following as indicated:

- Weight Reduction
- Dietary Approaches to Stop Hypertension (DASH) Eating Plan
- Dietary Sodium Restriction
- Increased Physical Activity
- Moderation in alcohol (ETOH) Consumption

**Second Hypertensive Reading:**

Requires a BP reading of Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg

**Second Hypertensive BP Reading Interventions:**

The current JNC report outlines BP follow-up interventions for a second hypertensive BP reading and **must** include one or more of the following as indicated:

- Anti-Hypertensive Pharmacologic Therapy
- Laboratory Tests
- Electrocardiogram (ECG)

**Recommended Blood Pressure Follow-up Interventions:**

- Normal BP: No follow-up required for Systolic BP <120 mmHg AND Diastolic BP < 80 mmHg
- Pre-Hypertensive BP: Follow-up with rescreen every year with systolic BP of 120 – 139 mmHg OR diastolic BP of 80 – 89 mmHg AND recommended lifestyle modifications OR referral to Alternate/Primary Care Provider
- First Hypertensive BP Reading: Patients with one elevated reading of systolic BP >= 140 mmHg OR diastolic BP >= 90 mmHg:
    - Follow-up with rescreen ≥ 1 day and ≤ 4 weeks AND recommend lifestyle modifications OR referral to Alternative/Primary Care Provider
- Second Hypertensive BP Reading: Patients with second elevated reading of systolic BP >= 140 mmHg OR diastolic BP >= 90 mmHg:
    - Follow-up with Recommended lifestyle modifications AND one or more of the Second Hypertensive Reading Interventions OR referral to Alternative/Primary Care Provider

**Recommended Blood Pressure Follow-Up Table**

| BP Classification | Systolic BP mmHg | Diastolic BP mmHg | Recommended Follow-Up *(must include all indicated actions for each BP Classification)* |
|---|---|---|---|
| ***Normal BP Reading*** | < 120 | AND < 80 | • No Follow-Up required |
| ***Pre-Hypertensive BP Reading*** | ≥ 120 AND ≤ 139 | OR ≥ 80 AND ≤ 89 | • Rescreen BP within a minimum of 1 year **AND** Recommend Lifestyle Modifications<br>**OR**<br>• Referral to Alternative/Primary Care Provider |
| ***First Hypertensive BP Reading*** | ≥ 140 | OR ≥ 90 | • Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks *AND* Recommend Lifestyle Modifications<br>**OR**<br>• Referral to Alternative/Primary Care Provider |
| ***Second Hypertensive BP Reading*** | ≥ 140 | OR ≥ 90 | • Recommend Lifestyle Modifications *AND* 1 or more of the Second Hypertensive Reading Interventions (see definitions)<br>**OR**<br>• Referral to Alternative/Primary Care Provider |

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

- Patient has an active diagnosis of hypertension
- Patient refuses to participate (either BP measurement or follow-up)
- 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. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated

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

**Normal Blood Pressure Reading Documented, Follow-Up not Required**

***Performance Met:*** **G8783:** Normal blood pressure reading documented, follow-up not required

**OR**

**Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, AND Indicated Follow-Up Documented**

***Performance Met:*** **G8950:** Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented

**OR**

**Blood Pressure Reading not Documented, Patient not Eligible**
***Other Performance Exclusion:*** **G8784:** Blood pressure reading not documented, documentation the patient is not eligible

**OR**

**Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up not Documented, Patient not Eligible**
***Other Performance Exclusion:*** **G8951:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, documentation the patient is not eligible

**OR**

**Blood Pressure Reading not Documented, Reason not Given**
***Performance Not Met:*** **G8785:** Blood pressure reading **not** documented, reason not given

**OR**

**Pre-Hypertensive or Hypertensive Blood Pressure Reading Documented, Indicated Follow-Up not Documented, Reason not Given**
***Performance Not Met:*** **G8952:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up **not** documented, reason not given

**RATIONALE:**
Hypertension is a prevalent condition that affects approximately 66.9 million people in the United States. It is estimated that about 20-40% of the adult population has hypertension; the majority of people over age 65 have a hypertension diagnosis (Appleton SL, et. al., 2012 and Luehr D, et. al., 2012). Winter (2013) noted that 1 in 3 American adults have hypertension and the lifetime risk of developing hypertension is 90% (Winter KH, et. al., 2013). The African American population or non-Hispanic Blacks, the elderly, diabetics and those with chronic kidney disease are at increased risk of stroke, myocardial infarction and renal disease. Non-Hispanic Blacks have the highest prevalence at 38.6% (Winter KH, et. al., 2013). Hypertension is a major risk factor for ischemic heart disease, left ventricular hypertrophy, renal failure, stroke and dementia (Luehr D, et. al., 2012).

