Alphabetical Clinical Topics Listing

Updated June 23, 2023

The following listings note the latest clinical condition and measure additions, deletions, and revisions that have been approved for posting as of June 23, 2023. Each clinical topic and measure displayed within this listing below is hyperlinked to the specific clinical topic or measure listing in the Index of Alphabetic Clinical Topics document. In addition, the heading notes the specific date in which the measures that follow were originally posted.

The green text included reflects new text/information that has been added or otherwise updated for the listing. Bowties (●) are also used to identify added text. The gray stricken (stricken) text identifies deletions from the measure. The bullets (●) and change/delta symbols (▲) identify added codes and revised codes, respectively. Blue underlined text indicates hyperlinked text.

For a complete listing of release and implementation dates for the code additions, deletions, and revisions, please see the Web-based Category II Code Section listing.

Footnotes

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org

3The Joint Commission, https://www.jointcommission.org

4National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at www.ncqa.org.


7Optum, www.optum.com

8American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


10American Gastroenterological Association (AGA), www.gastro.org/quality

11American Society of Anesthesiologists (ASA), www.asahq.org

Alphabetic Clinical Topics Listing of Performance Measures

by Clinical Condition or Topic

IMPORTANT: The Alphabetic Measure Index is a Web-based, alphabetical listing of clinical conditions and topics with which the measures and codes are associated. It appears only on the Category II code website and provides an overview of the performance measures, a listing of CPT Category II codes that may be used with each measure, as well as any applicable reporting instructions. It is intended to be used as a crosswalk to the Category II codes section to allow users an overview of the measures and the Category II codes that should be used with each measure and to link the Category II codes to the specific measures and measure sets from which these codes were derived. The clinical conditions or topics are listed in alphabetical order within the Measure Index to allow rapid access to the conditions/topics currently included in the Category II code set. This document is intended as a dynamic document and is updated to include the latest information regarding Category II coding.

In order for a patient to be included in the numerator for a particular performance measure, a patient must meet the denominator inclusion criteria for that measure. Prior to coding, users must review: (1) the complete description of the code in the Category II section of the CPT codebook and website; and (2) the specification documents of its associated performance measure as found on the measure developer’s website. The superscripted number that follows the specific title for the performance measure directs users to the footnotes at the bottom of each page of this appendix. The footnotes identify the measure developer and the developer's Web address.

Only modifiers 1P, 2P, 3P, and 8P can be used with Category II codes. Other modifiers may not be used with Category II codes. In addition, the modifiers included within the Category II code section and Appendix H are only intended to be used when parenthetical notes, guidelines, or reporting language specifically allow their use.

Footnotes
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7Optum, www.optum.com

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Performance Measure Exclusion Modifier

Performance measurement exclusion modifiers may be used to indicate that a service specified by a performance measure was considered, but, due to either medical, patient, or systems reason(s) documented in the medical record, the service was not provided. These modifiers serve as denominator exclusions from the performance measure. Not all listed measures provide for exclusions. The modifiers currently available include the noted listing:

1P Performance measure exclusion modifier due to medical reasons

Includes:
- not indicated (absence of organ/limb, already received/performed, other)
- contraindicated (patient allergic history, potential adverse drug interaction, other)
- other medical reasons

2P Performance measure exclusion modifier due to patient reasons

Includes:
- Patient declined
- Economic, social, or religious reasons
- Other patient reasons

3P Performance measure exclusion modifier due to system reasons

Includes:
- Resources to perform the services not available (eg, equipment, supplies)
- Insurance coverage or payer-related limitations
- Other reasons attributable to health care delivery system

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9American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

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Modifier 8P is intended to be used as a “reporting modifier” to allow the reporting of circumstances when an action described in a measure’s numerator is not performed and the reason is not otherwise specified.

8P Performance measure reporting modifier - action not performed, reason not otherwise specified

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### Acute Bronchitis (A-BRONCH)

#### Brief Description of Performance Measure and Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Avoidance of (Inappropriate) Antibiotic Treatment in Adults with Acute Bronchitis&lt;sup&gt;2&lt;/sup&gt;</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>To assess the percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or within 3 days after the date of service.</td>
<td>4120F</td>
<td>Antibiotic prescribed or dispensed</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td>4124F</td>
<td>Antibiotic neither prescribed nor dispensed</td>
</tr>
<tr>
<td>Patients who were dispensed an antibiotic prescription on or three days after the episode date.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients aged 18 – 64 years of age with a diagnosis of acute bronchitis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical reasons for prescribing or dispensing an antibiotic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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**Percentage** of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription on or 3 days after the episode date.

**Reporting Instructions:**

Report one of these codes code for a patient identified in the eligible population. For patient with appropriate medical exclusion criteria report 4120F with modifier 1P. There are no exclusions for 4124F.

### Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Otitis Externa- Topical therapy¹</td>
<td>4130F</td>
<td>Topical preparations (including OTC) prescribed for acute otitis externa</td>
</tr>
</tbody>
</table>

**Footnotes**

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6**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

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Last Updated June 23, 2023
### Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator: All patients aged 2 years and older with a diagnosis of AOE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s): Documentation of medical reason(s) for not prescribing topical preparations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not prescribing topical preparations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients aged 2 years and older with a diagnosis of AOE who were prescribed topical preparations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: For patient with appropriate exclusion criteria, report 4130F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Otitis Externa-Pain assessment¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient visits for those patients aged 2 years and older with a diagnosis of AOE with assessment for auricular or periauricular pain</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

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### Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

#### Brief Description of Performance Measure and Source and Reporting Instructions

- **Numerator**: Patient visits with assessment for auricular or periauricular pain
- **Denominator**: All patient visits for those patients aged 2 years and older with a diagnosis of AOE
- **Exclusion(s)**: Documentation of medical reason(s) for not assessing auricular or periauricular pain
- **Percentage**: Patient visits for those patients aged 2 years and older with a diagnosis of AOE with assessment for auricular or periauricular pain
- **Reporting Instructions**: Report at each encounter for AOE. For patient with appropriate exclusion criteria report 1116F with modifier 1P.

#### Systemic antimicrobial therapy – Avoidance of inappropriate use

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1116F</td>
<td>Auricular or periauricular pain assessed</td>
</tr>
</tbody>
</table>

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### Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

#### Brief Description of Performance Measure and Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Whether or not the patient aged 2 years and older with a diagnosis of AOE was not prescribed systemic antimicrobial therapy</th>
<th>4131F</th>
<th>Systemic antimicrobial therapy prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong>: Patients who were not prescribed systemic antimicrobial therapy</td>
<td>4132F</td>
<td>Systemic antimicrobial therapy not prescribed</td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 2 years and older with a diagnosis of AOE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for prescribing systemic antimicrobial therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: Report 4131F or 4132F for each patient. If there is a valid medical reason for prescribing systemic antimicrobial therapy, report 4131F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source and Reporting Instructions</strong></td>
</tr>
<tr>
<td>There are no performance exclusions for code 4132F. Do not report modifiers 1P, 2P, or 3P with this code.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2035F</td>
<td>Tympanic membrane mobility assessed with pneumatic otoscopy or tympanometry</td>
</tr>
</tbody>
</table>

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Last Updated June 23, 2023
Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Percentage** of patient visits for those patients aged 2 months through 12 years with a diagnosis of OME with assessment of tympanic membrane mobility with pneumatic otoscopy or tympanometry  
**Reporting Instructions:** Report at each encounter for OME. For patient with appropriate exclusion criteria report 2035F with modifier 1P or 2P. |  |  |
| **Otitis Media with Effusion -Hearing testing**  
Whether or not the patient aged 2 months through 12 years with a diagnosis of OME who received tympanostomy tube insertion had a hearing test performed within 6 months prior to tympanostomy tube insertion  
**Numerator:** Patients who had a hearing test performed within 6 months prior to tympanostomy tube insertion  
**Denominator:** All patients aged 2 months through 12 years with a diagnosis of OME who received tympanostomy tube insertion | 3230F | Documentation that hearing test was performed within 6 months prior to tympanostomy tube insertion |

Footnotes

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¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

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Last Updated June 23, 2023
| Acute Otitis Externa/Otitis Media with Effusion (AOE/OME) |
|---------------------------------|-----------------|-----------------|
| **Brief Description of Performance Measure and Source** | **CPT Category II** | **Code Descriptor(s)** |
| **and Reporting Instructions** | **Code(s)** | |
| Exclusion(s): Documentation of medical or system reason(s) | | |
| for not performing a hearing test within 6 months prior | | |
| to tympanostomy tube insertion | | |
| **Percentage** of patients aged 2 months through 12 years | 3230F | |
| with a diagnosis of OME who received tympanostomy tube | with modifier 1P or 3P. | |
| insertion who had a hearing test performed within 6 months | | |
| prior to tympanostomy tube insertion | | |
| **Reporting Instructions**: Report at time of tympanostomy | | |
| tube insertion procedure. Documentation should include that | | |
| hearing test was performed AND the actual results of the | | |
| hearing test are documented in the chart. Hearing test may | | |
| have been performed by reporting physician or other provider. | | |
| For patient with appropriate exclusion criteria, report 3230F | | |
| with modifier 1P or 3P. | | |
| **Otitis Media with Effusion Antihistamines or** | | |
| decongestants – Avoidance of inappropriate use[^1] | | |
| Whether or not the parent/caregiver of the patient aged 2 | | |
| months through 12 years with a diagnosis of OME was not | | |

**Footnotes**

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# Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
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<tbody>
<tr>
<td>prescribed or recommended to receive antihistamines or decongestants</td>
<td>4133F</td>
<td>Antihistamines or decongestants prescribed or recommended</td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who were not prescribed or recommended to receive antihistamines or decongestants</td>
<td>4134F</td>
<td>Antihistamines or decongestants neither prescribed nor recommended</td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 2 months through 12 years with a diagnosis of OME</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for prescribing or recommending to receive antihistamines or decongestants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 2 months through 12 years with a diagnosis of OME were not prescribed or recommended to receive antihistamines or decongestants</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: Report 4133F or 4134F for each patient. If there is a valid medical reason for prescribing or recommendation to receive antihistamines or decongestants, report 4133F with modifier 1P. There are no performance exclusions for code 4134F. Do not report modifiers 1P, 2P, or 3P with this code.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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### Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Systemic antimicrobials – Avoidance of inappropriate use</strong>¹</td>
<td>4131F, 4132F</td>
<td><strong>Systemic antimicrobial therapy prescribed</strong>&lt;br&gt;<strong>Systemic antimicrobial therapy not prescribed</strong></td>
</tr>
<tr>
<td>Whether the patient aged 2 months through 12 years with a diagnosis of OME was not prescribed systemic antimicrobials</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who were not prescribed systemic antimicrobials</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 2 months through 12 years with a diagnosis of OME</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for prescribing systemic antimicrobials</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: If there is a valid medical reason for prescribing systemic antimicrobials, report 4131F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for code 4132F. Do not report modifiers 1P, 2P, or 3P with this code.²</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

¹**Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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⁵Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

⁶**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

⁷**Optum**, [www.optum.com](http://www.optum.com)


¹⁰**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality).

¹¹**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org).

¹²**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org).
### Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

<table>
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<tr>
<th>Brief Description of Performance Measure and Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Otitis Media with Effusion Systemic steroids – Avoidance of inappropriate use</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 2 months through 12 years with a diagnosis of OME was not prescribed systemic corticosteroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were not prescribed systemic corticosteroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 2 months through 12 years with a diagnosis of OME</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for prescribing systemic corticosteroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic corticosteroids</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4135F or 4136F for each patient. If there is a valid medical reason for prescribing systemic corticosteroids, report 4135F with modifier 1P.</td>
<td>4135F</td>
<td>Systemic corticosteroids prescribed</td>
</tr>
<tr>
<td></td>
<td>4136F</td>
<td>Systemic corticosteroids not prescribed</td>
</tr>
</tbody>
</table>

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Footnotes

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8. **American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures) or [quality@aan.com](mailto:quality@aan.com)
10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)
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### Acute Otitis Externa/Otitis Media with Effusion (AOE/OME)

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<tbody>
<tr>
<td>There are no performance exclusions for code 4136F. Do not report modifiers 1P, 2P, or 3P with this code.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Amyotrophic Lateral Schlerosis (ALS)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALS Multidisciplinary Care Developed or Updated⁸</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

⁠¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

⁡National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

⁢The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

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⁦Optum, [www.optum.com](http://www.optum.com).

⁧American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures) or [quality@aan.com](mailto:quality@aan.com).


⁩American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

⁪American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

⁫American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
Whether or not the patient diagnosed with ALS had a multidisciplinary care plan* developed, if not done previously, and the plan was updated at least once annually

**Numerator:** Patients for whom a multi-disciplinary care plan* was developed, if not done previously, and the plan was updated at least once annually

*Multidisciplinary care plan should include a neurologist and at least four of the following specialists: pulmonologist, gastroenterologist, physiatrist, psychiatrist, social worker, occupational therapist, physical therapist, speech language pathologist, psychologist, respiratory therapist, genetic counselor, palliative care specialist, specialized nurse, dietician, or dentist.

**Denominator:** All patients with a diagnosis of amyotrophic lateral sclerosis

**Exclusion(s):** Documentation of a system reason for not developing and updating annually a multi-disciplinary care plan (eg, patient has no insurance to cover a multidisciplinary plan)

**Reporting Instructions:**

For all patients meeting denominator criteria, report 0580F.

0580F Multidisciplinary care plan developed or updated

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**Footnotes**

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### Amyotrophic Lateral Schlerosis (ALS)

<table>
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<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patient with appropriate exclusion criteria, report 0580F with modifier 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disease Modifying Pharmacotherapy for ALS Discussed</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td>4540F</td>
<td>Disease modifying pharmacotherapy discussed</td>
</tr>
<tr>
<td>Whether or not a patient diagnosed with ALS had a discussion with the clinician about disease-modifying pharmacotherapy (riluzole) to slow ALS disease progression at least once annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with whom the clinician discussed disease-modifying pharmacotherapy (riluzole) to slow ALS disease progression at least once annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with a diagnosis of amyotrophic lateral sclerosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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## Amyotrophic Lateral Schlerosis (ALS)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all patients meeting denominator criteria, report 4540F. There are no exclusions for this measure. Do not report modifiers 1P, 2P, or 3P with 4540F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALS Cognitive Impairment and Behavioral Impairment Screening</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td>3755F</td>
<td>Cognitive and behavioral impairment screening performed</td>
</tr>
<tr>
<td>Whether or not a patient diagnosed with ALS was screened at least once annually for cognitive impairment and behavioral impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who are screened at least once annually for cognitive impairment (eg, frontotemporal dementia screening or ALS Cognitive Behavioral Screen (CBS)) and behavioral impairment (eg, ALS CBS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with a diagnosis of amyotrophic lateral sclerosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of a medical (eg, patient currently diagnosed with severe cognitive impairment), patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Amyotrophic Lateral Schlerosis (ALS)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(eg, patient declines to be screened for cognitive or behavioral impairment), and/or system (eg, patient has no insurance to cover screening cost) reason(s) for screening the patient for cognitive and behavioral impairment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For all patients meeting denominator criteria, report 3755F. For patient with appropriate exclusion criteria, report 3755F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALS Symptomatic Therapy Treatment Offered</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not at all visits for a patient with a diagnosis of ALS, the patient was offered treatment* for pseudobulbar affect, sialorrhea, or ALS related symptoms**, if present</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patient visits with patient offered treatment* for pseudobulbar affect, sialorrhea, or ALS related symptoms**, if present.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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### ALS Treatment Measures

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3756F</td>
<td>Patient has pseudobulbar affect, sialorrhea, or ALS related symptoms</td>
</tr>
<tr>
<td>3757F</td>
<td>Patient does not have pseudobulbar affect, sialorrhea, or ALS related symptoms</td>
</tr>
<tr>
<td>4541F</td>
<td>Patient offered treatment for pseudobulbar affect, sialorrhea, or ALS related symptoms</td>
</tr>
</tbody>
</table>

**Denominator:** All visits for patients with a diagnosis of amyotrophic lateral sclerosis

**Exclusion(s):** None

**Reporting Instructions:**

For all patients meeting denominator criteria, report either 3756F or 3757F.

When 3756F is reported, also report 4541F.

There are no exclusions for this measure. Do not report modifiers 1P, 2P, or 3P with 4541F.

---

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Last Updated June 23, 2023
ALS Respiratory Insufficiency Querying and Referral for Pulmonary Function Testing

Whether or not a patient with a diagnosis of ALS was queried about symptoms of respiratory insufficiency (awake or associated with sleep) and referred for pulmonary function testing (eg, vital capacity [VC], maximum inspiratory pressure [MIP], sniff nasal pressure [SNP], or peak cough expiratory flow [PCEF]) at least every three months.

**Numerator:** Patients who were queried about symptoms of respiratory insufficiency (awake or associated with sleep) and referred for pulmonary function testing (eg, vital capacity [VC], maximum inspiratory pressure [MIP], sniff nasal pressure [SNP], or peak cough expiratory flow [PCEF]), at least every three months.

**Denominator:** All patients with a diagnosis of amyotrophic lateral sclerosis

**Exclusion(s):** Documentation of medical (eg, patient with severe cognitive impairment who cannot answer any queries) or patient (eg patient declines to be referred for pulmonary function testing) reason(s) for not querying about symptoms of respiratory insufficiency and referring for pulmonary function testing or peak cough expiratory flow.

<table>
<thead>
<tr>
<th>1503F</th>
<th>3758F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient queried about symptoms of respiratory insufficiency</td>
<td>Patient referred for pulmonary function testing or peak cough expiratory flow</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For all patients meeting denominator criteria, report 1503F and 3758F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patient with appropriate exclusion criteria, report 1503F and 3758F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALS Noninvasive Ventilation Treatment for Respiratory Insufficiency Discussed</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td>1504F</td>
<td>Patient has respiratory insufficiency</td>
</tr>
<tr>
<td>Whether or not the patient diagnosed with ALS and respiratory insufficiency had options for noninvasive respiratory support (eg, noninvasive ventilation [NIV], assisted cough) discussed with a clinician at least once annually</td>
<td>1505F</td>
<td>Patient does not have respiratory insufficiency</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with whom the clinician discussed at least once annually treatment options for noninvasive respiratory support (eg, noninvasive ventilation [NIV], assisted cough)</td>
<td>4550F</td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®)**, [www.ncqa.org](http://www.ncqa.org).


4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


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**Amyotrophic Lateral Sclerosis (ALS)**

**Brief Description of Performance Measure & Source**

For all patients meeting denominator criteria, report 1503F and 3758F.

For patient with appropriate exclusion criteria, report 1503F and 3758F with modifier 1P or 2P.

**ALS Noninvasive Ventilation Treatment for Respiratory Insufficiency Discussed**

Whether or not the patient diagnosed with ALS and respiratory insufficiency had options for noninvasive respiratory support (eg, noninvasive ventilation [NIV], assisted cough) discussed with a clinician at least once annually.

**Numerator:** Patients with whom the clinician discussed at least once annually treatment options for noninvasive respiratory support (eg, noninvasive ventilation [NIV], assisted cough).

- **Code(s):**
  - 1504F
  - 1505F
  - 4550F

**Code Descriptor(s):**

- Patient has respiratory insufficiency
- Patient does not have respiratory insufficiency
## Amyotrophic Lateral Sclerosis (ALS)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All patients with a diagnosis of amyotrophic lateral sclerosis and respiratory insufficiency</td>
<td></td>
<td>Options for noninvasive respiratory support discussed with patient</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of a medical (eg, patient is in a coma; patient has severe cognitive impairment and cannot communicate; patient is already on appropriate respiratory support) or patient (eg, patient declines to discuss treatment options) reason(s) for not discussing treatment options for noninvasive respiratory support</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For all patients meeting denominator criteria, report 1504F or 1505F. When 1504F is reported, also report 4550F. For patient with appropriate exclusion criteria, report 4550F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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7. **Optum, [www.optum.com](http://www.optum.com)


10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); [American Gastroenterological Association (AGA)](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org)
<table>
<thead>
<tr>
<th>Measure Description</th>
<th>CPT Category II</th>
<th>Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALS Screening for Dysphagia, Weight Loss, or Impaired Nutrition</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td></td>
<td>3759F</td>
<td>Patient screened for dysphagia, weight loss, and impaired nutrition, and results documented</td>
</tr>
</tbody>
</table>

**Numerator:**
Patients who were screened at least every three months for dysphagia, weight loss, or impaired nutrition* and the result(s) of the screening(s) were documented in the medical record

*Impaired nutrition includes: changes in nutritional biomarkers (serum prealbumin, total protein, or hemoglobin) or body mass index

**Denominator:** All patients with a diagnosis of amyotrophic lateral sclerosis

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**Footnotes**

1. Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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## Amyotrophic Lateral Schlerosis (ALS)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of a patient (eg, patient declines screening) or system (eg, equipment not available to complete the screenings; no insurance) reason(s) for not screening for dysphagia, weight loss, or impaired nutrition and documenting the result(s) of the screening(s) in the medical record</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For all patients meeting denominator criteria, report 3759F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patient with appropriate exclusion criteria, report 3759F with modifier 2P or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ALS Nutritional Support Offered

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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Whether or not the patient with a diagnosis of ALS and dysphagia, weight loss, or impaired nutrition was offered at least once annually dietary or enteral nutrition support via PEG or RIG*

**Numerator:** Patients who were offered at least once annually dietary or enteral nutrition support via PEG or RIG*

*PEG-percutaneous endoscopic gastrostomy

RIG-radiographic inserted gastrostomy

**Denominator:** All patients with a diagnosis of amyotrophic lateral sclerosis and dysphagia, weight loss, or impaired nutrition

**Exclusion(s):** Documentation of a medical reason for not offering dietary or enteral nutritional support via PEG or RIG (eg, patient already on PEG/RIG; patient cannot tolerate the procedure)

**Reporting Instructions:**

For all patients meeting denominator criteria, report 3760F or 3761F.

When 3760F is reported, also report 4551F.

<table>
<thead>
<tr>
<th>3760F</th>
<th>3761F</th>
<th>4551F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient exhibits dysphagia, weight loss, or impaired nutrition</td>
<td>Patient does not exhibit dysphagia, weight loss, or impaired nutrition</td>
<td>Nutritional support offered</td>
</tr>
</tbody>
</table>

Footnotes:

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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<table>
<thead>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patient with appropriate exclusion criteria, report 4551F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ALS Communication Support Referral</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td></td>
<td>Patient is dysarthric</td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of ALS, who is dysarthric was offered a referral at least once annually to a speech language pathologist for an augmentative/alternative communication evaluation</td>
<td></td>
<td>Patient is not dysarthric</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were offered a referral at least once annually to a speech language pathologist for an augmentative/alternative communication evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with a diagnosis of amyotrophic lateral sclerosis who are dysarthric</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of a medical reason for not offering a referral to a speech language pathologist for an augmentative/alternative communication evaluation (eg,</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>patient is already using an augmentative communication device)</td>
<td>3762F</td>
<td>Patient offered referral to a speech language pathologist</td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td>3763F</td>
<td></td>
</tr>
<tr>
<td>For all patients meeting denominator criteria, report 3762F or 3763F.</td>
<td>4552F</td>
<td></td>
</tr>
<tr>
<td>When 3762F is reported, also report 4552F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patient with appropriate exclusion criteria, report 4552F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ALS End of Life Planning Assistance**

Whether or not the patient with a diagnosis of ALS was offered at least once annually assistance in planning for end

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**Footnotes**

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Amyotrophic Lateral Schlerosis (ALS)

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>of life issues (eg, advance directives, invasive ventilation, or hospice)</td>
<td>4553F</td>
<td>Patient offered assistance in planning for end of life issues</td>
</tr>
</tbody>
</table>

**Numerator:** Patients who were offered at least once annually assistance in planning for end of life issues (eg, advance directives, invasive ventilation, or hospice)

**Denominator:** All patients with a diagnosis of amyotrophic lateral sclerosis

**Exclusion(s):** Documentation of a medical reason for not offering at least once annually assistance in planning for end of life issues (eg, patient in hospice and already in terminal phase)

**Reporting Instructions:**
- For all patients meeting denominator criteria, report 4553F.
- For patient with appropriate exclusion criteria, report 4553F with modifier 1P.

Footnotes

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### Amyotrophic Lateral Schlerosis (ALS)

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</tr>
</thead>
<tbody>
<tr>
<td><strong>ALS Falls Querying</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
<td>6080F</td>
<td>Patient (or caregiver) queried about falls</td>
</tr>
<tr>
<td>Whether or not at all visits for patients with a diagnosis of ALS, the patient was queried about falls within the past 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patient visits with patient queried about falls within the past 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All visits for patients with a diagnosis of amyotrophic lateral sclerosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For all patients meeting denominator criteria, report 6080F. There are no exclusions for this measure. Do not report modifiers 1P, 2P, or 3P with 6080F.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement<sup>®</sup> (PCPI), see the appropriate Payor website.