Hypertension is the most common reason for adult office visits other than pregnancy. Garrison (2013) stated that in 2007, 42 million ambulatory visits were attributed to hypertension (Garrison GM and Oberhelman S, 2013). It also has the highest utilization of prescription drugs. Numerous resources and treatment options are available, yet only about 40-50% of the hypertensive patients have their blood pressure under control (<140/90) (Appleton SL, et. al., 2012, Luehr D, et. al., 2012). In addition to medication non-compliance, poor outcomes are also attributed to poor adherence to lifestyle changes such as a low-sodium diet, weight loss, increased exercise and limiting alcohol intake. Many adults find it difficult to continue medications and lifestyle changes when they are asymptomatic. Symptoms of elevated blood pressure usually do not occur until secondary problems arise such as with vascular diseases (myocardial infarction, stroke, heart failure and renal insufficiency) (Luehr D, et. al., 2012).

Appropriate follow-up after blood pressure measurement is a pivotal component in preventing the progression of hypertension and the development of heart disease. Detection of marginally or fully elevated blood pressure by a specialty clinician warrants referral to a provider familiar with the management of hypertension and prehypertension. The 2010 ACCF/AHA Guideline for the Assessment of Cardiovascular Risk in Asymptomatic Adults continues to support using a global risk score such as the Framingham Risk Score, to assess risk of coronary heart disease (CHD) in all asymptomatic adults (Greenland P, et. al., 2010). Lifestyle modifications have demonstrated effectiveness in lowering blood pressure (JNC 7, 2003). The synergistic effect of several lifestyle modifications results in greater benefits than a single modification alone. Baseline diagnostic/laboratory testing establishes if a co-existing underlying condition is the etiology of hypertension and evaluates if end organ damage from hypertension has already occurred. Landmark trials such as ALLHAT have repeatedly proven the efficacy of pharmacologic therapy to

control blood pressure and reduce the complications of hypertension. Follow-up intervals based on blood pressure control have been established by the JNC 7 and the USPSTF.

**CLINICAL RECOMMENDATION STATEMENTS:**

The U.S. Preventive Services Task Force (USPSTF) recommends screening for high blood pressure in adults age 18 years and older. This is a grade A recommendation.

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# PQRS MEASURE 318 EMEASURE ID #139

## Falls: Screening for Fall Risk

### ELIGIBLE PATIENT POPULATION

Patients aged 65 years and older with a visit during the measurement period

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who were screened for future fall risk at least once within the measurement period

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Patient Safety

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM) or Crosscutting

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor or GPRO Web Interface

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **2015 GPRO Reporting Made Simple**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 321 CG-CAHPS Clinician/Group Survey

## Communication and Care Coordination

A CMS-certified survey vendor is a newer reporting mechanism, beginning in 2014, **available to group practices participating in PQRS via the Group Practice Reporting Option (GPRO)**.

The CMS-certified survey vendor reporting mechanism is available to group practices of 2 or more EPs wishing to supplement their PQRS reporting with the CAHPS for PQRS survey. Although r**equired for group practices of 100 or more EPs**, this is an extra and companion reporting option for groups with 2-99 EPs and for EHR and registry reporting.

### CG-CAHPS CLINICIAN/GROUP SURVEY

- Getting timely care, appointments, and information;
- How well providers Communicate;
- Patient's Rating of Provider;
- Access to Specialists;
- Health Promotion & Education;
- Shared Decision Making;
- Health Status/Functional Status;
- Courteous and Helpful Office Staff;
- Care Coordination;
- Between Visit Communication;
- Helping Your to Take Medication as Directed;
- Stewardship of Patient Resources

### REPORTING REQUIREMENTS

The CAHPS for PQRS survey is equal to **3 individual measures and 1 NQS Domain.**

- Group practices of 2-99 EPs that choose to register for CAHPS for PQRS will need to report on at least 6 additional measures covering at least 2 additional NQS domains via qualified registry, direct EHR product or EHR data submission vendor.
- Group practices of 25 – 99 EPs that choose to register for CAHPS for PQRS while reporting PQRS via GPRO Web Interface, must also report all required Web Interface measures.
- Group practices of 100 or more EPs reporting CAHPS for PQRS survey is a requirement of satisfactory reporting

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Person and Caregiver-Centered Experience and Outcomes

### REPORTING METHOD(S)

Certified Survey Vendor

**CMS will NOT bear the cost of administering CAHPS for PQRS for the 2015 program year.**

## CMS PQRS Resources:

- **CMS-Certified Survey Vendor Information**
- **2015 CMS-certified Survey Vendor Made Simple**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 325

## Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions

### ELIGIBLE PATIENT POPULATION

All medical records of patients aged ≥ 18 years on date of encounter with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], ESRD or congestive heart failure) being treated by another clinician

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Medical records of patients with communication to the clinician treating the comorbid condition

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Communication and Care Coordination

### TYPE OF MEASURE

Individual Measure

### REPORTING METHOD(S)

Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #325: Adult Major Depressive Disorder (MDD): Coordination of Care of Patients with Specific Comorbid Conditions – National Quality Strategy Domain: Communication and Care Coordination

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], End Stage Renal Disease [ESRD] or congestive heart failure) being treated by another clinician with communication to the clinician treating the comorbid condition

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for all patients with a diagnosis of MDD seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure for the primary management of patients with major depressive disorder 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 medical records of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) and a specific diagnosed comorbid condition (diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, chronic kidney disease [stages 4 or 5], ESRD or congestive heart failure) being treated by another clinician

**Definition:**
**Comorbid condition** – For the purposes of this measure, only the following comorbid conditions will be included:

1) Diabetes
2) Coronary artery disease
3) Stroke, including ischemic stroke and intracranial hemorrhage
4) Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease
5) Congestive Heart Failure

**Denominator Criteria (Eligible Cases):**
Patients aged ≥ 18 years on date of encounter
**AND**
**Diagnosis for MDD (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 296.20, 296.21, 296.22, 296.23, 296.24, 296.30, 296.31, 296.32, 296.33, 296.34
**Diagnosis for MDD (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** F32.0, F32.1, F32.2, F32.3, F32.9, F33.0, F33.1, F33.2, F33.3, F33.9
**AND**
**Patient encounter during the reporting period (CPT):** 90791, 90792, 90832, 90834, 90837, 90845, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

**AND**

**Diagnosis for Diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 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

**Diagnosis for Diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]**: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, E13.00, E13.01, E13.10, E13.11, E13.21, E13.22, E13.29, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, E13.36, E13.39, E13.40, E13.41, E13.42, E13.43, E13.44, E13.49, E13.51, E13.52, E13.59, E13.610, E13.618, E13.620, E13.621, E13.622, E13.628, E13.630, E13.638, E13.641, E13.649, E13.65, E13.69, E13.8, E13.9

**OR**

**Diagnosis for CAD (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82

**Diagnosis for CAD (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** I20.0, I20.1, I20.8, I20.9, I21.01, I21.02, I21.09, I21.11, I21.19, I21.21, I21.29, I21.3, I21.4, I22.0, I22.1, I22.2, I22.8, I22.9, I24.0, I24.1, I24.8, I24.9, I25.10, I25.110, I25.111, I25.118, I25.119, I25.2, I25.5, I25.6, I25.700, I25.701, I25.708, I25.709, I25.710, I25.711, I25.718, I25.719, I25.720, I25.721, I25.728, I25.729, I25.730, I25.731, I25.738, I25.739, I25.750, I25.751, I25.758, I25.759, I25.760, I25.761, I25.768, I25.769, I25.790, I25.791, I25.798, I25.799, I25.810, I25.811, I25.812, I25.82, I25.83, I25.89, I25.9, Z95.1, Z95.5, Z98.61

**OR**

**Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 430, 431, 432.0, 432.1, 432.9, 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91