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Last Updated June 23, 2023
Anesthesiology/Critical Care (CRIT)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention of Ventilator-Associated Pneumonia—Head Elevation¹</td>
<td>4167F</td>
<td>Head of bed elevation (30-45 degrees) on first ventilator day ordered</td>
</tr>
</tbody>
</table>

Footnotes

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷Optum, [www.optum.com](http://www.optum.com)


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)

¹²American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
### Anesthesiology/Critical Care (CRIT)

#### Brief Description of Performance Measure and Source and Reporting Instructions

**Numerator:** Patients who had an order on the first ventilator day for head of bed elevation (30-45 degrees)

**Denominator:** All patients aged 18 years and older receiving care in the ICU who receive mechanical ventilation

**Exclusion(s):** Documentation of medical reason(s) for not ordering head of bed elevation (30-45 degrees) on the first ventilator day

**Percentage of ICU patients aged 18 years and older who receive mechanical ventilation and who had an order for head of bed elevation (30-45 degrees) on first ventilator day report 4167F.**

For patients with appropriate exclusion criteria use 4167F with modifier 1P.

**Reporting Instructions:** Report 4168F or 4169F for each patient receiving critical care services (99291). If 4168F and patient has an order for head of bed elevation (30-45 degrees) on first ventilator day report 4167F.

#### CPT Category II Code(s)

- **Denominator Codes**
  - 4168F
  - 4169F

**Code Descriptor(s)**

- Patient receiving care in the intensive care unit (ICU) and receiving mechanical ventilation, 24 hours or less
- Patient either not receiving care in the intensive care unit (ICU) OR not receiving mechanical ventilation OR receiving mechanical ventilation greater than 24 hours

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**Footnotes**

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### Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter Insertion Protocol

Percentage of patients, regardless of age, who undergo central venous catheter (CVC) insertion, for whom CVC was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.

**Numerator:** Patients for whom central venous catheter (CVC) was inserted with all elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed.

**Definition:**

**Maximal Sterile Barrier Technique** includes all of the following elements: Cap AND mask AND sterile gown AND sterile gloves AND sterile full body drape.

**Sterile Ultrasound Techniques** require sterile gel and sterile probe covers.

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6030F</td>
<td>All elements of maximal sterile barrier technique, hand hygiene, skin preparation and, if ultrasound is used, sterile ultrasound techniques followed</td>
</tr>
</tbody>
</table>

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## Anesthesiology/Critical Care (CRIT)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All patients regardless of age, who undergo CVC insertion</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including increased risk of harm to patient if adherence to aseptic technique would cause delay in CVC insertion)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Append a modifier (1P) to CPT Category II code 6030F to report documented circumstances that appropriately exclude patients from the denominator. Append a reporting modifier (8P) to CPT Category II code 6030F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified. This measure is to be reported each time a CVC insertion is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform CVC insertion will submit this measure.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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3. **The Joint Commission,** [https://www.jointcommission.org](https://www.jointcommission.org)

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## Anesthesiology/Critical Care (CRIT)

### Brief Description of Performance Measure and Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Perioperative Temperature Management**¹  
Whether or not the patient undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom *either* active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time  
**Numerator:** Patients for whom *either*:  
- active warming was used intraoperatively for the purpose of maintaining normothermia, OR  
- at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time  
**Denominator Codes:**  
- **4250F**  
- **4255F**  
  
**Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time**  
**Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record** |

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**Footnotes**

¹**Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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⁴**National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

²Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

⁶**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

⁷**Optum**, [www.optum.com](http://www.optum.com)

⁸**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com


¹⁰**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

¹²**American College of Gastroenterology (AGG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
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<tbody>
<tr>
<td><strong>Denominator</strong></td>
<td>All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer</td>
<td>4256F</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td>Documentation of one of the following medical reason(s) for not using active warming intraoperatively for the purpose of maintaining normothermia OR achieving at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• intentional hypothermia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• not indicated due to anesthetic technique: peripheral nerve block without general anesthesia, OR monitored anesthesia care</td>
<td></td>
</tr>
<tr>
<td>**Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer for whom <em>either</em> active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes</td>
<td></td>
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11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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**Anesthesiology/Critical Care (CRIT)**

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<tr>
<td>immediately before or the 15 minutes immediately after anesthesia end time</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reporting Instructions:** Report 4255F or 4256F for each patient undergoing surgical or therapeutic procedures under general or neuraxial anesthesia. If patient’s anesthesia duration is 60 minutes or longer (4255F) and patient had at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) OR active warming was used intraoperatively (as described in measure) also report 4250F.

For patient with appropriate exclusion criteria, report 4250F with modifier 1P.

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7Optum, www.optum.com

8American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


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11American Society of Anesthesiologists (ASA), www.asahq.org

12American College of Gastroenterology (ACG), www.gi.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org
## Annual monitoring (AM)

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</thead>
</table>
| **Annual monitoring for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)**
Percentage of patients 18 years of age and older who received at least a 180-days supply of ambulatory medication therapy for a select therapeutic agent during the measurement year and at least one therapeutic monitoring event for the therapeutic agent in the measurement year.
- Annual monitoring for patients on angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- Annual monitoring for patients on digoxin
- Annual monitoring for patients on diuretics
- Annual monitoring for patients on anticonvulsants

**Numerator:**
Patients have received the annual appropriate therapeutic monitoring event for the therapeutic agent. Patients who are prescribed a medication in the following drug classes for at least 180-day supply and who have receive the appropriate therapeutic monitoring event for the therapeutic agent.
Appropriate annual monitoring for patients taking the following includes:
- ACE/ARB:

| | 4188F | Appropriate angiotensin converting enzyme (ACE) or angiotensin receptor blockers (ARB) therapeutic monitoring test ordered or performed |
| | 4189F | Appropriate digoxin therapeutic monitoring test ordered or performed |
| | 4190F | Appropriate diuretic therapeutic monitoring test ordered or performed |
| | 4191F | Appropriate anticonvulsant therapeutic monitoring test ordered or performed |
| | 4210F | Angiotensin converting enzyme (ACE) or angiotensin receptor blockers (ARB) medication therapy for 6 months or more. |

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### Annual monitoring (AM)

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</tr>
</thead>
<tbody>
<tr>
<td>at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</td>
<td>4220F</td>
<td>Digoxin medication therapy for 6 months or more</td>
</tr>
<tr>
<td>Digoxin, at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</td>
<td>4221F</td>
<td>Diuretic medication therapy for 6 months or more</td>
</tr>
<tr>
<td>Diuretic, at least one serum potassium and either a serum creatinine or a blood urea nitrogen therapeutic monitoring test in the measurement year.</td>
<td>4230F</td>
<td>Anticonvulsant medication therapy for 6 months or more</td>
</tr>
<tr>
<td>Anticonvulsant, at least one drug serum concentration level monitoring test for the prescribed drug in the measurement year.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Denominator: All patients 18 years and older who are prescribed at least 180-day supply (6 months) of medication in the following drug classes:
- angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB)
- digoxin
- diuretics
- anticonvulsants

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### Annual monitoring (AM)

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</thead>
</table>

**Exclusion(s):**
Medical reasons for not receiving the appropriate annual therapeutic monitoring

**Percentage of** patients 18 years and older who received at least a 180-days supply of ambulatory medication therapy for a select therapeutic agent and are receiving the appropriate annual therapeutic monitoring.

**Reporting Instructions:**
Report this code for a patient at least once during the measurement year for patients identified in the eligible population. For patient with appropriate exclusion criteria report 4188F, 4189F, 4190F, or 4191F with modifier 1P. Measure requirements will be met when the appropriate documentation is present in administrative claims or internal data bases.

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<table>
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<th>ASTMRA</th>
<th><strong>Brief Description of Performance Measure and Source and Reporting Instructions</strong></th>
<th>CPT Category II Code(s)</th>
<th><strong>Code Descriptor(s)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Assessment of Asthma Control</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>2015F</td>
<td>Asthma impairment assessed</td>
</tr>
<tr>
<td></td>
<td>Whether or not the patient aged 5 through 50 years with a diagnosis of asthma was evaluated at least once for asthma control</td>
<td>2016F</td>
<td>Asthma risk assessed</td>
</tr>
<tr>
<td></td>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Patients who were evaluated for asthma control*</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Evaluation of asthma control is defined as:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Documentation of an evaluation of asthma impairment which must include:  daytime symptoms AND nighttime awakenings AND interference with normal activity AND short-acting beta2-agonist use for symptom control.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: Completion of a validated questionnaire will also meet the numerator requirement for this component of the measure.</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td><strong>AND</strong></td>
<td></td>
<td></td>
</tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source and Reporting Instructions</strong></td>
<td><strong>CPT Category II Code(s)</strong></td>
</tr>
<tr>
<td>Documentation of asthma risk which must include the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
</tr>
<tr>
<td>All patients aged 5 through 50 years with a diagnosis of asthma</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
</tr>
<tr>
<td>Report 2015F and 2016F for each patient that was evaluated at least once for asthma control. Evaluation of asthma impairment and asthma risk must occur during the same medical encounter.</td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
</tr>
</tbody>
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</table>
| **Tobacco Use: Screening**<sup>1</sup>  
Whether or not the patient aged 5 through 50 years old (or caregiver) with a diagnosis of asthma was queried about tobacco use and exposure to second hand smoke in their home environment  
**Numerator:**  
Patients (or their primary caregiver) who were queried about tobacco use and exposure to second hand smoke in their home environment  
**Denominator:**  
All patients aged 5 through 50 years with a diagnosis of asthma  
**Exclusion(s):**  
None  
**Reporting Instructions:**  
1031F  
Smoking status and exposure to second hand smoke in the home assessed | |

Footnotes

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Asthma

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<tr>
<td>Report 1031F for each patient whose smoking status and exposure to second hand smoke in the home was assessed. There are no performance exclusions; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tobacco Use – Intervention**

Whether or not the patient aged 5 through 50 years with a diagnosis of asthma identified as a tobacco user and received tobacco cessation intervention during the measurement period.

**Numerator:** Patients (or their caregivers) who received tobacco use cessation intervention.

Note: Practitioners providing tobacco cessation interventions to a pediatric patient’s primary caregiver are still numerator compliant whether or not the primary caregiver is the source of second hand smoke in the home.

**Denominator:**

| Denominator Codes | 4000F | 4001F | Tobacco use cessation intervention, counseling | Tobacco use cessation intervention, pharmacologic therapy |

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 5 through 50 years with a diagnosis of asthma identified as tobacco users*</td>
<td>1032F</td>
<td>Current tobacco smoker OR currently exposed to secondhand smoke</td>
</tr>
<tr>
<td>*Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.</td>
<td>1033F</td>
<td>Current tobacco non-smoker AND not currently exposed to secondhand smoke</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 1032F or 1033F to indicate tobacco use status. If 1032F (tobacco smoker OR currently exposed to secondhand smoke), report 4000F OR 4001F to indicate type of tobacco use cessation intervention.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Pharmacologic Therapy for Persistent Asthma

1. All patients aged 5 through 50 years with a diagnosis of asthma identified as tobacco users*.
2. Tobacco users include patients who currently use tobacco AND patients who do not currently use tobacco, but are exposed to second hand smoke in their home environment.
3. **Exclusion(s):** None
4. **Reporting Instructions:** Report 1032F or 1033F to indicate tobacco use status. If 1032F (tobacco smoker OR currently exposed to secondhand smoke), report 4000F OR 4001F to indicate type of tobacco use cessation intervention.
5. There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

---

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement®, see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and [National Quality Forum](http://www.qualityforum.org)


10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
<table>
<thead>
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<th>Brief Description of Performance Measure and Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 5 through 50 years old with a diagnosis of persistent asthma was prescribed long-term medication</td>
<td>4140F</td>
<td>Inhaled corticosteroids prescribed</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td>4144F</td>
<td>Alternative long-term control medication prescribed</td>
</tr>
<tr>
<td>Patients who were prescribed long-term medication*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-term medication includes:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Patients prescribed inhaled corticosteroids (the preferred long-term control medication at any step of asthma pharmacological therapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Patients prescribed alternative long-term control medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See measure specifications for list of preferred and alternative long-term control medications</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>Denominator Codes</td>
<td>Persistent asthma (mild, moderate or severe)</td>
</tr>
<tr>
<td>All patients aged 5 through 50 years with a diagnosis of persistent asthma</td>
<td>1038F</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


## Asthma

<table>
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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of medical (e.g., patients diagnosed with Emphysema, COPD, Cystic Fibrosis, and Acute Respiratory Failure, other medical reason(s)) or patient reason(s) for not prescribing either an inhaled corticosteroid (ICS) or an alternative long-term control medication</td>
<td>1039F</td>
<td>Intermittent asthma</td>
</tr>
<tr>
<td>Medical exclusions can be found in the measure specifications</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 1038F or 1039F to indicate asthma severity. For patients with persistent asthma (1038F), report 4140F or 4144F for both. For patient with appropriate exclusion criteria report 4140F for 4144F, with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessment of Asthma Risk</strong>&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2016F</td>
<td>Asthma risk assessed</td>
</tr>
<tr>
<td>Whether or not the patient aged 5 through 50 years with a diagnosis of asthma exacerbation was evaluated for the number of asthma exacerbations requiring oral systemic corticosteroids (asthma risk)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

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## Asthma

### Brief Description of Performance Measure and Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients who were evaluated for the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months (asthma risk</strong>)**</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Asthma risk includes the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months**

<table>
<thead>
<tr>
<th>Denominator:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 5 through 50 years with a diagnosis of asthma exacerbation diagnosed during an emergency department or inpatient admission</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exclusion(s):</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reporting Instructions:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
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</table>

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## Asthma

### Brief Description of Performance Measure and Source and Reporting Instructions

Report this measure for each emergency department encounter or inpatient admission (with a diagnosis of acute asthma exacerbation).

There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

### Asthma Discharge Plan¹

Whether or not the patient aged 5 through 50 years old with a diagnosis of asthma exacerbation during an emergency department visit or inpatient admission was discharged with an asthma discharge plan

#### Numerator:

- Patients discharged with an asthma discharge plan*
- Patients provided with oral and written discharge instructions

*The asthma discharge plan must include:

1. Instructions regarding inhaled corticosteroid use

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5250F</td>
<td>Asthma discharge plan provided to patient</td>
</tr>
</tbody>
</table>

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Footnotes

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

⁵Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


⁷Optum, [www.optum.com](http://www.optum.com).


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

¹²American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
### Asthma

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Information regarding discharge medications and how to use them (eg, instruction on inhaler technique) <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Referral for a follow-up appointment <strong>AND</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Instructions for recognizing and managing relapse of exacerbation or recurrence of airflow obstruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The hospital discharge day management codes are to be used to report the total duration of time spent by a physician for final hospital discharge of a patient. The codes include, as appropriate, final examination of the patient, discussion of the hospital stay, even if the time spent by the physician on that date is not continuous, instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms. For a patient admitted and discharged from observation or inpatient status on the same date, the services should be reported with codes 99234-99236 as appropriate.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Denominator:**

---

Footnotes

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6**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

7**Optum**, [www.optum.com](http://www.optum.com)


10**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality).


12**American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org).
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<th><strong>Asthma</strong></th>
<th><strong>CPT Category II Code(s)</strong></th>
<th><strong>Code Descriptor(s)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients aged 5 through 50 years with a diagnosis of asthma exacerbation during an emergency department visit or inpatient admission</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report this measure for each emergency department encounter or inpatient admission with a diagnosis of acute asthma exacerbation. Report 5250F if an asthma discharge plan is provided to patient at time of discharge. There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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7. **Optum,** [www.optum.com](http://www.optum.com)

8. **American Academy of Neurology,** [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com


10. **American Gastroenterological Association (AGA),** [www.gastro.org/quality](http://www.gastro.org/quality)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assessment of Thromboembolic Risk Factors¹</td>
<td>1180F</td>
<td>All specified thromboembolic risk factors assessed</td>
</tr>
</tbody>
</table>

• Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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### Atrial Fibrillation and Atrial Flutter (AFIB)

#### Brief Description of Performance Measure and Source

Whether or not the patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter had an assessment of all of the specified thromboembolic risk factors documented during the 12 month reporting period

**Numerator**: Patients with an assessment of all of the specified thromboembolic risk factors* documented during the 12 month reporting period

*Thromboembolic risk factors to be assessed include: prior stroke or TIA, age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.

**Denominator**: All patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter

**Exclusion(s)**: Documentation of medical reason(s) for not assessing risk factors (eg, patients with transient or reversible causes of atrial fibrillation (eg, pneumonia or hyperthyroidism),

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1180F</td>
<td>All specified thromboembolic risk factors assessed</td>
</tr>
</tbody>
</table>
## Atrial Fibrillation and Atrial Flutter (AFIB)

<table>
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<tr>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>postoperative patients, patients who are pregnant, allergy to warfarin, risk of bleeding)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter with an assessment of all of the specified thromboembolic risk factors documented</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For the patient with appropriate exclusion criteria, report 1180F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Chronic Anticoagulation Therapy**

Whether or not the patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism was prescribed warfarin during the 12 month reporting period

**Numerator:** Patients who were prescribed warfarin during the 12 month reporting period

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4012F</td>
<td>Warfarin therapy prescribed</td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement** (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement (PCPI), see the appropriate Payor website.

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7. **Optum, www.optum.com.**

8. **American Academy of Neurology,** [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures) **or quality@aun.com.**


### Atrial Fibrillation and Atrial Flutter (AFIB)

#### Brief Description of Performance Measure and Source

**Denominator:** All patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism

**Definitions of Risk**

Patients are identified by ACC/AHA/ESC 2006 guidelines at **low risk** for thromboembolism if there are none of the following factors: prior stroke or TIA, age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.

Patients are identified by ACC/AHA/ESC 2006 guidelines at **intermediate risk** for thromboembolism if there is one of the following factors: age ≥ 75 years, hypertension, diabetes mellitus, and heart failure or impaired left ventricular systolic function.

Patients are identified by ACC/AHA/ESC 2006 guidelines at **high risk** for thromboembolism if there is a prior stroke or TIA OR two or more of the following factors: age ≥ 75 years,

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3550F</td>
<td>Low risk for thromboembolism</td>
</tr>
<tr>
<td>3551F</td>
<td>Intermediate risk for thromboembolism</td>
</tr>
<tr>
<td>3552F</td>
<td>High risk for thromboembolism</td>
</tr>
</tbody>
</table>

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**Footnotes**

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### Atrial Fibrillation and Atrial Flutter (AFIB)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter at high risk for thromboembolism who were prescribed warfarin during the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 3550F or 3551F or 3552F for each patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter. If the patient is classified as high risk, report 3554F or 3555F.</td>
<td></td>
<td></td>
</tr>
</tbody>
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Atrial Fibrillation and Atrial Flutter (AFIB)

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<tbody>
<tr>
<td>risk for thromboembolism and warfarin therapy is prescribed, also report 4012F. For the patient with appropriate exclusion criteria, report 4012F with modifier 1P or 2P.</td>
<td>3555F</td>
<td>Patient had International Normalized Ratio (INR) measurement performed</td>
</tr>
</tbody>
</table>

Monthly International Normalized Ratio (INR) Measurement¹

Calendar months during reporting year during which the patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter, receiving warfarin therapy, have at least one INR measurement made

**Numerator:** Number of calendar months in which at least one INR measurement was made

**Denominator:** Number of calendar months in which the patient aged 18 years and older with a diagnosis of

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7. **Optum, [www.optum.com](http://www.optum.com)**

8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**


10. **American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).**

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## Atrial Fibrillation and Atrial Flutter (AFIB)

### Brief Description of Performance Measure and Source

- **nonvalvular atrial fibrillation or atrial flutter received warfarin therapy**

#### Exclusion(s):
- Documentation of patient reason(s) for no INR measurement: Examples of patient reasons for no INR measurement include, but are not limited to:
  - Month(s) during a calendar year in which patient noncompliance with INR monitoring is documented, despite one or more documented attempts to contact the patient to ensure compliance.
- Documentation of system reason(s) for no INR measurement: Examples of system reasons for no INR measurement include, but are not limited to:
  - Month(s) during a calendar year in which monitoring of INR is documented as the responsibility of another caregiver.

#### Percentage
- of calendar months during the reporting year during which patients aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter,

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Denominator Codes</td>
<td></td>
</tr>
<tr>
<td>4300F</td>
<td>Patient receiving warfarin therapy for nonvalvular atrial fibrillation or atrial flutter</td>
</tr>
<tr>
<td>4301F</td>
<td>Patient not receiving warfarin therapy for nonvalvular atrial fibrillation or atrial flutter</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>receiving warfarin therapy, have at least one INR measurement made</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reporting Instructions:**

Report this measure one or more times during each calendar month during the reporting year.

Report 4300F or 4301F for each patient aged 18 years and older with a diagnosis of nonvalvular atrial fibrillation or atrial flutter. If warfarin therapy is received and the patient has at least one INR measurement during that calendar month, also report 3555F.

For the patient with appropriate exclusion criteria report 3555F with modifier 2P or 3P.

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### Back Pain (BkP)

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<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Visit for Back Pain²</strong> &lt;br&gt;Whether or not a patient with a diagnosis of back pain during the initial visit for the episode of back pain had back pain and function assessed.*</td>
<td>1130F</td>
<td>Back pain and function assessed, including all of the following: Pain assessment AND functional status AND patient history, including notation of presence or absence of “red flags” (warning signs) AND assessment of prior treatment and response, <strong>AND</strong> employment status</td>
</tr>
<tr>
<td><strong>Numerator:</strong> &lt;br&gt;Patients who had all five of the following components assessed*::</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pain assessment &lt;br&gt;• Functional status &lt;br&gt;• Patient history, including notation of presence or absence of warning signs &lt;br&gt;• Assessment of prior treatment and response and &lt;br&gt;• Employment status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> &lt;br&gt;All patients with diagnosis of back pain at the initial visit of the episode</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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⁶**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

⁷**Optum**, [www.optum.com](http://www.optum.com)


¹⁰**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

¹²**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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### Back Pain (BkP)

**Brief Description of Performance Measure and Source**

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<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0525F</td>
<td>Initial visit for episode</td>
</tr>
</tbody>
</table>

**”Red flags” (warning signs) include:**

- History of cancer or unexplained weight loss
- Current infection or immunosuppression
- Fracture or suspected fracture
  - Motor vehicle accident or industrial injury with suspicion of fracture
  - Major fall with suspicion of fracture
- Cauda equine syndrome or progressive neurologic deficit
  - Saddle anesthesia
  - Recent onset bladder dysfunction (urine retention, increased frequency, overflow incontinence)
  - Recent onset fecal incontinence (loss of bowel control)
  - Major motor weakness

**Percentage of patients with a diagnosis of back pain during the initial visit for the episode of back pain had back pain and function assessed.**

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<tbody>
<tr>
<td>0525F, 0526F</td>
<td>Reporting Instructions:</td>
</tr>
<tr>
<td></td>
<td>Report 0525F or 0526F for each patient. Use 0525F to indicate the initial visit and 0526F to indicate a subsequent visit during the episode of back pain.</td>
</tr>
<tr>
<td></td>
<td>Report 1130F for all patients for whom, during the initial visit of the episode of back pain, pain assessment, functional status, patient history, assessment of prior treatment and response, and employment status was assessed.</td>
</tr>
<tr>
<td></td>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
</tr>
<tr>
<td></td>
<td>*Note: Measure specifications should be referred to in order to determine criteria to meet any of the required assessments.</td>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Exam after Back Pain Onset</strong></td>
<td>2040F</td>
<td>Physical examination on the date of the initial visit for low back performed, in accordance with specifications</td>
</tr>
</tbody>
</table>

**Brief Description of Performance Measure and Source**

Whether or not a patient with a diagnosis of back pain received a physical examination during the initial visit for the episode of back pain

**Numerator:**

Patients who had a physical exam on the date of the initial visit for back pain*

- For patients **with** radicular symptoms, documentation of physical exam must include the following (at a minimum):
  - Indication of straight leg raise test, **and**
  - Notation of completion of neurovascular exam (a neurovascular exam must include ankle and knee reflexes; quadriceps, ankle and great toe dorsiflexion strength; plantar flexion; muscle strength; motor testing; pulses in lower extremities; and sensory exam)
- For patients **without** radicular symptoms, documentation of physical exam must include the following:

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# Back Pain (BkP)

## Brief Description of Performance Measure and Source

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

Denominator:

All patients with diagnosis of back pain at the initial visit of the episode

Exclusion(s): Medical exclusion for not receiving a physical examination (ie, patients with bilateral lower extremity amputations)

Percentage of patients with a diagnosis of back pain who received a physical examination on the date of the initial visit

Reporting Instructions:

Report 0525F or 0526F for each patient. Use code 0525F to indicate the initial visit and 0526F to indicate a subsequent visit during the episode of low back pain. Only initial visits (0525F) will be included in the numerator.

## CPT Category II Code(s) and Code Descriptor(s)

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<th>Denominator Codes</th>
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<tr>
<td>0525F</td>
<td>Initial visit for episode</td>
</tr>
<tr>
<td>0526F</td>
<td>Subsequent visit for episode</td>
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</thead>
</table>
| Report 2040F if a physical exam occurred as specified. If there is a valid medical reason for not receiving a physical examination during the initial visit for the episode of back pain, report 1P with 2040F  
*Note: Measure specifications should be referred to in order to determine criteria to meet any of the required assessments.* | | |

#### Mental Health Assessment after Back Pain Onset²

Whether or not a patient with a diagnosis of back pain received a mental health assessment.

Specifically a patient must have documentation of a mental health assessment present in the medical record prior to intervention (back surgery or epidural steroid injection) or when pain lasts longer than six weeks.

**Numerator:**

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## Back Pain (BkP)

### Brief Description of Performance Measure and Source

Patients with documentation of at least one mental health assessment prior to intervention or for patients with back pain lasting longer than six weeks*

**Denominator:**

All patients undergoing back surgery or epidural steroid injection (see technical specifications for list of procedures) or who have had back pain lasting longer than six weeks

**Exclusion(s):** None

**Percentage of** patients with a diagnosis of back pain for whom documentation of a mental health assessment is present in the medical record prior to intervention or when pain lasts longer than six weeks after the initial visit

**Reporting Instructions:**

If reporting at the time of procedure, it is not necessary to report one of the denominator codes. If reporting at time of E/M visit, use denominator codes to indicate duration of pain.

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<tr>
<th>CPT Category II Code(s)</th>
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<tr>
<td>2044F</td>
<td>Documentation of mental health assessment prior to intervention (back surgery or epidural steroid injection) or for back pain episode lasting longer than 6 weeks</td>
</tr>
<tr>
<td>1134F</td>
<td>Episode of back pain lasting 6 weeks or less</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>If a mental health assessment occurred as specified, report code 2044F. Report this measure only once during an episode of back pain. There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used. * Note: Measure specifications should be referred to in order to determine criteria to meet the mental health assessment requirement.</td>
<td>1135F</td>
<td>Episode of back pain lasting longer than 6 weeks</td>
</tr>
</tbody>
</table>

**Appropriate Imaging for Acute Back Pain**

Whether or not a patient with a diagnosis of back pain has a report of an imaging study performed during the six weeks after pain onset or order for an imaging study during the six weeks after pain onset, in the absence of “red flags” (warning signs - signs or symptoms that would warrant imaging) (overuse measure, lower performance is better)

“Red flags” (warning signs) include:

- History of cancer or
- Unexplained weight loss

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3330F</td>
<td>Imaging study ordered</td>
</tr>
<tr>
<td>3331F</td>
<td>Imaging study not ordered</td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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<thead>
<tr>
<th>Back Pain (BkP)</th>
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<th>Code Descriptor(s)</th>
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</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong></td>
<td><strong>Denominator Codes</strong></td>
<td><strong>Episode of back pain lasting 6 weeks or less</strong></td>
</tr>
<tr>
<td>Patients with an order for an imaging study</td>
<td>1134F</td>
<td>Episode of back pain lasting longer than 6 weeks</td>
</tr>
<tr>
<td>Note: Evidence of a report of an imaging study related to this episode is considered evidence of an order. See technical specifications for listing of applicable imaging studies. Include</td>
<td>1135F</td>
<td></td>
</tr>
<tr>
<td>• Current infection or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Immunosuppression</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fracture or suspected fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Motor vehicle accident or industrial injury with suspicion of fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Major fall with suspicion of fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cauda equine syndrome or progressive neurologic deficit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Saddle anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Recent onset bladder dysfunction (urine retention, increased frequency, overflow incontinence)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Recent onset fecal incontinence (loss of bowel control)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Major motor weakness</td>
<td></td>
<td></td>
</tr>
</tbody>
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Footnotes

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6Optum, www.optum.com

7American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


9American Society of Anesthesiologists (ASA), www.asahq.org

10American Gastroenterological Association (AGA), www.gastro.org/quality

11American College of Gastroenterology (ACG), www.gi.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org

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Back Pain (BkP)

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</tr>
</thead>
<tbody>
<tr>
<td>only those orders generated by the reporting physician or practice.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients with back pain lasting six weeks or less</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1P: Documentation of medical reason(s) for ordering or performing an imaging study, which include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• History of cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Current infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fracture or suspected fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cauda equina syndrome or progressive neurologic deficit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients with a diagnosis of back pain for whom the physician ordered imaging studies during the six weeks after pain onset, in the absence of &quot;red flags&quot; (warning signs) (overuse measure, lower performance is better)</td>
<td></td>
<td></td>
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### Back Pain (BkP)

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<tr>
<th>Reporting Instructions:</th>
<th>Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two codes must be reported for this measure. Report either 1134F or 1135F for each patient. If the duration of back pain is less than six weeks (1134F) and an imaging study was ordered, report 3330F; if an imaging study was not ordered, report 3331F. Evidence of an imaging study report for the back pain episode should be included as evidence of an order for an imaging study. If there is a valid medical reason to order an imaging study for patients with back pain lasting less than six weeks, report 1P with 3330F.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Advice for Normal Activities for Back Pain Patients

Whether or not a patient during the initial visit for an episode of back pain was counseled (advised) to maintain or resume normal activities*

Numerator:

<table>
<thead>
<tr>
<th>Footnotes</th>
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<tbody>
<tr>
<td>1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.</td>
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<td>3The Joint Commission, <a href="https://www.jointcommission.org">https://www.jointcommission.org</a></td>
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</tr>
<tr>
<td>6The Society of Thoracic Surgeons at <a href="http://www.sts.org">www.sts.org</a> and National Quality Forum, <a href="http://www.qualityforum.org">www.qualityforum.org</a></td>
</tr>
<tr>
<td>7Optum, <a href="http://www.optum.com">www.optum.com</a></td>
</tr>
<tr>
<td>8American Academy of Neurology, <a href="https://www.aan.com/practice/neuromuscular-quality-measures">https://www.aan.com/practice/neuromuscular-quality-measures</a>, or <a href="mailto:quality@aan.com">quality@aan.com</a></td>
</tr>
<tr>
<td>10American Gastroenterological Association (AGA), <a href="http://www.gastro.org/quality">www.gastro.org/quality</a></td>
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<td>11American Society of Anesthesiologists (ASA), <a href="http://www.asahq.org">www.asahq.org</a></td>
</tr>
<tr>
<td>12American College of Gastroenterology (ACG), <a href="http://www.gi.org">www.gi.org</a>; American Gastroenterological Association (AGA), <a href="http://www.gastro.org">www.gastro.org</a>; and American Society for Gastrointestinal Endoscopy (ASGE), <a href="http://www.asge.org">www.asge.org</a></td>
</tr>
</tbody>
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### Back Pain (BkP)

**Brief Description of Performance Measure and Source**

Patients with documentation on the date of the initial visit with the physician of advice to maintain or resume normal activities*

- **Denominator:** All patients with diagnosis of back pain at the initial visit of the episode
- **Exclusion(s):** None
- **Percentage of** patients whose physician advised them to maintain or resume normal activities.

**Reporting Instructions:**

Report 0525F or 0526F for each patient. Use 0525F to indicate the initial visit and 0526F to indicate a subsequent visit during the episode of back pain. Only initial visits (0525F) will be included in the numerator.

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>245F</td>
<td>Patient counseled during the initial visit to maintain or resume normal activities</td>
</tr>
<tr>
<td>0525F</td>
<td>Initial visit for episode</td>
</tr>
<tr>
<td>0526F</td>
<td>Subsequent visit for episode</td>
</tr>
</tbody>
</table>

---

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### Back Pain (BkP)

#### Brief Description of Performance Measure and Source

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<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4248F</td>
<td>Patient counseled during the initial visit for an episode of back pain against bed rest lasting 4 days or longer</td>
</tr>
</tbody>
</table>

#### Advice Against Bed Rest for Back Pain Patients

Whether or not a patient with an episode of back pain was counseled against bed rest lasting 4 days or longer during the initial visit

**Numerator:**

Patients with medical record documentation that a physician advised them against bed rest lasting four days or longer during the initial visit for back pain

**Denominator:**

There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.

* This advice must be tempered by consideration of the patient’s usual job or life demands. Heavy lifting, trunk twisting and bodily vibrations should be avoided in the acute phase.

---

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### Back Pain (BkP)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients with diagnosis of back pain at the initial visit of the episode</td>
<td>Denominator Codes</td>
<td>Initial visit for episode</td>
</tr>
<tr>
<td>Exclusion(s): None</td>
<td>0525F</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients with an episode of back pain who received advice against bed rest lasting four days or longer during initial visit with the physician</td>
<td>0526F</td>
<td>Subsequent visit for episode</td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 0525F or 0526F for each patient. Use 0525F to indicate the initial visit and 0526F to indicate a subsequent visit during the episode of back pain. Only initial visits (0525F) will be included in the numerator.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Recommendation for Exercise for Back Pain Patients

1. **Physician Consortium for Performance Improvement** (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement (PCPI), see the appropriate Payor website.

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</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not a patient during an episode of back pain lasting longer than 12 weeks received instructions for therapeutic exercise with follow up by physician <strong>or</strong> was counseled to perform supervised exercise</td>
<td>4240F</td>
<td>Instruction in therapeutic exercise with follow-up by the physician provided to patients during episode of back pain lasting longer than 12 weeks</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who were recommended a supervised exercise program <strong>or</strong></td>
<td>4242F</td>
<td>Counseling for supervised exercise program provided to patients during episode of back pain lasting longer than 12 weeks</td>
</tr>
<tr>
<td>Patients who were provided instructions for therapeutic exercise with follow-up by the physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients with back pain lasting longer than 12 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of patients who were recommended a supervised exercise program or who were provided instructions for</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>therapeutic exercise with follow-up by the physician during an episode of back pain lasting longer than 12 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td>Denominator Codes</td>
<td></td>
</tr>
<tr>
<td>Report either 1136F or 1137F for each patient. Report 4240F if instructions for therapeutic exercise with follow-up by the physician at the point of follow-up or after follow-up. If counseling for supervised exercise program was provided, report 4242F.</td>
<td>1136F</td>
<td>Episode of back pain lasting 12 weeks or less</td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td>1137F</td>
<td>Episode of back pain lasting longer than 12 weeks</td>
</tr>
</tbody>
</table>

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### Care for Older Adults (COA)

<table>
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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Care Planning²</td>
<td>1157F</td>
<td></td>
</tr>
</tbody>
</table>

#### Advance Care Planning²

Whether or not a patient aged 65 years and older had advance care planning during the measurement year.

**Numerator:**

Patients who have evidence of advance care planning² during the measurement year.

---

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# Care for Older Adults (COA)

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor</th>
</tr>
</thead>
</table>
| **Definitions:**  
> Advance care planning is a discussion about preferences for resuscitation, life-sustaining treatment and end of life care. Evidence of advance care planning must include either:  
> • The presence of an advance care plan in the medical record, or  
> • Documentation of an advance care planning discussion with the patient and the date on which it was discussed. The discussion must have occurred and be documented in the measurement year.  
> **Denominator:** All patients aged 65 years and older  
> **Exclusion(s): None**  
> **Percentage** of patients 65 years and older who have evidence of advance care planning during the measurement year.  
> **Reporting Instructions:** | 1158F | Advance care plan or similar legal document present in the medical record  
> Advance care planning discussion documented in the medical record |

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report 1157F or 1158F at least once during the measurement year. <strong>Alternatively: Report codes 1123F (Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record) or 1124F (Advance Care Planning discussed; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan), at least once during the measurement year.</strong> These codes represent documentation that exceeds the requirements of this numerator and when submitted will count toward the numerator. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td>1159F</td>
<td>Medication list documented in medical record</td>
</tr>
</tbody>
</table>

Footnotes

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

4National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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7Optum, [www.optum.com](http://www.optum.com).


10American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

11American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

12American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
### Care for Older Adults (COA)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>measurement year and the presence of a medication list in the medical record.</td>
<td>1160F</td>
<td>Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record</td>
</tr>
</tbody>
</table>

#### Numerator:

Patients who have evidence of at least one medication review\(^a\) conducted by a prescribing practitioner or clinical pharmacist during the measurement year AND the presence of a medication list\(^b\) in the medical record

#### Definitions:

\(^a\)Medication review: a review of a patient's medications including prescription medications, over the counter medications (OTC) or herbal therapies. Evidence of a medication review is documentation that a prescribing practitioner or clinical pharmacist has reviewed all medications that the patient is taking (including prescriptions, OTCs and herbal or supplemental therapies). If the patient is not taking any medications, documentation of this fact is also evidence of a medication review. A review of side effects for a single medication is not sufficient evidence of a medication review.

\(^b\)Medication list: a list of the medications that the patient is taking, including medications prescribed by the healthcare practitioner, over-the-counter medications and herbal or supplemental therapies. Medication lists that are not maintained by a prescribing practitioner or clinical pharmacist are not sufficient evidence of a medication list.
<table>
<thead>
<tr>
<th>Care for Older Adults (COA)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Description of Performance Measure &amp; Source</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>medication at the time of prescription alone is not sufficient evidence of a medication review.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>bMedication List: A medication list is a list of patient’s medications in the medical record which may include prescriptions, over the counter medications and herbal therapies or supplements</td>
<td></td>
</tr>
<tr>
<td>Denominator:</td>
<td>All patients aged 65 years and older</td>
<td></td>
</tr>
<tr>
<td>Exclusion(s):</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Percentage of patients aged 65 years and older with at least one medication review conducted by a prescribing practitioner or clinical pharmacist during the measurement year AND the presence of a medication list in the medical record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td>Report 1159F AND 1160F at least once during the measurement year. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P</td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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6The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7Optum, [www.optum.com](http://www.optum.com)


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### Care for Older Adults (COA)

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>may not be used. 1159F and 1160F do not need to be reported during the same visit.</td>
<td>1170F</td>
<td>Functional status assessed</td>
</tr>
</tbody>
</table>

#### Functional Status Assessment

Whether or not a patient aged 65 years and older had a functional status assessment during the measurement year.

**Numerator:**

Patients who have evidence of a functional status assessment during the measurement year.

*aDefinition: Evidence of functional status assessment may include the following:

- Functional independence
- Loss of independent performance, Activities of Daily Living (ADL), social activities, or Instrumental Activities of Daily Living (IADL)

---

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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5. Joint measure from [The Physician Consortium for Performance Improvement (PCPI)](https://www.pcpi.org) and [National Committee on Quality Assurance (NCQA)](http://www.ncqa.org) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and [National Quality Forum](https://www.qualityforum.org)


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<thead>
<tr>
<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1170F</td>
<td>Functional status assessed</td>
</tr>
</tbody>
</table>

---

**Care for Older Adults (COA)**

- **Brief Description of Performance Measure & Source**
  - Functional Status Assessment
    - Whether or not a patient aged 65 years and older had a functional status assessment during the measurement year.
    - **Numerator:** Patients who have evidence of a functional status assessment during the measurement year.
    - *Definition: Evidence of functional status assessment may include the following:
      - Functional independence
      - Loss of independent performance, Activities of Daily Living (ADL), social activities, or Instrumental Activities of Daily Living (IADL)

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</thead>
</table>
| - The level of assistance needed to accomplish daily activities  
- Result of assessment using a standardized functional status assessment tool. (See specification for list of standardized tools).  
**Denominator:** All patients aged 65 years and older  
**Exclusion(s):** None  
**Percentage** of patients aged 65 years and older with a functional status assessment during measurement year  
**Reporting Instructions:** Report 1170F at least once during the measurement year. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used. | | |

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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7. **Optum, [www.optum.com](http://www.optum.com).**

8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**


10. **American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).**

11. **American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).**

12. **American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).**

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</tr>
</thead>
<tbody>
<tr>
<td>Whether or not a patient aged 65 years and older had a pain screening during the measurement year.</td>
<td>1125F</td>
<td>Pain severity quantified; pain present</td>
</tr>
<tr>
<td>Patients who have evidence of at least one pain screening* or a pain management plan** during the measurement year.</td>
<td>1126F</td>
<td>Pain severity quantified; no pain present</td>
</tr>
<tr>
<td>**Plan of care to address pain documented</td>
<td>0521F</td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

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</tr>
</thead>
<tbody>
<tr>
<td>Denominator: All patients aged 65 years and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s): None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 65 years and older with a pain screening or pain management plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 1125F or 1126F if pain severity quantified or 0521F if plan of care documented at least once during the measurement year. You may report both 1125F and 0521F. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medication Reconciliation²**

Whether or not after each inpatient facility discharge the patient aged 65 years and older had discharge medications reconciled with their current medication list within 30 days of discharge

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**Footnotes**

¹**Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²**National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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⁶**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

⁷**Optum**, [www.optum.com](http://www.optum.com)

⁸**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aun.com


¹⁰**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

¹²**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Patients who had evidence of a medication reconciliation of the discharge medications with the current medication list within 30 days after every discharge.</td>
<td>1111F</td>
<td>Discharge medications reconciled with the current medication list in outpatient medical record</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All discharges from an acute or non-acute inpatient facility for patients aged 65 years and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of discharges for patients aged 65 years and older for whom medications were reconciled within 30 days of discharge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1 *Physician Consortium for Performance Improvement® (PCPI)* - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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6 *The Society of Thoracic Surgeons* at [www.sts.org](http://www.sts.org) and *National Quality Forum*, [www.qualityforum.org](http://www.qualityforum.org)

7 *Optum*, [www.optum.com](http://www.optum.com).


### Care for Older Adults (COA)

<table>
<thead>
<tr>
<th>Reporting Instructions:</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report 1111F within 30 days of each discharge from an inpatient facility. If multiple discharges occur in the year, 1111F should be reported within 30 days of each patient discharge. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Chronic Kidney Disease (CKD)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Blood Pressure Management</strong>¹</td>
<td>0513F</td>
<td></td>
</tr>
<tr>
<td>Number of visits with blood pressure measurement &lt;130/80 mmHg OR ≥130/80 mmHg with a documented plan of care for the patient aged 18 years and older with the diagnosis of Chronic Kidney Disease (CKD).</td>
<td>0513F</td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

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¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

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### Chronic Kidney Disease (CKD)

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<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]) Numerator: Patient visits with blood pressure &lt;130/80 mmHg OR ≥130/80 mmHg with a documented plan of care* A documented plan of care should include one or more of the following: recheck blood pressure at specified future date; initiate or alter pharmacologic therapy; documented review of patient’s home blood pressure log which indicates that patient’s blood pressure is or is not well controlled If multiple blood pressure measurements are taken at a single visit, use the most recent measurement taken at that visit Denominator: All visits for patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT), with a blood pressure &lt;130/80 mmHg OR blood pressure ≥ 130/80 with a documented plan of care</td>
<td>2000F</td>
<td>Elevated blood pressure plan of care documented</td>
</tr>
<tr>
<td></td>
<td>3074F</td>
<td>Blood pressure measured</td>
</tr>
<tr>
<td></td>
<td>3075F</td>
<td>Most recent systolic blood pressure, less than 130 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3077F</td>
<td>Most recent systolic blood pressure, 130 to 139 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3078F</td>
<td>Most recent systolic blood pressure, greater than or equal to 140 mm Hg</td>
</tr>
</tbody>
</table>

#### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
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### Chronic Kidney Disease (CKD)

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<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Reporting Instructions**: For the systolic blood pressure value, report one of the three systolic codes; for the diastolic blood pressure value, report one of the three diastolic codes. If 3075F, 3077F, 3079F or 3080F are reported and there is a documented plan of care for elevated BP during the visit, also report 0513F.  
There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used. | 3079F  
3080F | Most recent diastolic blood pressure,  
less than 80 mm Hg  
Most recent diastolic blood pressure,  
80 - 89 mm Hg  
Most recent diastolic blood pressure,  
greater than or equal to 90 mm Hg |

### ACE Inhibitor (ACE) or Angiotensin Receptor Blocker (ARB) Therapy

Whether or not the patient aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]) and hypertension and proteinuria was prescribed ACE inhibitor or ARB therapy during the 12 month reporting period

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**Footnotes**

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11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
### Chronic Kidney Disease (CKD)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Patients who were prescribed ACE inhibitor or ARB therapy during the 12 month reporting period</td>
<td>4010F</td>
<td>Angiotensin converting enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not RRT) and hypertension and proteinuria</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical or patient reason(s) for not prescribing ACE inhibitor or ARB therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of patients aged 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving RRT), and hypertension and proteinuria who were prescribed ACE inhibitor or ARB therapy during the 12 month reporting period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> In order to qualify for the denominator, three ICD-9 codes must be reported: one for each of the following conditions: CKD (stage 4 or 5), and Hypertension and Proteinuria. For patient with appropriate exclusion criteria, report 4010F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Laboratory Testing (Calcium, Phosphorus, and Intact Parathyroid Hormone (PTH), and Lipid Profile)**

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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)
4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.
5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).
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<tr>
<th>Chronic Kidney Disease (CKD)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]) had the following laboratory testing ordered at least once during the 12 month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile</td>
<td>3278F</td>
<td>Serum levels of calcium, phosphorus, intact Parathyroid Hormone (iPTH) and lipid profile</td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who had the following laboratory testing ordered at least once during the 12 month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact PTH, and/or lipid profile</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not ordering serum levels of calcium, phosphorus, intact PTH, and/or lipid profile</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT), who had the following laboratory testing ordered at least once</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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6**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

7**Optum**, [www.optum.com](http://www.optum.com)

8**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com)


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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>during the 12 month reporting period: serum levels of calcium, phosphorus and intact PTH, and lipid profile</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 3278F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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Last Updated June 23, 2023
Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)¹

Number of calendar months during which a patient aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), receiving ESA therapy, and has a hemoglobin level < 13 g/dL OR has a hemoglobin level ≥ 13 g/dL with a documented plan of care for elevated hemoglobin level

**Numerator:** Number of calendar months during which patients’ hemoglobin level is < 13 g/dL OR patients' hemoglobin level is ≥ 13 g/dL with a documented plan of care for elevated hemoglobin level

A documented plan of care should include reducing the ESA dose and repeating hemoglobin at a specified future date

**Denominator:** Calendar months for all patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT), receiving ESA therapy

**Exclusion(s):** None

**Percentage** of calendar months during the 12 month reporting period during which patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT), receiving ESA therapy, have a hemoglobin level < 13 g/dL OR whose hemoglobin level is ≥ 13 g/dL with a documented plan of care for elevated hemoglobin level

<table>
<thead>
<tr>
<th>Denominator Codes</th>
<th>Plan of care for elevated hemoglobin level documented for patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>0514F</td>
<td>Hemoglobin level greater than or equal to 13 g/dL</td>
</tr>
<tr>
<td>3279F</td>
<td>Hemoglobin level 11 g/dL to 12.9 g/dL</td>
</tr>
<tr>
<td>3280F</td>
<td>Hemoglobin level less than 11 g/dL</td>
</tr>
<tr>
<td>3281F</td>
<td>Patient receiving Erythropoiesis-Stimulating Agent (ESA) therapy</td>
</tr>
</tbody>
</table>

Footnotes

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

⁵Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


⁷Optum, [www.optum.com](http://www.optum.com).


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

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Last Updated June 23, 2023
**Influenza Immunization**

Whether or not the patient aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]) received the influenza immunization during the flu season (September through February)

**Numerator:** Patients who received the influenza immunization during the flu season (September through February)

**Denominator:** All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)

**Exclusion(s):** Documentation of medical, patient, or system reason(s) for patient not receiving the influenza immunization

**Percentage** of patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT),

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4172F</td>
<td>Patient not receiving Erythropoiesis-Stimulating Agent (ESA) therapy</td>
</tr>
<tr>
<td>4037F</td>
<td>Influenza immunization ordered or administered</td>
</tr>
</tbody>
</table>

Footnotes

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Last Updated June 23, 2023
<table>
<thead>
<tr>
<th>Referral for AV Fistula&lt;sup&gt;1&lt;/sup&gt;</th>
<th>4051F</th>
<th>Referred for an arteriovenous (AV) fistula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving Renal Replacement Therapy [RRT]), was referred for AV fistula at least once during the 12 month reporting period</td>
<td>Numerator: Patients who were referred for AV fistula at least once during the 12 month reporting period</td>
<td>Denominator: All patients aged 18 years and older with the diagnosis of advanced CKD (stage 4 or 5, not receiving RRT)</td>
</tr>
</tbody>
</table>

Footnotes

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### Chronic Obstructive Pulmonary Disease (COPD)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking Assessment</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not patient with COPD was queried about smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> All patients who were queried about smoking during one or more office visits each year</td>
<td>1000F</td>
<td>Tobacco use assessed</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with the diagnosis of COPD</td>
<td>1035F</td>
<td>Current smokeless tobacco user (eg, chew, snuff)</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> NONE</td>
<td>1034F</td>
<td>Current tobacco smoker</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients who were queried about smoking at least annually</td>
<td>1036F</td>
<td>Current tobacco non-user</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> When reporting 1000F, it is required to report 1034F, and/or 1035F, or 1036F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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Last Updated June 23, 2023
## Chronic Obstructive Pulmonary Disease (COPD)

### Brief Description of Performance Measure & Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Assessment of Symptoms¹</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not patient had COPD symptoms assessed at least annually</td>
<td>1015F</td>
<td>Chronic obstructive pulmonary disease (COPD) symptoms assessed (Includes assessment of at least one of the following: dyspnea, cough/sputum, wheezing), or respiratory symptom assessment tool completed</td>
</tr>
</tbody>
</table>

**Numerator:** All patients with COPD symptoms assessed during one or more office visits each year

**Denominator:** All patients with the diagnosis of COPD

**Exclusion(s):** NONE

**Percentage** of patients who were assessed for COPD symptoms at least annually

There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

### Spirometry Evaluation¹

Whether or not patient spirometry results were documented

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## Chronic Obstructive Pulmonary Disease (COPD)

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong>: All patients with documented spirometry results on the medical record</td>
<td>3023F</td>
<td>Spirometry results documented and reviewed</td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients with the diagnosis of COPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical, patient, or system reason(s) for not documenting and reviewing spirometry evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients with COPD who had a spirometry evaluation documented</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: For patient with appropriate exclusion criteria, report 3023F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Smoking Cessation Intervention</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>4000F</td>
<td>Tobacco use cessation intervention, counseling</td>
</tr>
<tr>
<td>Whether or not the patient who is a smoker received a smoking cessation intervention</td>
<td>4001F</td>
<td>Tobacco use cessation intervention, pharmacologic therapy</td>
</tr>
<tr>
<td><strong>Numerator</strong>: All smokers who received a smoking cessation intervention during one or more office visits each year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients with the diagnosis of COPD identified as smokers</td>
<td>1034F</td>
<td>Current tobacco smoker</td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: NONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of smokers with COPD who received a smoking cessation intervention at least annually</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 1034F for each cigarette smoker. Report either 1034F, 1035F, or 1036 for each patient. If patient is a smoker and received cessation intervention, report 4000F or 4001F, or both. Report 4000F or 4001F only if 1034F has been reported. There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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<sup>5</sup>Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


<sup>7</sup>**Optum**, [www.optum.com](http://www.optum.com).