**Diagnosis for Stroke, including ischemic stroke and intracranial hemorrhage (ICD-10-CM)[for use 10/01/2015-12/31/2015]:** I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.20, I60.21, I60.22, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.0, I61.1, I61.2, I61.3, I61.4, I61.5, I61.6, I61.8, I61.9, I62.00, I62.01, I62.02, I62.03, I62.1, I62.9, I63.00, I63.011, I63.012, I63.019, I63.02, I63.031, I63.032, I63.039, I63.09, I63.10, I63.111, I63.112, I63.119, I63.12, I63.131, I63.132, I63.139, I63.19, I63.20, I63.211, I63.212, I63.219, I63.22, I63.231, I63.232, I63.239, I63.29, I63.30, I63.311, I63.312, I63.319, I63.321, I63.322, I63.329, I63.331, I63.332, I63.339, I63.341, I63.342, I63.349, I63.39, I63.40, I63.411, I63.412, I63.419, I63.421, I63.422, I63.429, I63.431, I63.432, I63.439, I63.441, I63.442, I63.449, I63.49, I63.50, I63.511, I63.512, I63.519, I63.521, I63.522, I63.529, I63.531, I63.532, I63.539, I63.541, I63.542, I63.549, I63.59, I63.6, I63.8, I63.9

**OR**

**Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 585.4, 585.5, 585.6

**Diagnosis for Chronic Kidney Disease (Stages 4 and 5) and End Stage Renal Disease (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** N18.4, N18.5, N18.6

**OR**

**Diagnosis for heart failure (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
**Diagnosis for heart failure (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** I11.0, I13.0, I13.2, I50.1, I50.20, I50.21, I50.22, I50.23, I50.30, I50.31, I50.32, I50.33, I50.40, I50.41, I50.42, I50.43, I50.9

**NUMERATOR:**
Medical records of patients with communication to the clinician treating the comorbid condition

**Definition:**
**Communication** – Transmission of relevant clinical information which specifies that the patient has MDD.

**Numerator Options:**

| | |
|---|---|
| ***Performance Met:*** | Clinician treating Major Depressive Disorder communicates to clinician treating comorbid condition **(G8959)** |
| **OR** | |
| ***Patient Performance Exclusion:*** | Clinician treating Major Depressive Disorder did **not** communicate to clinician treating comorbid condition for specified patient reason **(G9232)** |
| **OR** | |
| ***Performance Not Met:*** | Clinician treating Major Depressive Disorder did **not** communicate to clinician treating comorbid condition, reason not given **(G8960)** |

**RATIONALE:**
Depressive disorders are more common among persons with chronic conditions (eg, obesity, cardiovascular disease, diabetes, asthma, arthritis, and cancer) and among those with unhealthy behaviors (eg, smoking, physical inactivity, and binge drinking). Comorbidities are more common in the elderly. The highest rates of depression are found in those with strokes (30% to 60%), coronary artery disease (up to 44%), cancer (up to 40%), Parkinson's disease (40%), and Alzheimer's disease (20% to 40%). The coordination of care for patients with depression and certain comorbid conditions is important for managing both the patient's depression and the other present medical condition. Improvements in the coordination of care between clinicians treating a patient with depression and other clinicians treating comorbid conditions can reduce the symptom exacerbation that depression and other conditions may cause to the other. Any [depression] treatment should be integrated with psychiatric management and any other treatments being provided for other diagnoses.

**CLINICAL RECOMMENDATION STATEMENTS:**
The following evidence statements are quoted verbatim from the referenced clinical guidelines. Only selected portions of the clinical guidelines are quoted here; for more details, please refer to the full guideline.

In patients with major depressive disorder, it is important to recognize and address the potential interplay between major depressive disorder and any co-occurring general medical conditions. (APA, 2010)

The clinical assessment should include identifying any potential interactions between medications used to treat depression and those used to treat general medical conditions. In addition, the psychiatrist (clinician) should consider the effects of prescribed psychotropic medications on the patient's general medical conditions, as well as the effects of interventions for such disorders on the patient's psychiatric condition. (APA, 2010)

Many patients with major depressive disorder will be evaluated by or receive treatment from other health care professionals in addition to the psychiatrist (clinician). If more than one clinician is involved in providing the care, all treating clinicians should have sufficient ongoing contact with the patient and with each other to ensure that care is

coordinated, relevant information is available to guide treatment decisions, and treatments are synchronized. (APA, 2010)

In ruling out general medical causes of depressive symptoms, it is important to ensure that a general medical evaluation has been done. (APA, 2010)

In patients with preexisting hypertension or cardiac conditions, treatment with specific antidepressant agents may suggest a need for monitoring of vital signs or cardiac rhythm (eg, electrocardiogram [ECG] with TCA treatment; heart rate and blood pressure assessment with SNRIs and TCAs). (APA, 2010)

In treating the depressive syndrome that commonly occurs following a stroke, consideration should be given to the potential for interactions between antidepressants and anticoagulating (including antiplatelet) medications. (APA, 2010)

The diagnostic work-up for MDD should include evaluation for existing or emerging medical conditions that may exacerbate the depression. These may include: Cardiovascular diseases, Chronic pain syndrome, Degenerative diseases, Immune disorders, Metabolic endocrine conditions (including kidney and lung diseases), Neoplasms, Trauma. Simultaneous treatment is often required for both the medical problem and psychiatric symptoms and can lead to overall improvement in function. (VA/DoD, 2009)

Indications for referral to a mental health specialist familiar with diabetes management may include gross noncompliance with medical regimen (by self or others), depression with the possibility of self-harm, debilitating anxiety (alone or with depression), indications of an eating disorder, or cognitive functioning that significantly impairs judgment. It is preferable to incorporate psychological assessment and treatment into routine care rather than waiting for identification of a specific problem or deterioration in psychological status. Although the clinician may not feel qualified to treat psychological problems, using the patient-provider relationship as a foundation for further treatment can increase the likelihood that the patient will accept referral for other services. It is important to establish that emotional well-being is part of diabetes management. (ADA, 2010)

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# PQRS MEASURE 366 EMEASURE ID #136

## ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

### ELIGIBLE PATIENT POPULATION

Children 6-12 years of age who were dispensed an ADHD medication during the Intake Period and who had a visit during the measurement period

### EXCLUSIONS

- Patients diagnosed with narcolepsy at any point in their history or during the measurement period.
- Patients who had an acute inpatient stay with a principal diagnosis of mental health or substance abuse

Patients who were actively on an ADHD medication in the 120 days prior to the Index Prescription Start Date.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who had at least one face-to-face visit with a practitioner with prescribing authority within 30 days after the IPSD

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 370 EMEASURE ID #159

## Depression Remission at Twelve Months

### ELIGIBLE PATIENT POPULATION

Adults age 18 and older with a diagnosis of major depression or dysthymia and an initial PHQ-9 score greater than nine during an outpatient encounter.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Adults who achieved remission at twelve months as demonstrated by a twelve month (+/- 30 days) PHQ-9 score of less than five.

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor or GPRO Web Interface

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 371 EMEASURE ID #160

## Depression Utilization of the PHQ-9 Tool

### ELIGIBLE PATIENT POPULATION

Adult patients age 18 and older with an office visit and the diagnosis of major depression or dysthymia during each four month period

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Adult patients who have a PHQ-9 tool administered at least once during the four-month period.

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Effective Clinical Care

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 374 EMEASURE ID #50

## Closing the Referral Loop: Receipt of Specialist Report

### ELIGIBLE PATIENT POPULATION

Number of patients, regardless of age, who were referred by one provider to another provider, and who had a visit during the measurement period.

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Number of patients with a referral, for which the referring provider received a report from the provider to whom the patient was referred.

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 2

Measure has Partial Applicability for PM&R


### NQS DOMAIN

Communication and Care Coordination

### TYPE OF MEASURE

Crosscutting or Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 375 EMEASURE ID #66

## Functional Status Assessment for Knee Replacement

### ELIGIBLE PATIENT POPULATION

Adults aged 18 and older who had a primary total knee arthroplasty (TKA) within the 12 month period that begins 180 days before the start of the measurement period and ends 185 days after the start of the measurement period and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after TKA procedure.

### EXCLUSIONS

Patients with multiple traumas at the time of the total knee arthroplasty or patients with severe cognitive impairment

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10 Global Health, PROMIS-29, KOOS) not more than 180 days prior to the primary TKA procedure, and at least 60 days and not more than 180 days after TKA procedure

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Person and Caregiver-Centered Experience and Outcomes

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 376 EMEASURE ID #56

## Functional Status Assessment for Hip Replacement

### ELIGIBLE PATIENT POPULATION

Adults aged 18 and older who had a primary total hip arthroplasty (THA) within the 12 month period that begins 180 days before the start of the measurement period and ends 185 days after the start of the measurement period and who had an outpatient encounter not more than 180 days prior to procedure, and at least 60 days and not more than 180 days after THA procedure.

### EXCLUSIONS

Patients with multiple trauma at the time of the total hip arthroplasty or patients with severe cognitive impairment

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients with patient reported functional status assessment results (e.g., VR-12, VR-36, PROMIS-10-Global Health, PROMIS-29, HOOS) not more than 180 days prior to the primary THA procedure, and at least 60 days and not more than 180 days after THA procedure.