<sup>10</sup>**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality).

<sup>11</sup>**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org).

<sup>12</sup>**American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org).

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### Chronic Obstructive Pulmonary Disease (COPD)

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inhaled Bronchodilator</strong>&lt;sup&gt;1&lt;/sup&gt; Whether or not the symptomatic patient was prescribed an inhaled bronchodilator</td>
<td>1035F</td>
<td>Current smokeless tobacco user (e.g., chew, snuff)</td>
</tr>
<tr>
<td></td>
<td>1036F</td>
<td>Current tobacco non-user</td>
</tr>
<tr>
<td><strong>Numerator:</strong> All symptomatic patients who were prescribed an inhaled bronchodilator</td>
<td>4025F</td>
<td>Inhaled bronchodilator prescribed</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with the diagnosis of COPD who have an FEV&lt;sub&gt;1&lt;/sub&gt;/FVC &lt; 70 % and have symptoms</td>
<td>3025F</td>
<td>Spirometry test results demonstrate FEV&lt;sub&gt;1&lt;/sub&gt;/FVC&lt;70% with COPD</td>
</tr>
<tr>
<td><strong>Denominator Inclusions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of COPD symptoms;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of FEV&lt;sub&gt;1&lt;/sub&gt;/FVC &lt; 70%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

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### Chronic Obstructive Pulmonary Disease (COPD)

#### Brief Description of Performance Measure & Source and Reporting Instructions

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<tr>
<th>Denominator Exclusions:</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of medical, patient, or system reason(s) for not prescribing an inhaled bronchodilator</td>
<td>3027F</td>
<td>symptoms (eg, dyspnea, cough/sputum, wheezing)</td>
</tr>
<tr>
<td><strong>Percentage</strong> of symptomatic patients with COPD who were prescribed an inhaled bronchodilator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td></td>
<td>Spirometry test results demonstrate FEV₁/FVC ≥ 70% or patient does not have COPD symptoms</td>
</tr>
<tr>
<td>Report either 3025F or 3027F for all COPD patients. For patients with appropriate exclusion criteria, report 4025F with modifier 1P, 2P or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Assessment of Oxygen Saturation¹

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Denominator:</th>
<th>Denominator Inclusion:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients with oxygen saturation assessed and documented</td>
<td>All patients with the diagnosis of COPD and a FEV₁ &lt; 40% of predicted value</td>
<td>Documentation of FEV₁ &lt; 40% of predicted value.</td>
</tr>
</tbody>
</table>

#### Reporting Instructions:

Report either 3025F or 3027F for all COPD patients. For patients with appropriate exclusion criteria, report 4025F with modifier 1P, 2P or 3P.

| 3027F | |
| 3028F | Oxygen saturation results documented and reviewed (Includes assessment through pulse oximetry or arterial blood gas measurement) |

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¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

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⁵Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷Optum, [www.optum.com](http://www.optum.com)

⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com)


¹⁰American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org)

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)

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</thead>
<tbody>
<tr>
<td><strong>Denominator Exclusions:</strong> Documentation of medical reason(s) for not assessing oxygen saturation</td>
<td>Denominator Codes</td>
<td></td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not assessing oxygen saturation</td>
<td>3040F</td>
<td>Functional expiratory volume (FEV&lt;sub&gt;1&lt;/sub&gt;) &lt; 40% of predicted value</td>
</tr>
<tr>
<td>Documentation of systems reason(s) for not assessing oxygen saturation</td>
<td>3042F</td>
<td>Functional expiratory volume (FEV&lt;sub&gt;1&lt;/sub&gt;) ≥ 40% of predicted value</td>
</tr>
<tr>
<td><strong>Percentage of COPD patients with oxygen saturation assessed at least annually</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: Report 3040F or 3042F for all COPD patients. If oxygen saturation assessed, also report 3028F. For patients with appropriate exclusion criteria, report 3028F with modifier 1P, 2P, or 3P</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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</tr>
</thead>
</table>
| **Long Term Oxygen Therapy**<sup>1</sup>  
Whether or not patient with COPD was prescribed long term oxygen therapy  
**Numerator:** All patients who were prescribed long term oxygen therapy  
**Denominator:** All patients with a diagnosis of COPD and an oxygen saturation ≤ 88% or a PaO<sub>2</sub> ≤ 55 mm Hg  
**Denominator Inclusion:** PaO<sub>2</sub> ≤55 mm Hg or oxygen saturation ≤ 88%  
**Denominator Exclusion:** Documentation of medical reason(s) for not prescribing long term oxygen therapy.  
Documentation of patient reason(s) for not prescribing long term oxygen therapy  
Documentation of system reason(s) for not prescribing long term oxygen therapy  
**Percentage** of patients with COPD that were prescribed long term oxygen therapy | 4030F | Long term oxygen therapy prescribed (more than fifteen hours per day) |
| | 3035F | Oxygen saturation ≤ 88 % or a PaO<sub>2</sub> ≤ 55 mm Hg |

### Footnotes

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7. **Optum, [www.optum.com](http://www.optum.com).**

8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**


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### Chronic Obstructive Pulmonary Disease (COPD)

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</thead>
<tbody>
<tr>
<td>3037F</td>
<td>Oxygen saturation &gt;88% or PaO₂ &gt;55 mmHg</td>
</tr>
</tbody>
</table>

**Reporting Instructions:** Report 3035F or 3037F for all COPD patients. Report 4030F with 3035F if long term oxygen therapy prescribed. For patients with appropriate exclusion criteria, report 4030F with modifier 1P, 2P or 3P.

**Recommendation of Influenza Immunization**

Whether or not the patient aged 18 years and older with a diagnosis of COPD was recommended to receive an influenza immunization annually

**Numerator:** Patients who were recommended to receive an influenza immunization annually

**Denominator:** All patients aged 18 years and older with a diagnosis of COPD

**Exclusion(s):** Documentation of medical (eg, documentation of immunization previously given during the current flu season*) or system reason(s) for not recommending an influenza immunization.

**Reporting Instructions:** Report 4035F for patients aged 18 years and older with a diagnosis of COPD who received influenza immunization. Report 4030F with 4035F if long term oxygen therapy prescribed.

*Footnotes*

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</tr>
</thead>
<tbody>
<tr>
<td><em>Current flu season is defined as September-February Percentage of patients aged 18 years and older with a diagnosis of COPD who were recommended to receive an influenza immunization annually Reporting Instructions: Report either 4035F for patients who have been recommended an influenza immunization or 4037F for patients for whom an influenza immunization was ordered or administered. For patients with appropriate exclusion criteria, report 4035F with modifier 1P or 3P. Influenza Immunization Administered¹ Whether or not the patient aged 18 years and older with a diagnosis of COPD received an influenza immunization during the current flu season Numerator: Patients who are administered an influenza immunization during the visit or who have already received an influenza immunization during the current flu season</em></td>
<td>4037F</td>
<td>Influenza immunization ordered or administered</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with a diagnosis of COPD seen during the flu season</td>
<td>4037F</td>
<td>Influenza immunization ordered or administered</td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical, patient, or system reason(s) for not administering the influenza immunization</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of COPD who received an influenza immunization during the current flu season</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: Report 4037F for patients for whom an influenza immunization was ordered or administered. For patient with appropriate exclusion criteria, report 4037F with modifier 1P, 2P or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Assessment of Pneumococcus Immunization Status**<sup>1</sup>  
Whether or not the patient aged 18 year and older with a diagnosis of COPD was assessed for pneumococcus immunization status  
**Numerator:** Patients who were assessed for pneumococcus immunization status  
**Denominator:** All patients aged 18 years and older with the diagnosis of COPD  
**Exclusion(s):** Documentation of medical (eg, documentation that pneumococcus immunization was not indicated), patient, or system reason(s) for not assessing pneumococcus immunization status  
**Percentage** of patients aged 18 years and older with a diagnosis of COPD who were assessed for pneumococcus immunization status  
**Reporting Instructions:** For patients with appropriate exclusion criteria, report 1022F with modifier 1P, 2P, or 3P. | 1022F | Pneumococcus immunization status assessed |

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<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>4040F</td>
<td>Pneumococcal vaccine administered or previously received (COPD)</td>
</tr>
</tbody>
</table>

**Pneumococcus Immunization Administered**

Whether or not the patient aged 18 years and older with a diagnosis of COPD received a pneumococcus immunization

**Numerator:** Patients who are administered a pneumococcus immunization during a visit or who have already received a pneumococcus immunization status

**Denominator:** All patients aged 18 years and older with the diagnosis of COPD

**Exclusions Criteria:** Documented medical, patient, or system (eg, pneumococcus immunization recommended, but not administered) reason(s) for not administering the pneumococcus immunization

**Percentage** of patients aged 18 years and older with a diagnosis of COPD who received a pneumococcus immunization

**Reporting Instructions:** Report 4040F for patients for whom a pneumococcal immunization was ordered or administered.

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<tbody>
<tr>
<td>For patients with appropriate exclusion criteria, report 4040F with modifier 1P, 2P, or 3P.</td>
<td></td>
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<tbody>
<tr>
<td><strong>Pulmonary Rehabilitation: Exercise Training Recommended</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>4033F, 1018F, 1019F</td>
<td>Pulmonary rehabilitation exercise training recommended</td>
</tr>
<tr>
<td><strong>Numerator</strong>: Whether or not patient exercise training was recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients with the diagnosis of COPD and dyspnea</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator Inclusion</strong>: Documentation of dyspnea (1019F)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator Exclusion</strong>: Documentation of medical or system reason(s) for not recommending exercise training</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients for whom exercise training was recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: Report 1018F or 1019F for all COPD patients. For patients with appropriate exclusion criteria, report 4033F with modifier 1P or 3P; Report 4033F with 1019F.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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Last Updated June 23, 2023
## Chronic Stable Coronary Artery Disease (CAD)

### Brief Description of Performance Measure & Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Blood Pressure Control¹</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not patient aged 18 years and older with a diagnosis of CAD has a blood pressure &lt; 140/90 OR has a blood pressure ≥ 140/90 and is prescribed 2 or more anti-hypertensive agents during the most recent office visit <strong>For complete measure language with definitions, please reference the measure worksheets at <a href="http://www.physicianconsortium.org">www.physicianconsortium.org</a></strong></td>
<td>3074F</td>
<td>Most recent systolic blood pressure &lt; 130 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3075F</td>
<td>Most recent systolic blood pressure 130 - 139 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3077F</td>
<td>Most recent systolic blood pressure ≥ 140 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3078F</td>
<td>Most recent diastolic blood pressure &lt; 80 mm Hg</td>
</tr>
</tbody>
</table>

### Numerator:

- Patients with a blood pressure < 140/90 mm Hg
- OR
- Patients with a blood pressure ≥140/90 mm Hg and prescribed 2 or more anti-hypertensive medications during the most recent office visit

### Denominator:

- Most recent systolic blood pressure < 130 mm Hg
- Most recent systolic blood pressure 130 - 139 mm Hg
- Most recent systolic blood pressure ≥ 140 mm Hg
- Most recent diastolic blood pressure < 80 mm Hg

---

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</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 18 years and older with a diagnosis of coronary artery disease</td>
<td>3079F</td>
<td>Most recent diastolic blood pressure 80 – 89 mm Hg</td>
</tr>
<tr>
<td>Exclusion(s):</td>
<td>3080F</td>
<td>Most recent diastolic blood pressure ≥ 90 mm Hg</td>
</tr>
<tr>
<td>Documentation of medical (eg, allergy, intolerant, postural hypotension, other medical reasons), patient (eg, patient declined, other patient reasons), or system (eg, financial reasons, other reasons attributable to the health care delivery system) reason(s) for not prescribing 2 or more anti-hypertensive agents</td>
<td>4145F</td>
<td>Two or more anti-hypertensive agents prescribed or currently being taken</td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the systolic blood pressure value, report one of the three systolic codes; for the diastolic blood pressure value, report one of the three diastolic codes. If 3077F or 3080F are reported AND patient is prescribed or currently taking two or more anti-hypertensive agents, report 4145F. For patient with appropriate exclusion criteria report 4145F, with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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6Optum, www.optum.com

7American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


9American Gastroenterological Association (AGA), www.gastro.org/quality

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</thead>
<tbody>
<tr>
<td>Lipid Control¹</td>
<td>3048F</td>
<td>Most recent LDL-C &lt; 100 mg/dL</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of CAD has an LDL-C result less than 100 mg/dL OR has an LDL-C result greater than or equal to 100 mg/dL and a plan of care is documented to achieve LDL-C less than 100 mg/dL, which includes prescription of a statin, at a minimum</td>
<td>3049F</td>
<td>Most recent LDL-C 100 - 129 mg/dL</td>
</tr>
<tr>
<td><strong>For complete measure language with definitions, please reference the measure worksheets at <a href="http://www.physicianconsortium.org">www.physicianconsortium.org</a></strong></td>
<td>3050F</td>
<td>Most recent LDL-C greater than or equal to 130 mg/dL</td>
</tr>
<tr>
<td>OR</td>
<td>4013F</td>
<td>Statin therapy prescribed or currently being taken</td>
</tr>
<tr>
<td>Patients who have a LDL-C result &lt; 100 mg/dL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who have a LDL-C result ≥100 mg/dL and have a documented plan of care to achieve LDL-C &lt;100 mg/dL, including at a minimum the prescription of a statin</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

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⁶**The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)**

⁷**Optum, [www.optum.com](http://www.optum.com)**

⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com](https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com)


¹⁰**American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)**

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### Chronic Stable Coronary Artery Disease (CAD)

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<tr>
<th>Denominator:</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 18 years and older with a diagnosis of coronary artery disease</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Exclusion(s):  
Documentation of medical (eg, allergy, intolerance to statin medication(s), other medical reasons), patient, (eg, patient declined, other patient reasons), or system (eg, financial reasons, other reasons attributable to the health care delivery system) reason(s) for not prescribing a statin  

### Reporting Instructions:  
Report 3048F OR 3049F OR 3050F to record patient LDL-C result value. If LDL-C result is greater than or equal to 100mg/dL (3049F or 3050F), report 4013F if statin therapy was prescribed or currently taken. In addition to 3049F or 3050F AND 4013F, if a plan of care is documented to achieve lipid control, also report 0556F.

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### Chronic Stable Coronary Artery Disease (CAD)

#### Brief Description of Performance Measure & Source and Reporting Instructions

For patient with appropriate exclusion criteria report 4013F, with modifier 1P, 2P, or 3P.

**Symptom and Activity Assessment**

Whether or not patient aged 18 years and older with a diagnosis of CAD have results of an evaluation of level of activity and results of evaluation of anginal symptoms documented in the medical record

**For complete measure language with definitions, please reference the measure worksheets at [www.physicianconsortium.org](http://www.physicianconsortium.org)**

**Numerator:**

Patients for whom there is documented results of an evaluation of level of activity

AND

an evaluation of presence or absence of anginal symptoms in the medical record

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1010F</td>
<td>Severity of angina assessed by level of activity</td>
</tr>
<tr>
<td>1011F</td>
<td>Angina present</td>
</tr>
<tr>
<td>1012F</td>
<td>Angina absent</td>
</tr>
</tbody>
</table>

#### Footnotes

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Last Updated June 23, 2023.
### Chronic Stable Coronary Artery Disease (CAD)

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<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients aged 18 years and older with a diagnosis of coronary artery disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This measure is paired with Measure #4 – Symptom Management. Implementers of this measure should not use this measure without the Symptom Management measure. Report 1010F if level of activity was evaluated. In addition, report 1011F or 1012F to indicate presence or absence of anginal symptoms upon assessment.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes:

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</tr>
</thead>
</table>
| **Symptom Management**<sup>1</sup>  
Whether or not the patient aged 18 years and older with a diagnosis of CAD with anginal symptoms is receiving appropriate management of anginal symptoms  
**For complete measure language with definitions, please reference the measure worksheets at [www.physicianconsortium.org]**  
**Numerator:**  
Patients with appropriate management of anginal symptoms  
**For definition of “appropriate management”, please reference the measure worksheets at [www.physicianconsortium.org]**  
**Denominator:**  
Plan of care to manage anginal symptoms documented | 0557F | |

---

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<tbody>
<tr>
<td>All patients aged 18 years and older with a diagnosis of coronary artery disease with results of an evaluation of both level of activity AND presence or absence of anginal symptoms</td>
<td>1010F</td>
<td>Severity of angina assessed by level of activity</td>
</tr>
<tr>
<td></td>
<td>1011F</td>
<td>Angina present</td>
</tr>
<tr>
<td></td>
<td>1012F</td>
<td>Angina absent</td>
</tr>
</tbody>
</table>

**Exclusion(s):**
Documentation of medical (eg, allergy, intolerance, other medical reason(s)), patient (eg, patient declined, other patient reason(s)), or system (eg, financial reasons, other reason(s) attributable to the health care system) reason(s) for not providing any specified element of plan of care to achieve control of anginal symptoms

**Reporting Instructions:**
This measure is paired with Measure #3 – Symptom and Activity Assessment. Implementers of this measure should not use this measure without the Symptom and Activity Assessment measure. Report 1010F and 1011F OR 1012F, if the patient's level of activity was evaluated and was assessed for presence or absence of anginal symptoms. If anginal

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<tbody>
<tr>
<td>Symptoms are present (1011F), report 0557F if plan of care to manage anginal symptoms is documented. For patient with appropriate exclusion criteria report 0557F, with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Tobacco Use : Screening and Cessation Intervention

Whether or not the patient aged 18 years and older with a diagnosis of CAD was screened for tobacco use AND received tobacco cessation counseling intervention if identified as a tobacco user

**For complete measure language with definitions, please reference the measure worksheets at [www.physicianconsortium.org]**

**Numerator:**

Patients who were screened for tobacco use

---

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<tbody>
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<td>who received tobacco cessation counseling intervention if identified as a tobacco user</td>
<td>4004F</td>
<td>Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user</td>
</tr>
<tr>
<td>Denominator: All patients aged 18 years and older with a diagnosis of coronary artery disease</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s): None</td>
<td>1036F</td>
<td>Current tobacco non-user</td>
</tr>
<tr>
<td>Reporting Instructions: Report 4004F for each patient that is identified as a tobacco user AND received tobacco cessation counseling. If patient is identified as a current tobacco non-user, report 1036F. There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


## Chronic Stable Coronary Artery Disease (CAD)

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<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
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</tr>
</thead>
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### Footnotes

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Last Updated June 23, 2023
## Chronic Stable Coronary Artery Disease (CAD)

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antiplatelet Therapy</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of CAD was prescribed aspirin or clopidogrel <strong>For complete measure language with definitions, please reference the measure worksheets at <a href="http://www.physicianconsortium.org">www.physicianconsortium.org</a></strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who were prescribed aspirin or clopidogrel</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients aged 18 years and older with a diagnosis of coronary artery disease</td>
<td>4086F</td>
<td>Aspirin or clopidogrel prescribed or currently being taken</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical (eg, allergy, intolerance, receiving other thienopyridine therapy, receiving warfarin therapy, bleeding coagulation disorders, other medical reason(s)), patient (eg, patient declined, other patient reason(s)), or</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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**Chronic Stable Coronary Artery Disease (CAD)**

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>system (eg, lack of drug availability, other reason(s) attributable to the health care system) reason(s) for not prescribing aspirin or clopidogrel</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 4086F for all patients meeting denominator criteria.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the patient with appropriate exclusion criteria, report 4086F, with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF &lt; 40%)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

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# Chronic Stable Coronary Artery Disease (CAD)

## Brief Description of Performance Measure & Source and Reporting Instructions

Whether or not the patient aged 18 years and older with a diagnosis of CAD who also has a prior MI or a current or prior LVEF < 40% was prescribed beta-blocker therapy

**For complete measure language with definitions, please reference the measure worksheets at www.physicianconsortium.org**

### Numerator:

Patients who were prescribed beta-blocker therapy

### Denominator:

All patients aged 18 years and older with a diagnosis of coronary artery disease who also have prior MI or a current or prior LVEF < 40%

### Exclusion(s):

Documentation of medical (eg, allergy, intolerance, other medical reason(s)), patient (eg, patient declined, other patient reason(s)), or system (eg, reason(s) attributable to the health

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4008F</td>
<td>Beta-Blocker therapy prescribed or currently being taken</td>
</tr>
</tbody>
</table>

## Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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## Chronic Stable Coronary Artery Disease (CAD)

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<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>care system) reason(s) for not prescribing beta-blocker therapy</td>
<td>Denominator Codes</td>
<td>Left ventricular ejection fraction (LVEF) &lt; 40% or documentation of moderately or severely depressed left ventricular systolic function</td>
</tr>
<tr>
<td>Reporting Instructions: If patient has CAD and prior MI (both diagnosis) identified through ICD-9 CM coding (see measure specifications for applicable ICD-9-CM codes) and was prescribed or currently taking beta-blocker therapy, report 4008F. Report 3021F or 3022F for each patient with a diagnosis of CAD (without prior MI). If the patient has ever had a left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F) AND was prescribed or currently taking beta-blocker therapy, report 4008F in addition. In the event that patient has CAD with a prior MI and LVEF &lt; 40% and was prescribed or currently taking beta-blocker therapy, report 3021F AND 4008F.</td>
<td>3021F</td>
<td>Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function</td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®)**, [www.ncqa.org](http://www.ncqa.org)

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## Chronic Stable Coronary Artery Disease (CAD)

### Brief Description of Performance Measure & Source and Reporting Instructions

For patient with appropriate exclusion criteria report 4008F with modifier 1P, 2P, or 3P.

**ACE Inhibitor or ARB Therapy—Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)**

Whether or not the patient aged 18 years and older with a diagnosis of CAD who also has diabetes or a current or prior LVEF < 40% was prescribed ACE inhibitor or ARB therapy

**For complete measure language with definitions, please reference the measure worksheets at www.physicianconsortium.org**

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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8. **American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com)


<table>
<thead>
<tr>
<th>Chronic Stable Coronary Artery Disease (CAD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
</tr>
<tr>
<td>Patients who were prescribed ACE inhibitor or ARB therapy</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
</tr>
<tr>
<td>All patients aged 18 years and older with a diagnosis of coronary artery disease who also have diabetes or a current or prior LVEF &lt; 40%</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
</tr>
<tr>
<td>Documentation of medical (eg, allergy, intolerance, other medical reason(s)), patient (eg, patient declined, other patient reason(s)), and system (eg, lack of drug availability, other reason(s) attributable to the health care system) reason(s) for not prescribing ACE inhibitor or ARB therapy</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
</tr>
<tr>
<td>1) If patient has CAD and diabetes (both diagnoses identified through ICD-9 CM coding; see measure specifications for applicable ICD-9-CM codes.) and was prescribed or</td>
</tr>
</tbody>
</table>

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### Chronic Stable Coronary Artery Disease (CAD)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>currently taking ACE inhibitor or ARB therapy report 4010F.</td>
<td>Denominator Codes</td>
<td>Left ventricular ejection fraction (LVEF) &lt; 40% or documentation of moderately or severely depressed left ventricular systolic function</td>
</tr>
<tr>
<td>2) Report 3021F OR 3022F for each patient with a diagnosis of CAD (without diabetes) to indicate left ventricular ejection fraction value. If the patient has ever had a left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F), also report 4010F if ACE or ARB therapy was prescribed or currently being taken.</td>
<td>3021F</td>
<td>Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function</td>
</tr>
<tr>
<td>3) If the patient has CAD, diabetes AND LVEF &lt; 40%, report 3021F and if ACE or ARB therapy prescribed or currently being taken, report 3021F and 4010F.</td>
<td>3022F</td>
<td>For patient with appropriate exclusion criteria, report 4010F with modifier 1P, 2P, or 3P.</td>
</tr>
</tbody>
</table>

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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)


10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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### Chronic Stable Coronary Artery Disease (CAD)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiac Rehabilitation Patient Referral From an Outpatient Setting</strong>¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not patient aged 18 years and older with a qualifying event/diagnosis was referred to an outpatient cardiac rehabilitation program [or already participated in an outpatient cardiac rehabilitation program]</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**For complete measure language with definitions, please reference the measure worksheets at <a href="http://www.physicianconsortium.org**%C2%B2">www.physicianconsortium.org**²</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients in an outpatient clinical practice who have had a qualifying event during the previous 12 months who have</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

¹**Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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³**The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴**National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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⁶**The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷**Optum**, [www.optum.com](http://www.optum.com)


¹⁰**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

¹²**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org).
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td>4500F</td>
<td>Referred to an outpatient cardiac rehabilitation program</td>
</tr>
<tr>
<td></td>
<td>4510F</td>
<td>Previous cardiac rehabilitation for qualifying cardiac event completed</td>
</tr>
<tr>
<td></td>
<td>1460F</td>
<td>Qualifying cardiac event/diagnosis in previous 12 months</td>
</tr>
</tbody>
</table>

**Denominator:**

Number of patients in an outpatient clinical practice who have had a qualifying event/diagnosis during the previous 12 months

**Exclusion(s):**

Documentation of medical (e.g., patient deemed by provider to have a medically unstable, life-threatening condition, other medical reason(s)), patient (e.g., patient resides in a long-term nursing care facility, other patient reason(s)), system (e.g., no cardiac rehabilitation program available within 60 minutes of travel time from the patient's home, other system reason(s))

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Footnotes

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Chronic Stable Coronary Artery Disease (CAD)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>reason(s) for not referring a patient to an outpatient CR program</td>
<td>1461F</td>
<td>No qualifying cardiac event/diagnosis in previous 12 months</td>
</tr>
</tbody>
</table>

**Reporting Instructions:**

Report 1460F OR 1461F to indicate presence or absence of qualifying cardiac event/diagnosis. For patients with 1460F reported, also report 4500F if referred to an outpatient cardiac rehabilitation program or 4510F if patient has already completed a cardiac rehabilitation program for the qualifying cardiac event.

For the patient with appropriate exclusion criteria, report 4500F, with modifier 1P, 2P or 3P.

---

Footnotes

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6. The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7. Optum, [www.optum.com](http://www.optum.com)


# Chronic Wound Care (CWC)

<table>
<thead>
<tr>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Wound Surface Culture Technique in Patients with Chronic Skin Ulcers (Overuse Measure)(^5) Patient visits for the patient aged 18 years and older with a diagnosis of chronic skin ulcer <strong>without</strong> the use of a wound surface culture technique*</td>
<td>4260F</td>
<td>Wound surface culture technique used</td>
</tr>
<tr>
<td></td>
<td>4261F</td>
<td>Technique other than surface culture of the wound exudate used (eg, Levine/deep swab technique, semi-quantitative or quantitative swab technique) OR wound surface culture technique not used</td>
</tr>
</tbody>
</table>

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

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**Footnotes**

\(^1\)Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

\(^2\)National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org).

\(^3\)The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org).

\(^4\)National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

\(^5\)Joint measure from [The Physician Consortium for Performance Improvement (PCPI)](http://www.pcpi.org) and [National Committee on Quality Assurance (NCQA)](http://www.ncqa.org) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


\(^7\)Optum, [www.optum.com](http://www.optum.com).


\(^10\)American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).


\(^12\)American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
## Chronic Wound Care (CWC)

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion(s): Documentation of medical reason for using a wound surface culture technique [eg, surface culture for methicillin-resistant staphylococcus aureus (MRSA) screening] <strong>Percentage</strong> of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer <strong>without</strong> the use of a wound surface culture technique*</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4260F or 4261F for each patient aged 18 years and older with a diagnosis of chronic skin ulcer. For patient with appropriate exclusion criteria, report 4260F-1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers (Overuse Measure)

Patient visits for the patient aged 18 years and older with a diagnosis of chronic skin ulcer without a prescription or recommendation to use wet to dry dressings

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

<table>
<thead>
<tr>
<th>Code Suffix</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4265F</td>
<td>Use of wet to dry dressings prescribed or recommended</td>
</tr>
<tr>
<td>4266F</td>
<td>Use of wet to dry dressings prescribed or recommended</td>
</tr>
</tbody>
</table>

---

**Footnotes**

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2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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</tr>
</thead>
</table>
| **Denominator:** All patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer  
**Exclusion(s):** Documentation of medical reason(s) for prescribing/recommending the use of wet to dry dressings (eg, presence of necrotic tissue requiring debridement, highly exudative wound that is unlikely to dry out between dressing changes)  
**Percentage** of patient visits for those patients aged 18 years and older with a diagnosis of chronic skin ulcer without a prescription or recommendation to use wet to dry dressings  
**Reporting Instructions:** Report 4165F or 4266F for each patient aged 18 years and older with a diagnosis of chronic skin ulcer. For patient visits with appropriate exclusion criteria report 4165F with modifier 1P. There are no performance exclusions for code 4266F. Do not report modifiers 1P, 2P, or 3P with this code. |                          | Use of wet to dry dressings neither prescribed nor recommended                                       |
| **Assessment of Wound Characteristics in Patients Undergoing Debridement**                                                                                                                               | 2050F                  | Wound characteristics including size AND nature of wound base tissue                                  |

**Footnotes**

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6. **The Society of Thoracic Surgeons at** [www.sts.org](http://www.sts.org) and **National Quality Forum,** [www.qualityforum.org](http://www.qualityforum.org)
10. **American Gastroenterological Association (AGA),** [www.gastro.org](http://www.gastro.org)
11. **American Society of Anesthesiologists (ASA),** [www.asahq.org](http://www.asahq.org)
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</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of chronic skin ulcer undergoing debridement had documentation of wound characteristics (including at a minimum: size AND nature of wound base tissue, AND amount of drainage) prior to debridement</td>
<td></td>
<td>AND amount of drainage prior to debridement</td>
</tr>
<tr>
<td><strong>Numerator:</strong> All patients aged 18 years and older with a diagnosis of chronic skin ulcer undergoing debridement</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> NONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of chronic skin ulcer undergoing debridement with documentation of wound characteristics (including at a minimum: size AND nature of wound base tissue AND amount of drainage) prior to debridement</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of Compression System in Patients with Venous Ulcers(^5)</strong>&lt;br&gt;Whether or not the patient aged 18 years and older with a diagnosis of venous ulcer was prescribed compression therapy within the 12 month reporting period</td>
<td>4267F</td>
<td>Compression therapy prescribed</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were prescribed compression therapy within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of venous ulcer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not prescribing compression therapy (eg, severe arterial occlusive disease)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of patient or system reason(s) for not prescribing compression therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

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7. **Optum, [www.optum.com](http://www.optum.com)**.


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</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of venous ulcer who were prescribed compression therapy within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria report 4267F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| **Patient Education Regarding Long Term Compression Therapy**<sup>5</sup> | | |
| Whether or not the patient aged 18 years and older with a diagnosis of venous ulcer received education regarding the need for long term compression therapy including interval replacement of compression stockings within the 12 month reporting period | 4268F | Patient education regarding the need for long term compression therapy including interval replacement of compression stockings, received |

| **Numerator:** Patients who received education regarding the need for long term compression therapy including interval replacement of compression stockings within the 12 month reporting period | | |
| **Denominator:** All patients aged 18 years and older with a diagnosis of venous ulcer | | |

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Footnotes

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> NONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of venous ulcer who received education regarding the need for long term compression therapy including interval replacement of compression stockings within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Offloading (Pressure Relief) of Diabetic Foot Ulcers</strong></th>
<th>4269F</th>
<th>Appropriate method of offloading (pressure relief) prescribed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of diabetes and foot ulcer was prescribed an appropriate method of offloading (pressure relief) within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were prescribed an appropriate* method of offloading (pressure relief) within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*An appropriate method of offloading includes any of the following: crutches, walkers, wheelchairs, custom shoes, depth</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Chronic Wound Care (CWC)**

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<tr>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>shoes, shoe modifications, custom inserts, custom relief orthotic walkers (CROW), diabetic boots, forefoot and heel relief shoes, or total contact casts</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with a diagnosis of diabetes and foot ulcer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for not prescribing an appropriate method of offloading (pressure relief) (eg, non-plantar location)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not prescribing an appropriate method of offloading (pressure relief)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of system reason(s) for not prescribing an appropriate method of offloading (pressure relief)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of diabetes and foot ulcer who were prescribed an appropriate method of offloading (pressure relief) within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Education Regarding Diabetic Foot Care</strong></td>
<td>4305F</td>
<td>Patient education regarding appropriate foot care AND daily inspection of the feet, received</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of diabetes and foot ulcer received education regarding appropriate foot care AND daily inspection of the feet within the 12 month reporting period</td>
<td>4305F</td>
<td>Patient education regarding appropriate foot care AND daily inspection of the feet, received</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who received education regarding appropriate foot care AND daily inspection of the feet within the 12 month reporting period</td>
<td>4305F</td>
<td>Patient education regarding appropriate foot care AND daily inspection of the feet, received</td>
</tr>
<tr>
<td>*Definition - Appropriate foot care may include self-inspection and surveillance, monitoring foot temperatures, appropriate daily foot hygiene, use of proper footwear, good diabetes control, and prompt recognition and professional treatment of newly discovered lesions.</td>
<td>4305F</td>
<td>Patient education regarding appropriate foot care AND daily inspection of the feet, received</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of diabetes and foot ulcer</td>
<td>4305F</td>
<td>Patient education regarding appropriate foot care AND daily inspection of the feet, received</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> NONE</td>
<td>4305F</td>
<td>Patient education regarding appropriate foot care AND daily inspection of the feet, received</td>
</tr>
</tbody>
</table>

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients aged 18 years and older with a diagnosis of diabetes and foot ulcer who received education regarding appropriate foot care AND daily inspection of the feet within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: There are no performance exclusions for this measure; modifiers 1P or 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Community-Acquired Bacterial Pneumonia (CAP)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest Radiograph¹</td>
<td>3006F</td>
<td></td>
</tr>
<tr>
<td>Whether or not patient had a chest X-ray performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator: All patients with a chest x-ray performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: All patients with the diagnosis of community-acquired bacterial pneumonia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷Optum, [www.optum.com](http://www.optum.com)

⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)

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<tr>
<th><strong>Community-Acquired Bacterial Pneumonia (CAP)</strong></th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s): NONE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical, patient, or system reason(s) for not performing a chest x-ray (eg, chest x-ray equipment not accessible).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of community-acquired bacterial pneumonia patients ≥18 years of age with a chest x-ray performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria, report 3006F with modifier 1P, 2P, or 3P.</td>
<td>0012F</td>
<td>Community-acquired bacterial pneumonia assessment</td>
</tr>
<tr>
<td><strong>Composite Measure: Community-Acquired Bacterial Pneumonia Assessment</strong> - See individual measures listed below for (includes all of the following components): Co-morbid conditions assessed (1026F) Vital signs recorded (2010F) Mental status assessed (2014F) Hydration status assessed (2018F)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessment of Co-morbid Conditions¹</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org

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⁷Optum, www.optum.com

⁸American Academy of Neurology. https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


Community-Acquired Bacterial Pneumonia (CAP)

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not patient was assessed for co-morbid conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> All patients assessed for history of co-morbid conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with the diagnosis of Community-Acquired Bacterial Pneumonia</td>
<td>1026F</td>
<td>Co-morbid conditions assessed (eg, includes assessment for presence or absence of: malignancy, liver disease, congestive heart failure, cerebrovascular disease, renal disease, chronic obstructive pulmonary disease, asthma, diabetes, other co-morbid conditions)</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> NONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients ≥18 years of age with Community-Acquired Bacterial Pneumonia who were assessed for co-morbid conditions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
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</table>
| **Vital Signs**<sup>1</sup>  
Whether or not patient had vital signs recorded  
Numerator: All patients with vital signs recorded  
Denominator: All patients with the diagnosis of Community-Acquired Bacterial Pneumonia  
Exclusion(s): NONE  
Percentage of Community-Acquired Bacterial Pneumonia patients ≥18 years of age with vital signs recorded | 2010F | Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed |

| Assessment of Oxygen Saturation<sup>1</sup>  
Whether or not patient had oxygen saturation assessed  
Numerator: All patients with oxygen saturation assessed  
Denominator: All patients with the diagnosis of community-acquired bacterial pneumonia  
Exclusion(s): Documentation of medical, patient, system reason(s) for not assessing oxygen saturation (eg, oxygen saturation equipment not available). | 3028F | Oxygen saturation results documented and reviewed (Includes assessment through pulse oximetry or arterial blood gas measurement) |

Footnotes

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</thead>
</table>
| **Percentage** of patients ≥18 years of age with community-acquired bacterial pneumonia with oxygen saturation assessed  
**Reporting Instructions:** For patients with appropriate exclusion criteria, report 3028F with modifier 1P, 2P or 3P. | 2014F | Mental status assessed |

### Assessment of Mental Status

**Percentage** of Community-Acquired Bacterial Pneumonia patients age ≥18 years of age with mental status assessed  
**Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

---

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</table>
| **Assessment of Hydration Status**<sup>1</sup> Whether or not had hydration status assessed  
**Numerator:** All patients with hydration status assessed  
**Denominator:** All patients with the diagnosis of community-acquired bacterial pneumonia  
**Exclusion(s):** NONE  
**Percentage** of community-acquired bacterial pneumonia patients age ≥18 years of age with hydration status assessed  
**Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used. | 2018F | Hydration status assessed (normal/mildly dehydrated/severely dehydrated) |
| **Level of Care Rationale**<sup>1</sup> Whether or not an assessment was made to determine the level of care  
**Numerator:** All patients with documented rationale for level of care  
**Denominator:** All patients with the diagnosis of community-acquired bacterial pneumonia | 6005F | |

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</tr>
</thead>
</table>
| Exclusion(s): NONE  
Percentage of community-acquired bacterial pneumonia patients ≥ 18 years of age who had a documented rationale for level of care based on severity of illness and safety of home care  
**Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used. | | Rationale (eg, severity of illness and safety) for level of care (eg, home, hospital) documented |

<table>
<thead>
<tr>
<th>Empiric Antibiotic¹</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not patient was prescribed an appropriate empiric antibiotic</td>
<td>4045F</td>
<td>Appropriate empiric antibiotic prescribed (See measure developer’s Web site for definition of appropriate antibiotic)</td>
</tr>
</tbody>
</table>

**Exclusion(s):** Documentation of medical, patient, or system reasons(s) for not prescribing an antibiotic.

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of community-acquired bacterial pneumonia patients ≥ 18 years of age who were prescribed an appropriate empiric antibiotic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: For patients with appropriate exclusion criteria, report 4045F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking Assessment&lt;sup&gt;1&lt;/sup&gt; Whether or not patient was queried about smoking</td>
<td>1000F</td>
<td>Tobacco use assessed</td>
</tr>
<tr>
<td>Numerator: All patients who were queried about smoking</td>
<td>1034F</td>
<td>Current tobacco smoker</td>
</tr>
<tr>
<td>Denominator: All patients with the diagnosis of community-acquired bacterial pneumonia</td>
<td>1035F</td>
<td>Current smokeless tobacco user (eg, chew, snuff)</td>
</tr>
<tr>
<td>Exclusion(s): NONE</td>
<td>1036F</td>
<td>Current tobacco non-user</td>
</tr>
<tr>
<td>Percentage of patients with community-acquired bacterial pneumonia who were queried about smoking</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: When reporting 1000F, it is required to report 1034F, and/or 1035F, or 1036F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
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## Community-Acquired Bacterial Pneumonia (CAP)

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<tr>
<th>Code Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tobacco use cessation intervention, counseling</td>
</tr>
<tr>
<td></td>
<td>Tobacco use cessation intervention, pharmacologic therapy</td>
</tr>
</tbody>
</table>

### Smoking Cessation Intervention

Whether or not patient received a smoking cessation intervention

**Numerator:** All patients who received a smoking cessation intervention

**Denominator:** All patients with the diagnosis of Community-Acquired Bacterial Pneumonia identified as smokers

**Exclusion(s):** NONE

**Percentage of patients ≥ 18 years of age with community-acquired bacterial pneumonia who received a smoking cessation intervention**

**Reporting Instructions:**

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7. **Optum**, www.optum.com


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</thead>
<tbody>
<tr>
<td>Report 1034F for each cigarette smoker. Report either 1034F, 1035F, or 1036F for each patient. If patient is a smoker and received cessation intervention, report 4000F or 4001F, or both. Report 4000F or 4001F only if 1034F has been reported. There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td>Denominator Codes</td>
<td>Current tobacco smoker</td>
</tr>
<tr>
<td></td>
<td>1034F</td>
<td>Current smokeless tobacco user (eg, chew, snuff)</td>
</tr>
<tr>
<td></td>
<td>1035F</td>
<td>Current tobacco non-user</td>
</tr>
<tr>
<td></td>
<td>1036F</td>
<td></td>
</tr>
</tbody>
</table>

### Assessment of Influenza Immunization Status¹²

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1030F</td>
<td>Influenza immunization status assessed</td>
</tr>
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<tbody>
<tr>
<td>Whether or not patient aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia was assessed for influenza immunization status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were assessed for influenza immunization status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 year and older with the diagnosis of community-acquired bacterial pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not assessing influenza immunization status (eg, documentation that immunization was not indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients age 18 years and older with a diagnosis of community-acquired bacterial pneumonia who were assessed for influenza immunization status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria, report 1030F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assessment of Pneumococcus Immunization Status¹</td>
<td></td>
<td></td>
</tr>
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<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not patient aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia was assessed for pneumococcus immunization status</td>
<td>1022F</td>
<td>Pneumococcus immunization status assessed</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were assessed for pneumococcus immunization status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not assessing pneumococcus immunization status (eg, documentation that immunization was not indicated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia who were assessed for pneumococcus immunization status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria, report 1022F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)**

3. [The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


7. **Optum, [www.optum.com](http://www.optum.com)**

8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com**


10. **American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)**

11. **American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)**

12. **American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org)**
### Coronary Artery Bypass Graft (CABG)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Use of Internal Mammary Artery (IMA) Graft in Primary, Isolated Coronary Artery Bypass Graft (CABG) Surgery</strong>⁶</td>
<td>4110F</td>
<td>Internal mammary artery graft performed for primary, isolated coronary artery bypass graft procedure</td>
</tr>
<tr>
<td>Whether or not a patient received an IMA graft in the performance of a primary, isolated CABG procedure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> All patients who received an IMA graft in isolated CABG procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients who received a primary isolated CABG procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Medical reasons for not receiving an IMA graft in the performance of a primary, isolated CABG procedure</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patients with documented medical reasons for not receiving an IMA graft in the performance of a primary, isolated CABG procedure, report modifier 1P with code 4110F.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Footnotes**

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³**The Joint Commission,** [https://www.jointcommission.org](https://www.jointcommission.org)

⁴**National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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⁶**The Society of Thoracic Surgeons at** [www.sts.org](http://www.sts.org) and **National Quality Forum,** [www.qualityforum.org](http://www.qualityforum.org)

⁷**Optum,** [www.optum.com](http://www.optum.com)


¹⁰**American Gastroenterological Association (AGA),** [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹**American Society of Anesthesiologists (ASA),** [www.asahq.org](http://www.asahq.org)

¹²**American College of Gastroenterology (AGC),** [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA),** [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE),** [www.asge.org](http://www.asge.org)

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## Coronary Artery Bypass Graft (CABG)

### Brief Description of Performance Measure & Source

**Use of Beta Blocker in Isolated Coronary Artery Bypass Graft (CABG) Surgery**

Whether or not a patient was administered beta blocker within 24 hours prior to surgical incision for isolated CABG surgery

**Numerator:** Patients who were administered beta blocker within 24 hours prior to surgical incision

**Denominator:** All patients undergoing isolated CABG surgery

**Exclusion(s):** Medical reasons for not administering beta blocker within 24 hours prior to surgical incision for isolated CABG surgery

**Percentage of** patients who were administered beta blocker within 24 hours prior to surgical incision for isolated CABG surgery

**Reporting Instructions:**

For patients with medical reasons for not administering beta blocker within 24 hours prior to surgical incision for isolated CABG surgery, report modifier 1P with code 4115F.

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4115F</td>
<td>Beta blocker administered within 24 hours prior to surgical incision</td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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The measures for Coronary Artery Disease have been deleted. See the measures included in the [Chronic Stable Coronary Artery Disease](#) measures.

For Critical Care, see Anesthesiology/Critical Care (CRIT)

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**Footnotes**

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<table>
<thead>
<tr>
<th>Dementia (DEM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
</tr>
</tbody>
</table>

---

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Staging of Dementia

Whether or not the patient, regardless of age, with a diagnosis of dementia had severity of dementia classified as mild, moderate or severe at least once within a 12 month period

<table>
<thead>
<tr>
<th>Numerator:</th>
<th>Denominator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients whose severity of dementia was classified as mild, moderate or severe*</td>
<td>All patients, regardless of age, with a diagnosis of dementia</td>
</tr>
</tbody>
</table>

*See measure specifications for additional information regarding classification of dementia severity and for definitions of mild, moderate, and severe dementia.

**Reporting Instructions:**

Report 1490F OR 1491F OR 1493F to indicate dementia severity classification.

There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.

**Footnotes**

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<table>
<thead>
<tr>
<th>Cognitive Assessment¹</th>
<th>1494F</th>
<th>Cognition assessed and reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient, regardless of age, with a diagnosis of dementia had an assessment of cognition performed and the results were reviewed at least once within a 12 month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients for whom an assessment of cognition* is performed and the results reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*See measure specifications for examples.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients, regardless of age, with a diagnosis of dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical (eg, patient with very advanced stage dementia, other medical reason(s)) or patient reason(s) for not assessing cognition</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 1494F if assessment of cognition is performed and the results reviewed.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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⁷Optum, www.optum.com

⁸American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


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### Dementia (DEM)

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<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the patient with appropriate exclusion criteria, report 1494F with modifier 1P or 2P; modifier 3P may not be reported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

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<table>
<thead>
<tr>
<th>Functional Status Assessment¹</th>
<th>Numerator:</th>
<th>Denominator:</th>
<th>Exclusion(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient, regardless of age, with a diagnosis of dementia had an assessment of functional status performed and the results reviewed at least once within a 12 month period</td>
<td>Patients for whom an assessment of functional status* is performed and the results reviewed</td>
<td>All patients, regardless of age, with a diagnosis of dementia</td>
<td>Functional status for dementia assessed and results reviewed</td>
</tr>
</tbody>
</table>

* 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 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:

- Barthel ADL Index
- Katz Index of Independence in ADL

Footnotes

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⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com).


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### Dementia (DEM)

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<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of medical reason(s) for not assessing functional status (e.g., patient is severely impaired and caregiver knowledge is limited, other medical reason(s))</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 1175F if assessment of functional status is performed and the results reviewed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the patient with appropriate exclusion criteria, report 1175F with modifier 1P; modifiers 2P and 3P may not be reported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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### Neuropsychiatric Symptom Assessment

Whether or not the patient, regardless of age, with a diagnosis of dementia had an assessment of neuropsychiatric symptoms 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.

**Neuropsychiatric symptoms can be assessed by direct examination of the patient or knowledgeable informant. Please see measure specifications for examples of neuropsychiatric symptoms.**

#### Denominator:

All patients, regardless of age, with a diagnosis of dementia.

#### Exclusion(s):

None.

#### Reporting Instructions:

This measure is paired with measure #5- Management of Neuropsychiatric Symptoms. Implementers of this measure should not use this Neuropsychiatric Symptom Assessment.