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Person and Caregiver-Centered Experience and Outcomes

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 377 EMEASURE ID #90

## Functional Status Assessment for Complex Chronic Conditions

### ELIGIBLE PATIENT POPULATION

Adults aged 65 years and older who had two outpatient encounters during the measurement year and an active diagnosis of heart failure.

### EXCLUSIONS

Patients with severe cognitive impairment or patients with an active diagnosis of cancer

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients with patient reported functional status assessment results (e.g., VR-12; VR-36; MLHF-Q; KCCQ; PROMIS-10 Global Health, PROMIS-29) present in the EHR within two weeks before or during the initial encounter and the follow-up encounter during the

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Person and Caregiver-Centered Experience and Outcomes

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

# PQRS MEASURE 382 EMEASURE ID #177

## Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment

### ELIGIBLE PATIENT POPULATION

All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder

### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patient visits with an assessment for suicide risk

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 3

Limited applicability to a subset of AAPM&R members


### NQS DOMAIN

Patient Safety

### TYPE OF MEASURE

Electronic Clinical Quality Measure (CQM)

### REPORTING METHOD(S)

Direct EHR Vendor / Data Submission Vendor

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **Medicare EHR Incentive Program Website**
- **eCQM Library**
- **Certified EHR Technology Resources**
- **CMS PQRS Help Desk**

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# PQRS MEASURE 386

## Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences

This measure is appropriate for use in outpatient and long term care (e.g., nursing home, ambulatory).

### ELIGIBLE PATIENT POPULATION

All patients with a diagnosis of Amyotrophic Lateral Sclerosis (ALS)

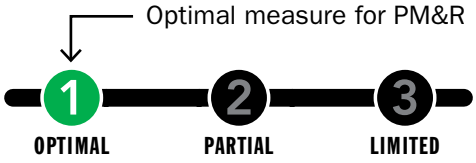
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who were offered assistance in planning for end of life issues (e.g., advance directives, invasive ventilation, or hospice) at least once annually.

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99354, 99355

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Person and Caregiver-Centered Experience and Outcomes

### TYPE OF MEASURE

Individual

### REPORTING METHOD(S)

Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #386: Amyotrophic Lateral Sclerosis (ALS) Patient Care Preferences – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
Percentage of patients diagnosed with Amyotrophic Lateral Sclerosis (ALS) who were offered assistance in planning for end of life issues (eg,advance directives, invasive ventilation, hospice) at least once annually

**INSTRUCTIONS:**
This measure is to be reported a minimum of **once per reporting period** for patients with a diagnosis of ALS 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. This measure is appropriate for use in outpatient and long term care (eg, nursing home, ambulatory). For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.

**Measure Reporting via Registry:**
ICD-9-CM/ICD-10-CM diagnosis codes and CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes 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 with a diagnosis of Amyotrophic Lateral Sclerosis (ALS)

**Denominator Criteria (Eligible Cases):**
**Diagnosis of Amyotrophic Lateral Sclerosis (ICD-9-CM) [for use 1/1/2015-9/30/2015]:** 335.20
**Diagnosis for Amyotrophic Lateral Sclerosis (ICD-10-CM) [for use 10/01/2015-12/31/2015]:** G12.21
**AND**
**Patient encounter during the reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99354, 99355

**NUMERATOR:**
Patients who were offered assistance in planning for end of life issues (eg,advance directives, invasive ventilation, or hospice) at least once annually

**Definition:**
**Assistance with end of life issues** – assessment of patient concerns, desires and needs relating to end of life issues. Bases on patient's disease progression this may include discussions regarding invasive ventilation, advance directives and hospice.

**Numerator Options:**

| | |
|---|---|
| ***Performance Met:*** | Patient offered assistance with end of life issues during the measurement period **(G9380)** |
| **OR** | |
| ***Medical Performance Exclusion:*** | Documentation of medical reason(s) for **not** offering assistance with end of life issues (eg, patient in hospice |

and in terminal phase) during the measurement period **(G9381)**

**OR**

***Performance Not Met:*** Patient **not** offered assistance with end of life issues during the measurement period **(G9382)**

**RATIONALE:**

Palliative care should be adopted from the time of diagnosis. Many patients are not adequately informed about advance directives and end of life decision making and many hospice workers are not familiar with ALS. Management of the terminal phase of ALS is unsatisfactory in 33% - 61% of cases in Europe and only 8% of palliative care units are involved from the time of diagnosis.[6] The current system of palliative care in the USA is highly decentralized. Between 60-88% of patients die in a medical facility in some countries and not at home, while over 58% of seriously ill ALS patients do not have hospice care. Approaches to end of life care vary widely and are not standardized either in timing or content.