---

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### Dementia (DEM)

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>without the Management of Neuropsychiatric Symptoms measure. Report 1181F if assessment of neuropsychiatric symptoms performed and results reviewed. There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

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### Management of Neuropsychiatric Symptoms

Whether or not the patient, regardless of age, with a diagnosis of dementia received or was 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

**Denominator:**

All patients, regardless of age, with a diagnosis of dementia who have one or more neuropsychiatric symptoms

**Exclusion(s):**

None

**Reporting Instructions:**

This measure is paired with Measure #4 – Neuropsychiatric Symptom Assessment. Implementers of this measure should not use this measure without the Neuropsychiatric Symptom Assessment measure. Report 1182F OR 1183F to indicate number of neuropsychiatric symptoms. If one or more neuropsychiatric symptoms present (1182F), report 4525F if

<table>
<thead>
<tr>
<th>Denominator Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1182F</td>
<td>Neuropsychiatric symptoms, one or more present</td>
</tr>
<tr>
<td>1183F</td>
<td>Neuropsychiatric symptoms, absent</td>
</tr>
</tbody>
</table>

| 1182F              | Neuropsychiatric intervention ordered |
| 4525F              | Neuropsychiatric intervention received |

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7. **Optum, [www.optum.com](http://www.optum.com)**


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### Dementia (DEM)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>patient was recommended to receive or report 4526F if patient has received an intervention for neuropsychiatric symptoms. There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th><strong>Screening for Depressive Symptoms¹</strong></th>
<th>3725F</th>
<th>Screening for depression performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient, regardless of age, with a diagnosis of dementia was screened for depressive symptoms within a 12 month period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who were screened for depressive symptoms*</td>
<td>3725F</td>
<td></td>
</tr>
<tr>
<td>*See measure specifications for definition of screening for depressive symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients, regardless of age, with a diagnosis of dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 3725F if patient was screened for depressive symptoms.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Counseling Regarding Safety Concerns¹**

1. Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2. National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
3. The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)
4. National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.
5. Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed by the Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).
6. The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)
7. Optum, [www.optum.com](http://www.optum.com)
8. American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com)
10. American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org/quality)
11. American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)
12. American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org)
Whether or not the patient, regardless of age, with a diagnosis of dementia (or the patient’s caregiver) was 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

*Counseling should include a discussion with the patient and their caregiver(s) regarding one or more of the common safety concerns listed in the measure specifications and potential risks to the patient.

**Denominator:**
All patients, regardless of age, with a diagnosis of dementia

**Exclusion(s):**
Documentation of medical reason(s) for not counseling regarding safety concerns (e.g., patient at end of life, other medical reason(s))

**Reporting Instructions:**
Report 6101F if patient (or caregiver) counseled regarding safety concerns or report 6102F if patient (or caregiver) was referred for counseling regarding safety concerns.

<table>
<thead>
<tr>
<th>6101F</th>
<th>Safety counseling for Dementia provided</th>
</tr>
</thead>
<tbody>
<tr>
<td>6102F</td>
<td>Safety counseling for Dementia ordered</td>
</tr>
</tbody>
</table>

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1. Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement®, see the appropriate Payor website.
2. National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
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<tr>
<th>Dementia (DEM)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
</tr>
<tr>
<td>For the patient with appropriate exclusion criteria, report 6102F with modifier 1P; modifiers 2P and 3P may not be reported.</td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

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<table>
<thead>
<tr>
<th><strong>Counseling Regarding Risks of Driving</strong>&lt;sup&gt;1&lt;/sup&gt;</th>
<th>6110F</th>
<th>Counseling provided regarding risks of driving and the alternatives to driving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient, regardless of age, with a diagnosis of dementia (or their caregiver) was counseled regarding the risks of driving and driving alternatives within a 12 month period</td>
<td>6110F</td>
<td>Counseling provided regarding risks of driving and the alternatives to driving</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients or their caregiver(s) who were counseled regarding the risks of driving and the alternatives to driving</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients, regardless of age, with a diagnosis of dementia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical reason(s) for not counseling regarding the risks of driving (eg, patient is no longer driving, other medical reason(s))</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 6110F if patient (or caregiver) was counseled regarding the risks of driving and alternatives to driving.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the patient with appropriate exclusion criteria, report 6110F with modifier 1P, modifiers 2P and 3P may not be reported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1Midwest Regional Medical Group, Inc. - For more information on measures developed by the Physician Consortium for Performance Improvement (PCPI), see the appropriate Payor website.

2National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

4National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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6[The Society of Thoracic Surgeons](http://www.sts.org) and [National Quality Forum](http://www.qualityforum.org)

7Optum, [www.optum.com](http://www.optum.com)


10American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

11American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

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## Palliative Care Counseling and Advance Care Planning
Whether or not the patient, regardless of age, with a diagnosis of dementia (or their caregiver) received 1) comprehensive counseling regarding ongoing palliation and symptom management and end of life decisions AND 2) has an advance care plan or surrogate decision maker in the medical record or documentation in the medical record that the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan** within two years of initial diagnosis or assumption of care

### Numerator:
Patients or their caregiver(s) who received 1) comprehensive counseling regarding ongoing palliation and symptom management and end of life decisions* AND 2) have an advance care plan or surrogate decision maker in the medical record or documentation in the medical record that the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan

*Comprehensive counseling regarding end of life decisions includes a discussion of the risks and benefits of various medical interventions to address the major clinical issues associated with advanced dementia. See measure specifications for details.

### Denominator:
- **4350F**: Counseling provided on symptom management, end of life decisions, and palliation
- **1123F**: Advance care planning discussed and documented advance care plan or surrogate decision maker documented in the medical record
- **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

---

### Footnotes
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5. Joint measure from the **Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

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### Dementia (DEM)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All patients, regardless of age, with a diagnosis of dementia</td>
<td></td>
<td>decision maker or provide an advance care plan</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> No</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4350F if patient (or caregiver) received comprehensive counseling regarding ongoing palliation and symptom management and end of life decisions. In addition, report 1123F or 1124F, to indicate advance care planning discussion and decision regarding an advance care plan. There are no performance exclusions for this measure; modifiers1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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Caregiver Education and Support
Whether or not the caregiver for a patient with a diagnosis of dementia, regardless of age, was provided with education on 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 disease management and health behavior changes AND referred to additional resources for support

*See measure specification for details

**Denominator:**
All patients, regardless of age, with a diagnosis of dementia

**Exclusion(s):**
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)

**Reporting Instructions:**

4322F  Caregiver provided with education and referred to additional resources for support

---

Footnotes

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6The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

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## Dementia (DEM)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report 4322F if patient's caregiver was provided education on disease management and health behavior changes performed AND referred to additional resources for support. For the patient with appropriate exclusion criteria, report 4322F with modifier 1P; modifiers 2P and 3P may not be reported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Diabetes (DM)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A1c Management</strong>&lt;sup&gt;4&lt;/sup&gt; Whether or not patient received one or more A1c test(s) <strong>Numerator:</strong> Patients who received one or more A1c test(s) <strong>Denominator:</strong> Patients with diagnosed diabetes 18-75 years of age</td>
<td>3044F</td>
<td><strong>Most recent hemoglobin A1c (HbA1c) level &lt; 7.0%</strong></td>
</tr>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the PCPI, see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the NDQIA, see the appropriate Payor website.

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**Diabetes (DM)**

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</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients with diagnosed diabetes aged 18-75 years with one or more A1c test(s).</td>
<td>▶3052F ◄</td>
<td>▶Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% ◄</td>
</tr>
<tr>
<td>Exclusion(s): NONE</td>
<td>3046F</td>
<td>Most recent hemoglobin A1c (HbA1c) level &gt; 9.0%</td>
</tr>
<tr>
<td>Reporting Instructions: In order to meet this measure, the date of test, when it was performed, and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. The measure may also be met by reporting the Category I code, 83036 Hemoglobin; glycosylated (A1C), when performed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▶To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3051F, 3052F. ◄</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**A1c Management**

- **Whether or not patient’s most recent A1c level > 9.0% (poor control)**
- **Numerator:** Patients with most recent A1c level > 9.0% (poor control)
- **Denominator:** Patients diagnosed with diabetes 18-75 years of age

<table>
<thead>
<tr>
<th></th>
<th>▶3044F ◄</th>
<th>Most recent hemoglobin A1c level &lt; 7.0%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▶3051F ◄</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% ◄</td>
</tr>
<tr>
<td></td>
<td>▶3052F ◄</td>
<td></td>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong> of patients with most recent A1c level &gt; 9.0% (poor control)</td>
<td>3046F</td>
<td>▶Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% ◄</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> NONE</td>
<td></td>
<td>Most recent hemoglobin A1c level &gt; 9.0%</td>
</tr>
<tr>
<td>▶<strong>Reporting Instructions:</strong> In order to meet this measure, the date of test when it was performed and the corresponding result are required. For this reason, report one of the four Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3051F, and 3052F. ◄</td>
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</tr>
<tr>
<td><strong>Code</strong></td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td>▶Exclusion(s): Documentation of medical reasons for not pursuing tight control of A1c level (eg, steroid-induced or gestational diabetes, frailty and/or advanced illness)</td>
</tr>
<tr>
<td>▶Percentage of patients with most recent A1c level controlled</td>
</tr>
<tr>
<td>CPT Category II Code(s)</td>
</tr>
<tr>
<td>3046F</td>
</tr>
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<thead>
<tr>
<th>Diabetes (DM)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lipid Management</strong>: Whether or not patient received at least one LDL-C test</td>
<td>3048F</td>
<td>Most recent LDL-C &lt;100 mg/dL</td>
</tr>
<tr>
<td><strong>Numerator: Patients who received at least one LDL-C test</strong></td>
<td>3049F</td>
<td>Most recent LDL-C 100-129 mg/dL</td>
</tr>
<tr>
<td><strong>Denominator: Patients diagnosed with diabetes aged 18-75 years of age</strong></td>
<td>3050F</td>
<td>Most recent LDL-C ≥ 130 mg/dL</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients diagnosed with diabetes aged 18-75 years with at least one LDL-C test</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s): NONE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> In order to meet this measure, the date of test when it was performed and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. The measure may also be met by reporting the listed lipid test category I codes, when performed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lipid Management</strong>: Whether or not patient's most recent LDL-C &lt; 130 mg/dL</td>
<td>3048F</td>
<td>Most recent LDL-C &lt;100 mg/dL</td>
</tr>
<tr>
<td><strong>Numerator: Patients with most recent LDL-C &lt; 130 mg/dL</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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Diabetes (DM)

Brief Description of Performance Measure & Source and Reporting Instructions

CPT Category II Code(s) | Code Descriptor(s)
--- | ---
3049F | Most recent LDL-C 100-129 mg/dL
3050F | Most recent LDL-C ≥ 130 mg/dL

Denominator: Patients diagnosed with diabetes aged 18-75 years

Percentage of patients diagnosed with diabetes aged 18-75 years with most recent LDL-C < 130 mg/dL

Exclusion(s): NONE

Reporting Instructions: In order to meet this measure, the date of test when it was performed and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code.

There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

Lipid Management

Whether or not patient’s most recent LDL-C < 100 mg/dL

Numerator: Patients whose most recent LDL-C is <100 mg/dL

CPT Category II Code(s) | Code Descriptor(s)
--- | ---
3048F | Most recent LDL-C <100 mg/dL
3049F | Most recent LDL-C 100-129 mg/dL

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7Optum, www.optum.com

8American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


10American Gastroenterological Association (AGA), www.gastro.org/quality

11American Society of Anesthesiologists (ASA), www.asahq.org

12American College of Gastroenterology (AGC), www.gi.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org
### Diabetes (DM)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Denominator:** Patients diagnosed with diabetes 18-75 years of age  
Percentage of patients diagnosed with diabetes 18-75 years of age whose most recent LDL-C < 100 mg/dL  
**Exclusion(s):** NONE | 3050F | Most recent LDL-C ≥ 130 mg/dL |
| **Reporting Instructions:** In order to meet this measure, the date of test, when it was performed and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. | | |
| **Urine Protein Screening** | 3060F | Positive microalbuminuria test result documented and reviewed |
| Whether or not a patient received at least one test for microalbumin during the measurement year OR had evidence of medical attention for existing nephropathy, OR has documentation of microalbuminuria or albuminuria, OR is on an Angiotensin converting enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) | 3061F | Negative microalbuminuria test result documented and reviewed |
| **Numerator:** Patients with at least one test for microalbumin during the measurement year; or who had evidence of medical attention for existing nephropathy or documentation of | 3062F | |

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8. **American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com)


10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

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# Diabetes (DM)

## Brief Description of Performance Measure & Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Denominator:</th>
<th>Patients diagnosed with diabetes 18-75 years of age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion(s):</td>
<td>NONE</td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td>of patients diagnosed with diabetes 18-75 years of age with at least one test for microalbumin during the measurement year; or who had evidence of medical attention for existing nephropathy or documentation of microalbuminuria or albuminuria or are on an ACE inhibitor or ARB therapy</td>
</tr>
</tbody>
</table>

### Reporting Instructions:

- **Code(s)**: 3066F, 3061F, and 3062F may be used to indicate that a patient received at least one test for microalbuminuria.
- **Code(s)**: 3066F may be used if there is evidence of nephropathy OR if there was a patient visit to a nephrologist.

## CPT Category II Code(s)

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3066F</td>
<td>Positive macroalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>4010F</td>
<td>Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)</td>
</tr>
<tr>
<td></td>
<td>Angiotensin converting enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken</td>
</tr>
</tbody>
</table>

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### Diabetes (DM)

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<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.</td>
<td>Codes 3062F may be used to indicate that a patient had documentation of microalbuminuria or albuminuria.</td>
</tr>
<tr>
<td>4.</td>
<td>Codes 4010F may be used if patient is on an ACE inhibitor or ARB therapy.</td>
</tr>
<tr>
<td>5.</td>
<td>Any CPT category I code and corresponding result, when performed, and reported with any of the following ICD-9 diagnosis or procedure codes found in specifications: ICD-9-CM Codes 39.27, 39.42, 39.43, 39.53, 39.93-39.95, 54.98, 55.4-55.6, 250.4, 403, 404, 405.01, 405.11, 405.91, 581.81, 582.9, 583.81, 584-586, 588, 753.0, 753.1, 791.0; V-Codes V42.0, V45.1, V56</td>
</tr>
<tr>
<td></td>
<td>CPT category I codes for microalbumin measurement or quantitative timed urine albumin measurement and corresponding result as follows: 82042, 82043, 82044, 83518, 84156 or (84160, 84165, 84166) with code 81050</td>
</tr>
<tr>
<td></td>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
</tr>
</tbody>
</table>

---

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**Diabetes (DM)**

**Brief Description of Performance Measure & Source and Reporting Instructions**

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<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3060F</td>
<td>Positive microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3061F</td>
<td>Negative microalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3062F</td>
<td>Positive macroalbuminuria test result documented and reviewed</td>
</tr>
<tr>
<td>3066F</td>
<td>Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)</td>
</tr>
</tbody>
</table>

**Urine Protein Screening (Medical Attention for Nephropathy)**

To assess the percentage of patients aged 18 – 75 years of age with diabetes (type 1 and type 2) who received urine protein screening or medical attention for nephropathy.

**Numerator:**
Patients who have a nephropathy screening during one or more office visits within 12 months. This measure is looking for a nephropathy screening test or evidence of nephropathy.

**Denominator:**
All patients aged 18 – 75 years of age with the diagnosis of diabetes

**Exclusion(s):** None.

The percentage of patients aged 18 – 75 years of age with diabetes (type 1 and type 2) who received urine protein screening or medical attention for nephropathy.

**Reporting Instructions:**
Report one or more of these codes for urine protein screening or medical attention to nephropathy at least once per reporting period.

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### Diabetes (DM)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are no exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Eye Examination 4

Whether or not patient received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist or imaging validated to match diagnosis from these photos during the reporting year, or during the prior year if patient is at low risk* for retinopathy

**Numerator:** Patients who received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist or imaging validated to match diagnosis from these photos during the reporting year, or during the prior year, if patient is at low risk* for retinopathy

**Denominator:** Patients with diagnosed diabetes 18-75 years of age; Low risk patient (defined as a patient who had no evidence of retinopathy in the prior year) must have had an evaluation in the prior year

**Exclusion(s):** NONE

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4010F</td>
<td>Angiotensin converting enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken</td>
</tr>
<tr>
<td>2022F</td>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy</td>
</tr>
<tr>
<td>2023F</td>
<td>without evidence of retinopathy</td>
</tr>
<tr>
<td>2024F</td>
<td>OR</td>
</tr>
<tr>
<td>2025F</td>
<td>7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy</td>
</tr>
<tr>
<td>2025F</td>
<td>without evidence of retinopathy</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2026F</td>
<td>OR</td>
</tr>
<tr>
<td>2033F</td>
<td>Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed; with evidence of retinopathy without evidence of retinopathy OR Low risk for retinopathy (no evidence of retinopathy in the prior year)</td>
</tr>
<tr>
<td>3072F</td>
<td></td>
</tr>
</tbody>
</table>

**Percentage** of patients who received a dilated eye exam or seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist or imaging validated to match diagnosis from these photos during the reporting year.

**Reporting Instructions:** Only one of these codes should be reported.

There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

* A patient is considered low risk if the following criterion is met: has no evidence of retinopathy on one of the accepted examination in the prior year.

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</thead>
<tbody>
<tr>
<td><strong>Foot Examination</strong>&lt;sup&gt;4&lt;/sup&gt;</td>
<td>2028F</td>
<td>Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when any of the 3 components are completed)</td>
</tr>
<tr>
<td>Brief Description of Performance Measure &amp; Source and Reporting Instructions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not patient received at least one foot exam, defined in any manner</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who received at least one foot exam, defined in any manner</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> Patients diagnosed with diabetes 18-75 years of age</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Patients with bilateral foot/leg amputation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients diagnosed with diabetes 18-75 years of age receiving at least one foot exam, defined in any manner</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 2028F with modifier 1P for patients with bilateral foot/leg amputation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Diabetes (DM)

#### Brief Description of Performance Measure & Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Blood Pressure Management&lt;sup&gt;2&lt;/sup&gt;</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not patient’s most recent blood pressure is &lt; 130 mm Hg systolic and &lt; 80 mm Hg diastolic</td>
<td>3074F, 3075F, 3077F, 3078F, 3080F with modifier 1P</td>
<td>Blood pressure measured</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients whose most recent blood pressure is &lt; 130 mm Hg systolic and &lt; 80 mm Hg diastolic.</td>
<td>3074F</td>
<td>Most recent systolic blood pressure &lt; 130 mm Hg</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Patients diagnosed with diabetes 18-75 years of age.</td>
<td>3075F</td>
<td>Most recent systolic blood pressure 130 to 139 mm Hg</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reasons that diastolic &lt; 80 is not medically indicated.</td>
<td>3077F</td>
<td>Most recent systolic blood pressure ≥ 140 mm Hg</td>
</tr>
<tr>
<td>Documentation of medical reasons that systolic &lt; 130 is not medically indicated.</td>
<td>3078F</td>
<td>Most recent diastolic blood pressure &lt; 80 mm Hg</td>
</tr>
</tbody>
</table>

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*Code 2000F has been included with the Diabetes measure set to reflect potential use in the Physician Quality Reporting Initiative (PQRI) to identify non-performance of a blood pressure check. To identify non-performance of a blood pressure check report code 2000F with modifier 8P. 2000F is not valid for another use in this measure.*

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3079F</td>
<td>Most recent diastolic blood pressure 80 - 89 mm Hg</td>
</tr>
<tr>
<td>3080F</td>
<td>Most recent diastolic blood pressure ≥ 90 mm Hg</td>
</tr>
</tbody>
</table>

**Blood Pressure Management**

Whether or not patient’s most recent blood pressure is < 140/80 mm Hg

**Numerator:** Patients in whose most recent blood pressure < 140/80 mm Hg

**Denominator:** Patients diagnosed with diabetes 18-75 years of age

**Exclusion(s): None**

**Percentage** of patients diagnosed with diabetes 18-75 years of age with most recent blood pressure < 140/80 mm Hg

**Reporting Instruction:** Two codes must be reported here. For the systolic blood pressure value, report one of the two

### CPT Category II Code(s) and Code Descriptors

#### Systolic Codes:

- **3074F**
  - Most recent systolic blood pressure < 130 mm Hg
- **3075F**
  - Most recent systolic blood pressure 130 to 139 mm Hg
- **3077F**
  - Most recent systolic blood pressure ≥ 140 mm Hg

#### Diastolic Codes

- **3078F**
  - Most recent diastolic blood pressure < 80 mm Hg
- **3079F**
  - Most recent diastolic blood pressure 80 - 89 mm Hg

---

**Footnotes**

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3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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Last Updated June 23, 2023
Diabetes (DM)

Brief Description of Performance Measure & Source and Reporting Instructions

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3080F</td>
<td>Most recent diastolic blood pressure ≥ 90 mm Hg</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Smoking Cessation 4</th>
<th>Tobacco use cessation intervention, counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>4000F</td>
<td>Tobacco use cessation intervention, pharmacologic therapy</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Denominator Codes</th>
<th>Smoking Cessation 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1034F</td>
<td>Current tobacco smoker</td>
</tr>
<tr>
<td>1035F</td>
<td>Current smokeless tobacco user (eg, chew, snuff)</td>
</tr>
<tr>
<td>1036F</td>
<td>Current tobacco non-user</td>
</tr>
</tbody>
</table>

Numerator: Patients whose smoking status was ascertained and documented

Denominator: Patients diagnosed with diabetes 18-75 years of age whose smoking status was ascertained and documented

Reporting Instructions: Report 1034F for each cigarette smoker. Report either 1034F, 1035F, or 1036F for each patient. If patient is a smoker and received cessation intervention, report 4000F or 4001F, or both. Report 4000F or 4001F only if 1034F has been reported.

Footnotes

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# Diabetes (DM)

## Brief Description of Performance Measure & Source and Reporting Instructions

There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

### Appropriate Eye Exam for People with Diabetes

**Whether or not patients aged 18 – 75 years of age with diabetes (type 1 and type 2) had a dilated eye exam.**

#### Numerator:

Patients who have an eye exam for diabetic retinal disease

#### Denominator:

All patients aged 18 – 75 years of age with the diagnosis of diabetes

#### Exclusion(s): None

The percentage of patients aged 18 – 75 years of age with diabetes (type 1 and type 2) who had a retinal eye exam.

#### Reporting Instructions:

Report either code 2022F, 2023F, 2024F, 2025F, 2026F, 2033F, or 3072F for each patient. The date of service for codes 2022F, 2023F, 2025F, 2026F, 2033F should match the service date of the service with the eye care professional. 3072F should be filed with a date of service for the current year to appropriately reflect prior year’s risk.

### CPT Category II Code(s)

<table>
<thead>
<tr>
<th>Code</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2022F</td>
<td>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy</td>
</tr>
<tr>
<td>2023F</td>
<td>without evidence of retinopathy</td>
</tr>
<tr>
<td>2024F</td>
<td>7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy</td>
</tr>
<tr>
<td>2025F</td>
<td>without evidence of retinopathy</td>
</tr>
<tr>
<td>2026F</td>
<td>Eye imaging validated to match diagnosis from seven standard field</td>
</tr>
</tbody>
</table>

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### Diabetes (DM)

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</tr>
</thead>
<tbody>
<tr>
<td>There are no exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td>2033F</td>
<td>stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy</td>
</tr>
<tr>
<td></td>
<td>3072F</td>
<td>without evidence of retinopathy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Low risk for retinopathy (no evidence of retinopathy in the prior year)</td>
</tr>
</tbody>
</table>

### Distal Symmetric Polyneuropathy (DSP)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distal Symmetric Polyneuropathy (DSP) Diagnosis Criteria: DSP Symptoms and Signs&lt;sup&gt;8&lt;/sup&gt; Whether or not the patient diagnosed with distal symmetric polyneuropathy had their neuropathic symptoms and signs* reviewed and documented at the initial evaluation for distal symmetric polyneuropathy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

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12. **American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
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</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Patients who had their neuropathic symptoms and signs* reviewed and documented at the initial evaluation for distal symmetric polyneuropathy</td>
<td>1500F</td>
<td>Symptoms and signs of distal symmetric polyneuropathy reviewed and documented</td>
</tr>
<tr>
<td></td>
<td>1119F</td>
<td>Initial evaluation for condition</td>
</tr>
<tr>
<td></td>
<td>1501F</td>
<td>Not initial evaluation for condition</td>
</tr>
</tbody>
</table>

**Definitions:**

*Neuropathic Symptoms: numbness, altered sensation, or pain in the feet.*

Neuropathic Signs: decreased or absent ankle reflexes, decreased distal sensation, and distal muscle weakness or atrophy

**Denominator:** All patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy

**Exclusion(s):** Documentation of a medical reason for not reviewing and documenting neuropathic symptoms and signs (eg, patient has profound mental retardation, language disturbance, or cognitive impairment)

**Reporting Instructions:**

1. **CPT Category II Code(s):** 1500F, 1119F, 1501F

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Distal Symmetric Polyneuropathy (DSP)

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</tr>
</thead>
<tbody>
<tr>
<td>For all patients meeting denominator criteria, report either 1119F or 1501F. When 1119F is reported, also report 1500F. For patient with appropriate exclusion criteria, report 1500F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Distal Symmetric Polyneuropathy (DSP) Diagnosis Criteria – Electrodiagnostic Studies**

Whether or not the patient age 18 years and older diagnosed with distal symmetric polyneuropathy had electrodiagnostic studies conducted, documented, and reviewed within 6 months of the initial evaluation for distal symmetric polyneuropathy

**Numerator:** Patients who had electrodiagnostic (EDX) studies conducted, documented, and reviewed within 6 months of the initial evaluation for distal symmetric polyneuropathy

Note: It may be necessary to look for findings in the patient medical record or request studies previously conducted from

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8. **American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com.**
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</thead>
<tbody>
<tr>
<td>another physician office which may require additional time. Another electrodiagnostic study should not be performed if a satisfactory study has already been done and can be reviewed.</td>
<td>3751F 3752F 3753F</td>
<td>Electrodiagnostic studies for distal symmetric polyneuropathy conducted (or requested), documented, and reviewed within 6 months of initial evaluation for condition. Electrodiagnostic studies for distal symmetric polyneuropathy <strong>not</strong> conducted (or requested), documented, or reviewed within 6 months of initial evaluation for condition. Patient has clear clinical symptoms and signs that are highly suggestive of neuropathy AND cannot be attributed to another condition, AND has an obvious cause for the neuropathy.</td>
</tr>
</tbody>
</table>

**Denominator:**

All patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy

**Exclusion(s):**

Documentation of a medical (eg, patient has a skin condition which contraindicates EDX), patient (eg, patient declines to undergo testing), or system (eg, patient does not have insurance to pay for the testing) reason(s) for not conducting, documenting, and reviewing EDX studies.

**Reporting Instructions:**

For all patients meeting denominator criteria, report either 3751F or 3752F or 3753F.
<table>
<thead>
<tr>
<th>Distal Symmetric Polyneuropathy (DSP)</th>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes/Pre-Diabetes Screening for Patients with DSP</strong></td>
<td>Whether or not the patient age 18 years and older diagnosed with distal symmetric polyneuropathy had screening tests for diabetes (eg, fasting blood sugar test, hemoglobin A1C, or a 2 hour Glucose Tolerance Test) reviewed, requested, or ordered when seen for the initial evaluation for distal symmetric polyneuropathy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who had screening tests for diabetes (eg, fasting blood sugar test, hemoglobin A1C, or a 2-hour Glucose Tolerance Test) reviewed, requested, or ordered</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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6The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7Optum, [www.optum.com](http://www.optum.com)


10American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org/quality).

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>when seen for an initial evaluation for distal symmetric polyneuropathy</td>
<td>3754F</td>
<td>Screening tests for diabetes mellitus reviewed, requested, or ordered</td>
</tr>
<tr>
<td></td>
<td>1119F</td>
<td>Initial evaluation for condition</td>
</tr>
<tr>
<td></td>
<td>1501F</td>
<td>Not initial evaluation for condition</td>
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</tr>
</thead>
<tbody>
<tr>
<td>For patient with appropriate exclusion criteria, report 3754F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Screening for Unhealthy Alcohol Use**<sup>8</sup>  
Whether or not the patient age 18 years and older diagnosed with distal symmetric polyneuropathy was screened with a validated screening instrument for unhealthy alcohol use* when seen for the initial evaluation for distal symmetric polyneuropathy  

*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. | 3016F | Patient screened for unhealthy alcohol use using a validated screening instrument  
Initial evaluation for condition  |
| | 1119F |  |

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</thead>
</table>
| Unhealthy alcohol use can be assessed using one of a number of available valid and reliable instruments available from medical literature. Examples include, but are not limited to:  
  - CAGE-AID (Cut-down, Annoyed, Guilty, Eye-opener)  
  - AUDIT C (Alcohol Use Disorders Identification Test – Consumption)  
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.  
**Denominator:**  
All patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy.  
**Exclusion(s):**  
Not initial evaluation for condition | 1501F |  |

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</thead>
<tbody>
<tr>
<td>Documentation of medical (eg, patient diagnosed with alcoholism) or patient (eg, patient declines to answer questions/completed the screening) reason(s) for not screening patient with a validated screening instrument for unhealthy alcohol use.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For all patients meeting denominator criteria, report either 1119F or 1501F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When 1119F is reported, also report 3016F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patient with appropriate exclusion criteria, report 3016F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Querying about Pain and Pain Interference with Function</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not at the visit for the patient age 18 years and older with a diagnosis of distal symmetric polyneuropathy, the patient was queried about pain and pain interference with</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Distal Symmetric Polyneuropathy (DSP)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>function using a valid and reliable instrument (eg, Graded Chronic Pain Scale).</td>
<td>1502F</td>
<td>Patient queried about pain and pain interference with function using a valid and reliable instrument</td>
</tr>
</tbody>
</table>

**Numerator:** Patient visits with patient queried about pain and pain interference with function using a valid and reliable instrument (eg, Graded Chronic Pain Scale).

**Note:** Neuropathic pain can be assessed using one of a number of available valid and reliable instruments available from medical literature. Examples include, but are not limited to:

Graded Chronic Pain Scale

**Denominator:** All visits for patients age 18 years and older with a diagnosis of distal symmetric polyneuropathy

**Exclusion(s):** Documentation of a medical (eg, patient cognitively impaired and unable to respond) or patient (eg, patient declines to respond to questions) reason(s) for not querying patient about pain and pain interference with function.

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**Footnotes**

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**Distal Symmetric Polyneuropathy (DSP)**

**Brief Description of Performance Measure & Source and Reporting Instructions**

<table>
<thead>
<tr>
<th>Reporting Instructions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>For all visits meeting denominator criteria, report 1502F.</td>
</tr>
<tr>
<td>For visits with appropriate exclusion criteria, report 1502F with modifier 1P or 2P.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6080F</td>
<td>Patient (or caregiver) queried about falls</td>
</tr>
</tbody>
</table>

**Querying about Falls for Patients with DSP**

Whether or not a patient age 18 years old and older with a diagnosis of distal symmetric polyneuropathy was queried at least once annually about falls within the past 12 months

**Numerator:** Patients who were queried at least once annually about falls within the past 12 months

Note: Participants are encouraged to use validated assessments. An example of this is the multi-factorial falls risk assessment, which is to be performed once a year as part of an exam.

**Exclusion(s):** Documentation of a medical (eg, patient is cognitively impaired and unable to communicate) or patient (eg, patient declines to answer the query about falls)

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**Footnotes**

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### Distal Symmetric Polyneuropathy (DSP)

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>reason(s) for not querying about falls within the past 12 months Reporting Instructions: For all patients meeting denominator criteria, report 6080F. For patient with appropriate exclusion criteria, report 6080F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Emergency Medicine (EM)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electrocardiogram Performed for Non-Traumatic Chest Pain $^5$ Whether or not the patient aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain had an ECG performed</td>
<td>3120F</td>
<td>12-Lead ECG performed</td>
</tr>
</tbody>
</table>

**Footnotes**

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not performing an ECG; documentation of patient reason(s) for not performing an ECG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had an ECG performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 3120F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Aspirin at Arrival for Acute Myocardial Infarction (AMI)</strong></td>
<td>4084F</td>
<td>Aspirin received within 24 hours before emergency department arrival or during emergency department stay</td>
</tr>
</tbody>
</table>

Footnotes

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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6The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7Optum, [www.optum.com](http://www.optum.com)

8American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com).


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</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Patients who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with an emergency department discharge diagnosis of acute myocardial infarction</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not receiving aspirin within 24 hours before emergency department arrival or during emergency department stay; documentation of patient reason(s) for not receiving aspirin within 24 hours before emergency department arrival or during emergency department stay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients with AMI who had documentation of receiving aspirin within 24 hours before or after hospital arrival</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 4084F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Electrocardiogram Performed for Syncope</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 60 years and older with an emergency department discharge diagnosis of syncope had an ECG performed</td>
<td>3120F</td>
<td>12-Lead ECG performed</td>
</tr>
</tbody>
</table>

Footnotes

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<tbody>
<tr>
<td><strong>Emergency Medicine (EM)</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Denominator:** All patients aged 60 years and older with an emergency department discharge diagnosis of syncope

**Exclusion(s):** Documentation of medical reason(s) for not performing an ECG; documentation of patient reason(s) for not performing an ECG

Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had an ECG performed

**Reporting Instructions:** For patient with appropriate exclusion criteria, report 3120F with modifier 1P or 2P.

**Vital Signs for Community-Acquired Bacterial Pneumonia**: Whether or not the patient aged 18 years and older with the diagnosis of community-acquired pneumonia had vital signs documented and reviewed

**Numerator:** Patients with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

**Denominator:** All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia

| 2010F | Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed |

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**Emergency Medicine (EM)**

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia</strong></td>
<td>3028F</td>
<td>Oxygen saturation results documented and reviewed (Includes assessment through pulse oximetry or arterial blood gas measurement)</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia had oxygen saturation documented and reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with oxygen saturation documented and reviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of physician reason(s) for not documented and reviewed oxygen saturation; documentation of patient reason(s) for not assessing documented and</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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### Emergency Medicine (EM)

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</tr>
</thead>
<tbody>
<tr>
<td>reviewed oxygen saturation; documentation of system reason(s) for not documented and reviewed oxygen saturation Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed</td>
<td>2014F</td>
<td>Mental status assessed</td>
</tr>
</tbody>
</table>
| **Assessment of Mental Status for Community-Acquired Bacterial Pneumonia**<sup>6</sup>  
Whether or not the patient aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia had mental status assessed  
**Numerator:** Patients with mental status assessed  
**Denominator:** All patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with mental status assessed  
**Exclusions:** None | | |

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**Footnotes**

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</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with mental status assessed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Empiric Antibiotic for Community-Acquired Bacterial Pneumonia</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia had an appropriate empiric antibiotic prescribed</td>
<td>4045F</td>
<td>Appropriate empiric antibiotic prescribed</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with an appropriate empiric antibiotic prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate empiric antibiotic for treatment of community-acquired bacterial pneumonia (CAP) should include any medication from one of the following four drug classes: Fluoroquinolones, Macrolides, Doxycycline, Beta Lactam with Macrolide or Doxycycline (as defined by current ATS/IDSA guidelines).</td>
<td></td>
<td></td>
</tr>
</tbody>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All patients 18 years and older with the diagnosis of community-acquired bacterial pneumonia</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of physician reason(s) for not prescribing an antibiotic; documentation of patient reason(s) for not prescribing an antibiotic; documentation of system reason(s) for not prescribing an antibiotic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients aged 18 years and older with the diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria, report 4045F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### End Stage Renal Disease (ESRD)

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan of Care for Inadequate Hemodialysis</strong>¹</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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⁶**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and [National Quality Forum](http://www.qualityforum.org).


⁸**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures) or [quality@aan.com](mailto:quality@aan.com).


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¹¹**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org).

¹²**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org).
### End Stage Renal Disease (ESRD)

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<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of calendar months during which a patient aged 18 years and older with a diagnosis of ESRD receiving hemodialysis has Kt/V ≥1.2 OR has Kt/V &lt;1.2 with a documented plan of care</td>
<td>0505F</td>
<td>Hemodialysis plan of care documented</td>
</tr>
<tr>
<td>Numerator: Number of calendar months during which patients aged 18 years and older with a diagnosis of ESRD receiving hemodialysis have Kt/V ≥1.2 OR have Kt/V &lt;1.2 with a documented plan of care</td>
<td>3082F</td>
<td>Kt/V less than 1.2 (Clearance of urea (Kt)/volume (V))</td>
</tr>
<tr>
<td>A documented plan of care may include checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the time of dialysis sessions, adjusting dialysis prescription, or documenting residual renal function.</td>
<td>3083F</td>
<td>Kt/V equal to or greater than 1.2 and less than 1.7 (Clearance of urea (Kt)/volume (V))</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Calendar months for all patients aged 18 years and older with a diagnosis of ESRD who are receiving hemodialysis</td>
<td>3084F</td>
<td>Kt/V greater than or equal to 1.7 (Clearance of urea (Kt)/volume (V))</td>
</tr>
<tr>
<td><strong>Exclusion(s): None</strong></td>
<td>4052F</td>
<td>Hemodialysis via functioning arterio-venous (AV) fistula</td>
</tr>
<tr>
<td><strong>Percentage</strong> of calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of ESRD receiving hemodialysis have Kt/V ≥1.2 OR have Kt/V &lt;1.2 with a documented plan of care</td>
<td>4053F</td>
<td>Hemodialysis via functioning arterio-venous (AV) graft</td>
</tr>
<tr>
<td></td>
<td>4054F</td>
<td>Hemodialysis via catheter</td>
</tr>
</tbody>
</table>

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**Footnotes**

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<tr>
<td>diagnosis of ESRD receiving hemodialysis have a Kt/V ≥1.2 OR have a Kt/V &lt;1.2 with a documented plan of care</td>
<td>0507F</td>
<td>Peritoneal dialysis plan of care documented</td>
</tr>
</tbody>
</table>

**Plan of Care for Inadequate Peritoneal Dialysis**

Whether or not a patient aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis has a Kt/V ≥1.7 OR has a Kt/V<1.7 with a documented plan of care at least three times during the 12-month reporting period

**Numerator:** Patients who have a Kt/V ≥1.7 OR have a Kt/V <1.7 with a documented plan of at least three times during the 12-month reporting period

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| A documented plan of care may include assessing for non-adherence with the peritoneal prescription, sampling, and collection; assessing for error in the peritoneal dialysis prescription and/or inadequate monitoring of the delivered dose; performing peritoneal equilibrium testing; assessing for inadequate patient education; increasing the exchange volume; increasing the number of exchanges per 24 hours; assessing for modality (continuous ambulatory peritoneal dialysis (CAPD) or continuous cyclic peritoneal dialysis (CCPD).  
**Denominator:** All patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis  
**Exclusion(s):** None  
**Percentage** of patients aged 18 years and older with a diagnosis of ESRD receiving peritoneal dialysis who have a Kt/V ≥1.7 OR have a Kt/V<1.7 with a documented plan of care at least three times during the 12-month reporting period  
**Reporting Instructions:** | 3082F | Kt/V <1.2 (Clearance of urea (Kt)/volume (V)) |
|                                                   | 3083F | Kt/V equal to or greater than 1.2 and less than 1.7 (Clearance of urea (Kt)/volume (V)) |
|                                                   | 3084F | Kt/V ≥ 1.7 (Clearance of urea (Kt)/volume (V)) |

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<tbody>
<tr>
<td>Report 3082F or 3083F or 3084F for the corresponding Kt/V measurement during the calendar month when patient is receiving peritoneal dialysis. If Kt/V &lt; 1.7 (3082F or 3083F), and patient has a plan of care, also report 0507F. There are no performance exclusions for this measure; modifiers 1P or 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Influenza Immunization</strong>¹</td>
<td>4037F</td>
<td>Influenza immunization ordered or administered</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of ESRD and receiving dialysis received the influenza immunization during the flu season (September through February)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who received the influenza immunization during the flu season (September through February)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with a diagnosis of ESRD and receiving dialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical, patient, or system reason(s) for patient not receiving the influenza immunization during the flu season (September through February)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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<tbody>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of ESRD and receiving dialysis who received the influenza immunization during flu season (September through February)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: For patient with appropriate exclusion criteria use 4037F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Vascular Access-Patients receiving Hemodialysis</strong></td>
<td>4051F</td>
<td>Referred for an arterio-venous (AV) fistula</td>
</tr>
</tbody>
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<tr>
<td>functioning AV fistula or is referred for an AV fistula at least once during the 12-month reporting period</td>
<td>4052F&lt;br&gt;Denominator Codes:&lt;br&gt;4052F&lt;br&gt;4053F&lt;br&gt;4054F&lt;br&gt;4055F</td>
<td>Hemodialysis via functioning arterio-venous (AV) fistula&lt;br&gt;Hemodialysis via functioning arterio-venous (AV) fistula&lt;br&gt;Hemodialysis via arterio-venous (AV) graft&lt;br&gt;Patient receiving peritoneal dialysis</td>
</tr>
<tr>
<td>Numerator: Patients who have a functioning AV fistula OR patients who are referred for AV fistula at least once during the 12-month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: All patients aged 18 years and older with a diagnosis of ESRD and receiving hemodialysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s): Documentation of medical or patient reason(s) for not having a functioning AV fistula or being referred for an AV fistula (eg, documentation of a functioning AV graft)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients aged 18 years and older with a diagnosis of ESRD and receiving hemodialysis who have a functioning AV fistula OR patients who are referred for an AV fistula at least once during the 12-month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: Report 4052F or 4053F or 4054F or 4055F to specify the type of access for each patient receiving hemodialysis. If patient is receiving hemodialysis via functioning AV fistula, report 4052F only once; additional codes do not need to be reported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>For patient receiving hemodialysis via a catheter, report 4051F if referred for an AV fistula. For patient receiving hemodialysis via AV graft, reporting 4053F will exclude patient from measure; 1P or 2P is not required. For patient with appropriate exclusion criteria, report 4051F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Vascular Access-Patients Receiving Hemodialysis with a Permanent Catheter

- **Numerator:** Patients who are referred for evaluation for AV fistula at least once during the 12-month reporting period
- **Denominator:** All patients aged 18 years and older with a diagnosis of ESRD receiving hemodialysis with a permanent catheter

### Footnotes

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<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) (eg, documentation of a functioning AV graft, documentation that patient is enrolled in Hospice) or patient reason(s) for not being referred for evaluation for AV fistula</td>
<td>4051F</td>
<td>Referred for an arterio-venous (AV) fistula</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of ESRD receiving hemodialysis with a permanent catheter who are referred for evaluation for AV fistula at least once during the 12 month reporting period</td>
<td>4052F</td>
<td>Hemodialysis via functioning arterio-venous (AV) fistula</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4052F or 4053F or 4054F or 4055F for each patient.</td>
<td>4053F</td>
<td><strong>Hemodialysis via functioning arterio-venous (AV) graft</strong></td>
</tr>
<tr>
<td>If patient has a permanent catheter (4054F) and has been referred for evaluation for AV fistula, also report 4051F. For patient with appropriate exclusion criteria, report 4051F with modifier 1P or 2P. For patient receiving hemodialysis via AV graft, reporting 4053F alone will exclude patient from measure; 1P or 2P is not required.</td>
<td>4054F</td>
<td><strong>Hemodialysis via catheter</strong></td>
</tr>
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<tbody>
<tr>
<td>4055F</td>
<td>Patient receiving peritoneal dialysis</td>
</tr>
<tr>
<td>3279F</td>
<td>Hemoglobin level greater than or equal to 13 g/dL</td>
</tr>
<tr>
<td>3280F</td>
<td>Hemoglobin level 11 g/dL to 12.9 g/dL</td>
</tr>
</tbody>
</table>

### Plan of Care for Anemia

Number of calendar months during which a patient with a diagnosis of ESRD receiving dialysis had a hemoglobin (Hgb) ≥ 11 g/dL OR had a Hgb < 11 g/dL with a documented plan of care

**Numerator:** Number of calendar months during which patients have a Hgb ≥ 11 g/dL OR have a Hgb < 11 with a documented plan of care

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<tbody>
<tr>
<td><strong>Denominator:</strong> Calendar months during which all patients aged 18 years and older with a diagnosis of ESRD are receiving dialysis</td>
<td>3281F</td>
<td>Hemoglobin level less than 11 g/dL</td>
</tr>
<tr>
<td><strong>Exclusion(s): None</strong></td>
<td>0516F</td>
<td>Anemia plan of care documented</td>
</tr>
<tr>
<td><strong>Percentage</strong> of calendar months during the 12-month reporting period in which patients aged 18 years and older with a diagnosis of ESRD who are receiving dialysis have a Hgb ≥ 11 g/dL OR have a Hgb &lt; 11 g/dL with a documented plan of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report this measure for each calendar month a patient is receiving dialysis. Report the code that corresponds to the hemoglobin value. If hemoglobin &lt;11 g/dL (3281F) and patient has a documented plan of care, also report 0516F. There are no performance exclusions for this measure; modifiers 1P or 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

1. Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2. National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
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6. The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)
7. Optum, [www.optum.com](http://www.optum.com)
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## Endoscopy and Polyp Surveillance (End/Polyp)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appropriate follow-up interval for normal colonoscopy in average risk patients ⁵</td>
<td>0528F</td>
<td>Recommended follow-up interval for repeat colonoscopy of at least 10 years documented in colonoscopy report</td>
</tr>
</tbody>
</table>

| Appropriate follow-up interval for normal colonoscopy in average risk patients ⁵  
Whether or not the patient aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report  
**Numerator:** Colonoscopy reports with a recommended follow-up interval for repeat colonoscopy of at least 10 years  
**Denominator:** All colonoscopy reports for patients aged 50 years and older receiving screening colonoscopy without biopsy or polypectomy  
**Exclusion(s):** Documentation of medical reason(s) for not recommending at least a 10-year follow-up interval (e.g., above average risk patient, inadequate prep)  
**Percentage** of patients aged 50 years and older receiving a screening colonoscopy without biopsy or polypectomy who had a recommended follow-up interval of at least 10 years for repeat colonoscopy documented in their colonoscopy report |

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**Footnotes**

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⁷Optum, [www.optum.com](http://www.optum.com).


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<tbody>
<tr>
<td><strong>Reporting Instructions</strong>: For patient with appropriate exclusion criteria report 0528F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surveillance Colonoscopy Interval for Patients with a History of Colonic Polyps - Avoidance of Inappropriate Use</strong></td>
<td>0529F</td>
<td>Interval of 3 or more years since patient’s last colonoscopy, documented</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp in a previous colonoscopy finding, had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who had an interval of 3 or more years since their last colonoscopy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older receiving a surveillance colonoscopy with a history of colonic polyp(s) in a previous colonoscopy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for an interval of less than 3 years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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| removal of adenomas, or last colonoscopy found greater than 10 adenomas)  
Documentation of system reason(s) for an interval of less than 3 years since the last colonoscopy (eg, unable to locate previous colonoscopy report)  
**Percentage** of patients aged 18 years and older receiving a surveillance colonoscopy, with a history of a prior colonic polyp(s) in a previous colonoscopy finding, who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report  
**Reporting Instructions:** For patient with appropriate exclusion criteria report 0529F with modifier 1P or 3P. |  |  |
| **Comprehensive Colonoscopy Documentation**  
Whether or not the final colonoscopy report for a patient aged 18 years and older included documentation of all of the following: pre-procedure risk assessment; depth of insertion; quality of the bowel prep; complete description of polyp(s) |  |  |

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</tr>
</thead>
<tbody>
<tr>
<td>found, including location of each polyp, size, number and gross morphology; and recommendations for follow-up</td>
<td>3018F</td>
<td>Pre-procedure risk assessment AND depth of insertion AND quality of the bowel prep AND complete description of polyp(s) found, including location of each polyp, size, number and gross morphology AND recommendations for follow-up in final colonoscopy report, documented</td>
</tr>
</tbody>
</table>

**Numerator:** Final colonoscopy reports that include documentation of ALL of the following:

- Pre-procedure risk assessment (eg, ASA class, Mallampati score)
- Depth of insertion (ie, to cecum or other landmark)
- Quality of the bowel prep (ie, prep was either adequate or inadequate)
- Complete description of polyp(s) found, including location of each polyp, size, number and gross morphology
- Recommendations for follow-up

**Denominator:** All final colonoscopy reports for patients aged 18 years and older

**Percentage** of final colonoscopy reports for patients aged 18 years and older that include documentation of all of the following: pre-procedure risk assessment; depth of insertion; quality of the bowel prep; complete description of polyp(s)

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<th></th>
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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
<td><strong>CPT Category II Code(s)</strong></td>
</tr>
<tr>
<td>found, including location of each polyp, size, number and gross morphology; and recommendations for follow-up</td>
<td></td>
</tr>
</tbody>
</table>

**Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P or 2P or 3P may not be used.

<table>
<thead>
<tr>
<th><strong>Epilepsy (EPI)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
<td><strong>CPT Category II Code(s)</strong></td>
</tr>
<tr>
<td>Seizure Type(s) and Current Seizure Frequency(ies)²⁸</td>
<td>1200F</td>
</tr>
</tbody>
</table>

**Numerator:** Patient visits with seizure type(s) specified and current seizure frequency for each seizure type documented in the medical record

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Footnotes

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⁸**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com)


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Epilepsy (EPI)