J Neurol Neurosurg Psychiatry 2011; 82(4):413-8

Neuron Disord 2001; 2(4):203–208

Ann Neurol 2009; 65:S1:S24-8

Amyotroph Lateral Scler Other Motor Neuron Disord 2004; 5:240 –244

Amyotroph Lateral Scler 2001; 2:159

Palliat Med 2000; 14:42

National Hospice and Palliative Care Organization (NHPCO). Facts and Figures: Hospice Care in America. National Hospice and Palliative Care Organization (NHPCO), 2009. Available online at: http://www.nhpco.org/files/public/

Acta Neurol Scand 2010; 122(3):217-23. Epub 2010 Jan 15

Eur J Neurol 2008 Nov;15(11):1245-51

J Neurol Sci 1997; 152(Suppl 1):S82-S89

Am J Hosp Palliat Care 2006; 23(3): 212-216

**CLINICAL RECOMMENDATION STATEMENTS:**

No clinical recommendation statements provided.

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# PQRS MEASURE 402

## Tobacco Use and Help with Quitting Among Adolescents

### ELIGIBLE PATIENT POPULATION

All patients aged 12-20 years on date of encounter with a visit during the measurement period.

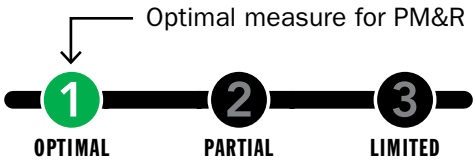
### CLINICAL ACTION REQUIRED BY THE MEASURE FOR PERFORMANCE

Patients who were screened for tobacco use at least once within 18 months (during the measurement period or the six months prior to the measurement period) AND who received tobacco cessation counseling intervention if identified as a tobacco user

### RELEVANT PM&R CPT CODES FOR THIS MEASURE

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

### AAPM&R PERFORMANCE METRICS COMMITTEE RATING: 1




### NQS DOMAIN

Community/Population Health

### TYPE OF MEASURE

Individual or Crosscutting

### REPORTING METHOD(S)

Registry

### FULL MEASURE SPECIFICATION

Click **here** to access the full measure specification.

## Additional Resources:

- **AAPM&R PQRS Resources**
- **AAPM&R Sponsored Registry –** PQRSwizard®

## CMS PQRS Resources:

- **2015 Registry Reporting Made Simple**
- **CMS PQRS Help Desk**

## Measure #402: Tobacco Use and Help with Quitting Among Adolescents – National Quality Strategy Domain: Community / Population Health

**2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:**
**REGISTRY ONLY**

**DESCRIPTION:**
The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting 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 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 12-20 years with a visit during the measurement period.

**Denominator Criteria (Eligible Cases):**
Patients aged 12-20 years on date of encounter
**AND**
**Patient encounter during the reporting period (CPT):** 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 18 months (during the measurement period or the six months prior to the measurement period) **AND** who received tobacco cessation counseling intervention if identified as a tobacco user

**Definitions:**
**Tobacco Use Status** – Any documentation of smoking or tobacco use status, including 'never' or 'non-use'.
**Tobacco User** – Any documentation of active or current use of tobacco products, including smoking.

***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* ***G9460****.*

**Numerator Options:**

| | |
|---|---|
| ***Performance Met:*** | Patient documented as tobacco user AND received tobacco cessation intervention (**must** include at least one of the following: advice given to quit smoking or tobacco use, counseling on the benefits of quitting smoking or tobacco use, assistance with or referral to external smoking or tobacco cessation support programs, or current enrollment in smoking or tobacco |

| | |
|---|---|
| | use cessation program) if identified as a tobacco user **(G9458)** |
| **OR** | |
| ***Performance Met:*** | Currently a tobacco non-user **(G9459)** |
| **OR** | |
| ***Performance Not Met:*** | Tobacco assessment OR tobacco cessation intervention **not** performed, reason not otherwise specified **(G9460)** |

**RATIONALE:**
This measure is intended to promote adolescent 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:

The U.S. Preventive Services Task Force recommends that primary care clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents. (Strength of Recommendation = B) (U.S. Preventive Services Task Force, 2013)

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)