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong>: All visits for patients with a diagnosis of epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) (e.g., patient is unable to communicate and no informant is available) or patient reason(s) (e.g., patient and/or informant refuses to answer or comply) for not documenting seizure type(s) and current seizure frequency for each seizure type</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patient visits for patients with a diagnosis of epilepsy who had the seizure type(s) and current seizure frequency for each seizure type documented in the medical record for all visits during the measurement period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: For the patient with appropriate exclusion criteria report 1200F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Documentation of Etiology of Epilepsy of Epilepsy Syndrome**
Whether or not the visit for the patient with a diagnosis of epilepsy had etiology of epilepsy or epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic

| | 1205F |

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<tbody>
<tr>
<td><strong>Numerator:</strong> Patient visits with etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic</td>
<td></td>
<td>Etiology of epilepsy or epilepsy syndrome(s) reviewed and documented</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All visits for patients with a diagnosis of epilepsy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patient visits for patients with a diagnosis of epilepsy who had etiology of epilepsy or epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or cryptogenic</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Electroencephalogram (EEG) ordered, reviewed or requested</strong>&lt;sup&gt;8&lt;/sup&gt; Whether or not the patient with a diagnosis of epilepsy seen for an initial evaluation had at least one electroencephalogram (EEG) ordered or, if an EEG was performed previously, then results reviewed or requested</td>
<td></td>
<td></td>
</tr>
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<tr>
<td><strong>Numerator</strong>: Patients who had at least one electroencephalogram (EEG) ordered or, if an EEG was performed previously, then results reviewed or requested</td>
<td>3650F</td>
<td>Electroencephalogram (EEG) ordered, reviewed or requested</td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients with a diagnosis of epilepsy seen for an initial evaluation</td>
<td>1119F</td>
<td>Initial Evaluation for condition</td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for not ordering, reviewing results or requesting results of at least one EEG (eg patient has a serious skin condition that prevents EEG electrode adhesion); documentation of patient reason(s) for not ordering, reviewing results or requesting results of at least one EEG (eg patient refuses to cooperate); or documentation of system reason(s) for not ordering, reviewing results or requesting results of at least one EEG (eg no insurance or patient cannot pay)</td>
<td>1121F</td>
<td>Subsequent evaluation for condition</td>
</tr>
<tr>
<td><strong>Percentage of</strong> patients with the diagnosis of epilepsy seen for an initial evaluation who had at least one EEG ordered or, if an EEG was performed previously, then results reviewed or requested</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: If this measure is reported on the same claim as an E/M service for “new patient” (99201-</td>
<td></td>
<td></td>
</tr>
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<td>99205), the denominator code (1119F or 1121F) does not need to be reported If reporting an established patient code or consultation code, (99212-99215 or 99241-99245), the reporting physician should use 1119F to report initial evaluation for condition or 1121F to denote a subsequent evaluation If EEG is ordered, reviewed or requested also report 3650F. For the patient with appropriate exclusion criteria report 3650F with modifier 1P, 2P or 3P.</td>
<td>3324F</td>
<td>MRI or CT scan ordered, reviewed or requested.</td>
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**Epilepsy (EPI)**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not ordering, reviewing results or requesting results of a MRI or CT (eg diagnosis of an idiopathic epilepsy syndrome); documentation of patient reason(s) for not ordering, reviewing results or requesting results of a MRI or CT (eg patient refusal) ; or documentation of system reason(s) (for not ordering, reviewing results or requesting results of a MRI or CT (eg no insurance or patient unable to pay))</td>
<td>1121F</td>
<td>Subsequent evaluation for condition</td>
</tr>
<tr>
<td><strong>Percentage of</strong> patients with the diagnosis of epilepsy seen for an initial evaluation who had a MRI or CT (MRI Preferred) ordered or, if obtained previously, then results reviewed or requested during the measurement period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> If this measure is reported on the same claim as an E/M service for &quot;new patient&quot; (99201-99205), the denominator code (1119F or 1121F) does not need to be reported</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If reporting an established patient code or consultation code, (99212-99215 or 99241-99245), the reporting physician should use 1119F to report initial evaluation for condition or 1121F to denote a subsequent evaluation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## Epilepsy (EPI)

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</thead>
<tbody>
<tr>
<td>If MRI or CT is ordered, reviewed or requested also report 3324F. For the patient with appropriate exclusion criteria report 3324F with modifier 1P, 2P or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Querying and Counseling about Anti-Epileptic Drug (AED) Side-Effects**6  
Whether or not at the visit for the patient with a diagnosis of epilepsy the patient was queried and counseled about anti-epileptic drug (AED) side-effects and the counseling was documented in the medical record  
**Numerator:** Patient visits with patient queried and counseled about anti-epileptic drug (AED) side-effects and the counseling was documented in the medical record  
**Denominator:** All visits for patients with a diagnosis of epilepsy  
**Exclusion(s):** Documentation of medical reason(s) (eg for not querying and counseling patient about anti-epileptic drug (AED) side-effects (eg patient is NOT receiving an AED; patient is unable to communicate and no informant is available) | 6070F                  | Patient queried and counseled about anti-epileptic drug (AED) side effects |

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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of patients with a diagnosis of epilepsy who were queried and counseled about anti-epileptic drug (AED) side-effects and the counseling was documented in the medical record for all visits during the measurement period</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For the patient with appropriate exclusion criteria report 6070F with modifier 1P, including patients who are not taking an AED.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Therapy Referral Consideration for Intractable Epilepsy</strong></td>
<td><strong>5200F</strong></td>
<td><strong>Consideration of referral for a neurological evaluation of appropriateness for surgical therapy for intractable epilepsy within the past 3 years</strong></td>
</tr>
<tr>
<td><strong>Whether or not the patient with a diagnosis of intractable epilepsy was considered for referral for a neurological evaluation of appropriateness for surgical therapy and the consideration was documented in the medical record within the past 3 years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were considered for referral for a neurological evaluation of appropriateness for surgical therapy and the consideration was documented in the medical record within the past 3 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with a diagnosis of intractable epilepsy</td>
<td></td>
<td></td>
</tr>
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<tbody>
<tr>
<td><strong>Exclusion(s): None</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of patients with a diagnosis of intractable epilepsy who were considered for referral for a neurological evaluation of appropriateness for surgical therapy and the consideration was documented in the medical record within the past 3 years</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Counseling about Epilepsy Specific Safety Issues</strong></td>
<td></td>
<td>4330F</td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of epilepsy (or their caregiver(s)) was counseled about context-specific safety issues, appropriate to the patient’s age, seizure type(s) and frequency(ies), occupation and leisure activities, etc. (such as injury prevention, burns, appropriate driving restrictions or bathing) at least once a year</td>
<td></td>
<td>Counseling about epilepsy specific safety issues provided to patient (or caregiver(s))</td>
</tr>
</tbody>
</table>

### Footnotes

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</table>
| **Counseling for Women of Childbearing Potential with Epilepsy**<sup>8</sup>  
Whether or not a female of childbearing potential (12-44 years old) with a diagnosis of epilepsy was counseled about how driving restrictions or bathing) at least once a year and counseling documented in the medical record  
**Denominator:** All patients with a diagnosis of epilepsy  
**Exclusion(s):** Documentation of system reason for not counseling about context-specific safety issues (ie, caregiver is not available for the patient who is unable to comprehend counseling about safety issues)  
**Percentage of** patients with a diagnosis of epilepsy (or their caregiver(s)) who were counseled about context-specific safety issues, appropriate to the patient’s age, seizure type(s) and frequency(ies), occupation and leisure activities, etc. (eg injury prevention, burns, appropriate driving restrictions or bathing) at least once a year and documented in the medical record during the measurement period.  
**Reporting Instructions:** For the patient with appropriate exclusion criteria, report code 4330F with modifier 3P. | | |

Footnotes

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</tr>
</thead>
<tbody>
<tr>
<td>epilepsy and its treatment may affect contraception and pregnancy and the counseling was documented in the medical record.</td>
<td>4340F</td>
<td>Counseling for women of childbearing potential with epilepsy</td>
</tr>
</tbody>
</table>

**Numerator:** Female patients counseled about how epilepsy and its treatment may affect contraception and pregnancy and the counseling was documented in the medical record at least once a year

**Denominator:** All females of childbearing potential (12-44 years old) with a diagnosis of epilepsy

**Exclusion(s):** Documentation of medical reason(s) for not counseling female patient of childbearing age (12-44 years old) about how epilepsy and its treatment may affect contraception and pregnancy, (e.g. patient is surgically sterile)

**Percentage of** female patients of childbearing potential (12-44 years old) with a diagnosis of epilepsy who were counseled about how epilepsy and its treatment may affect contraception and pregnancy and the counseling was documented in the medical record during the measurement period.

**Reporting Instructions:** For the patient with appropriate exclusion criteria report 4340F with modifier 1P.
<table>
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</thead>
<tbody>
<tr>
<td><strong>Primary Open-Angle Glaucoma: Optic Nerve Evaluation</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td>2027F</td>
<td>Optic nerve head evaluation performed</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of primary open-angle glaucoma had an optic nerve head evaluation during one or more office visits within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td>Patients who have an optic nerve head evaluation during one or more office visits within 12 months</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td>Documentation of medical reason(s) for not performing an optic nerve head evaluation</td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma who have an optic nerve head evaluation during one or more office visits within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
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<th>Eye Care (EC)</th>
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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
</tr>
<tr>
<td><strong>CPT Category II Code(s)</strong></td>
</tr>
<tr>
<td>For patients with appropriate exclusion criteria, report 2027F with modifier 1P. Modifier 1P may also be used if physician is asked to report on this measure but is not the physician providing the primary management of primary open angle glaucoma.</td>
</tr>
<tr>
<td><strong>Primary Open-Angle Glaucoma: Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of primary open-angle glaucoma whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level</td>
</tr>
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<tr>
<td>Reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plan of care may include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or unable to achieve due to health system reasons, and/or referral to a specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of system reason(s) for not reducing the IOP by at least 15% from the pre-intervention level or documenting a plan of care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months</td>
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<tbody>
<tr>
<td>Reporting Instructions: Report 3284F or 3285F for each patient. If Intraocular pressure (IOP) is reduced by a value less than 15% from the pre-intervention level and there is a plan of care documented, also report 0517F. For patient with appropriate exclusion criteria, report 0517F with modifier 3P. The system reason exclusion may be used if a physician is asked to report on this measure but is not the ophthalmologist or optometrist providing the primary management for primary open-angle glaucoma.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age-Related Eye Disease Study (AREDS): AREDS Formulation Prescribed/Recommended⁵</td>
<td>4007F</td>
<td>Age-Related Eye Disease Study (AREDS) formulation prescribed or recommended</td>
</tr>
<tr>
<td>Whether or not the patient aged 50 years and older with a diagnosis of age-related macular degeneration had the AREDS formulation prescribed/recommended within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator: Patients who had the AREDS formulation prescribed/recommended within 12 months</td>
<td></td>
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<tbody>
<tr>
<td><strong>Denominator:</strong> All patients aged 50 years and older with a diagnosis of age-related macular degeneration</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not prescribing/recommending antioxidant vitamin or mineral supplements the AREDS formulation (eg, mild AMD, patient smokes, patient does not meet criteria for antioxidant vitamin or mineral supplements as outlined in the Age-Related Eye Disease Study)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had the AREDS formulation prescribed/recommended within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria, report 4007F with modifier 1P. Report 4007F with 1P modifier for patient with mild AMD. Modifier 1P may be used if physician is asked to report on this measure but is not the physician providing the primary management of AMD.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from the **Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


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<th>CPT Category II Code(s)</th>
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</thead>
<tbody>
<tr>
<td><strong>Age-Related Macular Degeneration: Dilated Macular Examination</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td>2019F</td>
<td>Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity</td>
</tr>
</tbody>
</table>

Whether or not the patient aged 50 years and older with a diagnosis of age-related macular degeneration had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

**Numerator:** Patients who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

**Denominator:** All patients aged 50 years and older with a diagnosis of age-related macular degeneration

**Exclusion(s):** Documentation of medical or patient reason(s) for not performing a dilated macular examination

**Percentage** of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

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Footnotes

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
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</thead>
</table>
| documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months  
**Reporting Instructions:** For patient with appropriate exclusion criteria, report 2019F with modifier 1P or 2P.  
Modifier 1P may also be used if physician is asked to report on this measure but is not the physician providing the primary management of AMD.  
**Numerator:** Patients who were assessed for visual functional status during one or more office visits within 12 months  
Medical record must include:  
Documentation that patient is operating well with vision or not operating well with vision based on discussion with the patient | 1055F | Visual functional status assessed |

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Eye Care (EC)

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<tbody>
<tr>
<td>Documentation of use of a standardized scale or completion of an assessment questionnaire [eg, VF-14, ADVS (Activities of Daily Vision Scale), or VFQ (Visual Function Questionnaire)]</td>
<td>1055F</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of cataract(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not assessing for visual functional status</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of cataract(s) who were assessed for visual functional status during one or more office visits within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 1055F with modifier 1P. Modifier 1P may be used if physician is asked to report on this measure but is not the physician providing the primary management for cataract(s).</td>
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Footnotes

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7. **Optum, [www.optum.com](http://www.optum.com).**

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</table>
| Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation<sup>5</sup>  
Whether or not the patient aged 18 years and older who had cataract surgery had documentation of pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation performed and documented within six months prior to the procedure  
**Numerator:** Patients who had the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation performed and documented within six months prior to the procedure  
**Denominator:** All patients aged 18 years and older who had cataract surgery  
**Exclusion(s):** Documentation of medical reason(s) for not performing the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation  
**Percentage** of patients aged 18 years and older who had cataract surgery who had documentation of pre-surgical axial length, corneal power measurement and method of intraocular power calculation. | 3073F | Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation must be performed within 12 months prior to surgery |

Footnotes

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<sup>2</sup>National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

<sup>3</sup>The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

<sup>4</sup>National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

<sup>5</sup>Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


<sup>7</sup>Optum, [www.optum.com](http://www.optum.com).


<sup>10</sup>American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

<sup>11</sup>American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

<sup>12</sup>American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

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<tr>
<td><strong>lens power calculation performed and documented within six months prior to the procedure</strong></td>
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<td></td>
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<tr>
<td><strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria, report 3073F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</strong></td>
<td>2021F</td>
<td>Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy</td>
</tr>
<tr>
<td>whether or not the patient aged 18 years and older with a diagnosis of diabetic retinopathy had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months</td>
<td></td>
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</tr>
<tr>
<td>Medical record must include: Documentation of the level of severity of retinopathy (eg background diabetic retinopathy,</td>
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### Eye Care (EC)

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<tbody>
<tr>
<td>proliferative diabetic retinopathy, nonproliferative diabetic retinopathy) AND Documentation of whether macular edema was present or absent</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of diabetic retinopathy <strong>Exclusion(s):</strong> Documentation of medical or patient reason(s) for not receiving a dilated macular or fundus examination</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria, report 2021F with modifier 1P or 2P.</td>
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</table>

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Footnotes

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4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.
5. Joint measure from [The Physician Consortium for Performance Improvement (PCPI)](https://www.thencc.org) and [National Committee on Quality Assurance (NCQA)](http://www.ncqa.org) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).
### Brief Description of Performance Measure & Source

<table>
<thead>
<tr>
<th><strong>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</strong>&lt;sup&gt;5&lt;/sup&gt;</th>
<th><strong>CPT Category II Code(s)</strong></th>
<th><strong>Code Descriptor(s)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed had documented communication to the physician who manages the ongoing care of the patient with diabetes regarding the findings of the dilated macular or fundus exam at least once within 12 months</td>
<td>5010F, 2021F</td>
<td>Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care. Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy.</td>
</tr>
</tbody>
</table>

**Modifier 1P may be used if physician is asked to report on this measure but is not the physician providing the primary management of diabetic retinopathy.**

**Numerator:** Patients with documentation, at least once within 12 months, of communication of the findings of the dilated macular or fundus exam to the physician who manages the patient’s diabetic care.

Documentation in the medical record indicating that the results of the macular or fundus exam were communicated (eg, verbally, or by letter) with the physician managing the patient’s diabetic care.

OR

Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care.

**Denominator Code:**

**5010F**

Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care.

**2021F**

Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy.

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**Footnotes**

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<tbody>
<tr>
<td>A copy of a letter in the medical record to the physician managing the patient’s diabetic care outlining the findings of the dilated macular or fundus exam.</td>
<td></td>
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</tbody>
</table>

**Denominator:** All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed.

**Exclusion(s):** Documentation of medical reason(s) for not communicating the findings of the macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

Documentation of patient reason(s) for not communicating the findings of the macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes.

**Percentage** of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes regarding the findings of the dilated macular or fundus exam at least once within 12 months.

**Reporting Instructions:**

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Footnotes

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### Brief Description of Performance Measure & Source

- **Report 2021F** for each patient who had a dilated macular or fundus exam performed meeting the denominator inclusion. Do not report 5010F without a modifier unless reporting 2021F. Also report 5010F where findings of dilated macular or fundus exam communicated to the physician managing the diabetes care; for patients with appropriate exclusion criteria, report 5010F with modifier 1P or 2P.

- Modifier 1P may be used if physician is asked to report on this measure but is not the physician providing the primary management of diabetic retinopathy.

**Primary Open-Angle Glaucoma: Counseling on Glaucoma**

Whether or not the patient aged 18 years and older with a diagnosis of primary open-angle glaucoma or his/her caregiver(s) were counseled within 12 months about 1) the potential impact of glaucoma on visual functioning and quality of life, and 2) the importance of treatment adherence.

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<tbody>
<tr>
<td><strong>Numerator:</strong> Patients or their caregiver(s) who were counseled within 12 months about 1) the potential impact of glaucoma on their visual functioning and quality of life and 2) the importance of treatment adherence</td>
<td>4174F</td>
<td>Counseling about the potential impact of glaucoma on visual functioning and quality of life, and importance of treatment adherence provided to patient and/or caregiver(s)</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not providing counseling to the patient or caregiver(s) (eg, patient has impaired mental status and no caregiver) Documentation of system reason(s) for not providing counseling to the patient or caregiver(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma or their caregiver(s) who were counseled within 12 months about 1) the potential impact of glaucoma on visual functioning and quality of life, and 2) the importance of treatment adherence</td>
<td></td>
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</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 4174F with modifier 1P or 3P. The system reason exclusion may be used if a physician is asked to report on this measure but is not the physician providing the primary management for primary open-angle glaucoma.</td>
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6. [The Society of Thoracic Surgeons](http://www.sts.org) and [National Quality Forum](http://www.qualityforum.org).
7. [Optum](http://www.optum.com).
### Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery

**Brief Description:** Whether or not the patient aged 18 years and older who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.

**Numerator:** Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery.

**Denominator:** All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the visual outcome of surgery.

**Exclusion(s):** Patients with comorbid conditions that impact the visual outcome of surgery (see measure technical specifications for a detailed list of conditions).

**Percentage:** Percentage of patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.

**CPT Category II Code(s):** 4175F

**Code Descriptor(s):** Best-corrected visual acuity of 20/40 or better (distance or near) achieved within the 90 days following cataract surgery.

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<tbody>
<tr>
<td><strong>Cataracts: Comprehensive Pre-operative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement</strong>&lt;sup&gt;5&lt;/sup&gt; Whether or not the patient aged 18 years and older who had cataract surgery with intraocular lens (IOL) placement received a comprehensive preoperative assessment of 1) dilated fundus exam, 2) axial length, corneal keratometry measurement and method of IOL power calculation; and 3) functional or medical indication(s) for surgery prior to the cataract surgery with IOL placement within 12 months prior to cataract surgery</td>
<td>0014F</td>
<td>Comprehensive preoperative assessment performed for cataract surgery with intraocular lens (IOL) placement</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who received a comprehensive preoperative assessment of 1) dilated fundus exam, 2) axial length, corneal keratometry measurement and method of IOL power calculation; and 3) functional or medical indication(s) for surgery prior to the cataract surgery with IOL placement within 12 months prior to cataract surgery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org

3The Joint Commission, https://www.jointcommission.org

4National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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7Optum, www.optum.com

8American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures or quality@aan.com


10American Gastroenterological Association (AGA), www.gastro.org/quality

11American Society of Anesthesiologists (ASA), www.asahq.org

Eye Care (EC)

<table>
<thead>
<tr>
<th>Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Denominator: All patients aged 18 years and older who had cataract surgery with IOL placement</td>
<td>2020F</td>
<td>Dilated fundus evaluation performed within 12 months prior to cataract surgery</td>
</tr>
<tr>
<td>Exclusion(s): None</td>
<td>3073F</td>
<td>Pre-surgical (cataract) axial length, corneal power measurement and method of intraocular lens power calculation documented (must be performed within twelve months prior to surgery)</td>
</tr>
<tr>
<td>Percentage of patients aged 18 years and older with a procedure of cataract surgery with IOL placement who received a comprehensive preoperative assessment of 1) dilated fundus exam, 2) axial length, corneal keratometry measurement, and method of IOL power calculation; and 3) functional or medical indication(s) for surgery prior to the cataract surgery with IOL placement within 12 months prior to cataract surgery</td>
<td>3325F</td>
<td>Preoperative assessment of functional or medical indication(s) for surgery prior to the cataract surgery with intraocular lens placement (must be performed within twelve months prior to cataract surgery)</td>
</tr>
<tr>
<td>Reporting Instructions: If all three components of the numerator are performed, report composite code 0014F for this measure. If fewer than all three components are performed, report only the code(s) for the components that have been performed. There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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7Optum, www.optum.com

8American College of Gastroenterology (AGA), www.gastro.org/quality

9American Society of Anesthesiologists (ASA), www.asahq.org

10American Society of Gastroenterology (AGA), www.gastro.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org

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| **Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement**<sup>5</sup>  
Whether or not the patient aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) and/or his/her caregiver(s) were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD  
**Numerator:** Patients and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD  
**Denominator:** All patients aged 50 years and older with a diagnosis of age-related macular degeneration  
**Exclusion(s):** Documentation of system reason(s) for not counseling the patient and/or caregiver(s) on the benefits and/or risks of the AREDS formulation  
**Percentage** of patients aged 50 years and older with a diagnosis of age-related macular degeneration and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD | 4177F | Counseling about the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of age-related macular degeneration (AMD) provided to patient and/or caregiver(s) |

**Footnotes**

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2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)
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**Reporting Instructions:**
For patient with appropriate exclusion criteria, report 4177F with modifier 3P. The system reason exclusion may be used if a physician is asked to report on this measure but is not the physician providing the primary management for age-related macular degeneration.

### Gastroesophageal Reflux Disease (GERD)

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</table>

**Assessment for Alarm Symptoms**

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# Gastroesophageal Reflux Disease (GERD)

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</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with diagnosis of GERD, seen for an initial evaluation, was assessed for the presence or absence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding</td>
<td>1070F, 1071F</td>
<td>Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; none present&lt;br&gt;Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present</td>
</tr>
</tbody>
</table>

### Footnotes

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</table>
| **Upper endoscopy for patients with alarm symptoms**<sup>5</sup>  
Whether or not the patient aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with documentation of at least one alarm symptom was either referred for upper endoscopy or had an upper endoscopy performed  
**Numerator:**  
Patients who were either referred for an upper endoscopy or had an upper endoscopy performed  
**Denominator:**  
All patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with documentation of at least one alarm symptom (involuntary weight loss, dysphagia, or GI bleeding)  
**Exclusion(s):**  
- 3130F  
- 3132F  
  - Upper gastrointestinal endoscopy performed  
  - Documentation of referral for upper gastrointestinal endoscopy | 3130F | Upper gastrointestinal endoscopy performed |
|  | 3132F | Documentation of referral for upper gastrointestinal endoscopy |

**Footnotes**

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## Gastroesophageal Reflux Disease (GERD)

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</tr>
</thead>
<tbody>
<tr>
<td>Documentation of medical, patient, or system reason(s) for not referring for or not performing an upper endoscopy</td>
<td>Denominator Codes</td>
<td>Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; none present</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with at least one alarm symptom, who were either referred for an upper endoscopy or had an upper endoscopy performed</td>
<td>1070F</td>
<td>Alarm symptoms (involuntary weight loss, dysphagia, or gastrointestinal bleeding) assessed; one or more present</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 1070F or 1071F for each patient. If patient had documentation of at least one GERD alarm symptom and had upper endoscopy performed, report 3130F or the corresponding Category I code. If patient had documentation of at least one GERD alarm symptom and was referred for upper endoscopy, report 3132F. For patient with appropriate exclusion criteria, report either 3130F or 3132F with modifier 1P, 2P or 3P.</td>
<td>1071F</td>
<td></td>
</tr>
</tbody>
</table>
**Gastroesophageal Reflux Disease (GERD)**

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<tr>
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<th>CPT Category II Code(s)</th>
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</tr>
</thead>
</table>
| **Biopsy for Barrett's Esophagus**<sup>5</sup>  
Whether or not the patient aged 18 years and older with a diagnosis of GERD or heartburn whose endoscopy report indicates a suspicion of Barrett's esophagus had a forceps esophageal biopsy performed  
**Numerator:**  
Patients who had a forceps esophageal biopsy performed  
**Denominator:**  
All patients aged 18 years and older with a diagnosis of GERD or heartburn whose endoscopy report indicates a suspicion of Barrett's esophagus  
**Exclusion(s):**  
Documentation of medical reason(s) for not performing a forceps esophageal biopsy  
**Percentage** of patients aged 18 years and older with a diagnosis of GERD or heartburn whose endoscopy report indicates a suspicion of Barrett's esophagus who had a forceps esophageal biopsy performed | 3150F | Forceps esophageal biopsy performed |

**Footnotes**

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2. **National Committee on Quality Assurance (NCQA)**<sup>2</sup>, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
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10. **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org), or quality@aan.com.

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### Gastroesophageal Reflux Disease (GERD)

#### Brief Description of Performance Measure & Source and Reporting Instructions:

**Reporting Instructions:** This measure should be reported by the physician performing the endoscopy. Report 3140F or 3141F for each patient. If endoscopy report included documentation that Barrett’s esophagus was suspected, also report 3150F if patient had esophageal biopsy performed. For patient with appropriate exclusion criteria, report 3150F with modifier 1P.

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3141F</td>
<td>Upper gastrointestinal endoscopy report indicates suspicion of Barrett’s esophagus</td>
</tr>
<tr>
<td></td>
<td>Upper gastrointestinal endoscopy report indicates no suspicion of Barrett’s esophagus</td>
</tr>
</tbody>
</table>

#### Barium Swallow – Inappropriate Use

Whether or not the patient aged 18 years and older seen for an initial evaluation of GERD did not have a Barium swallow test ordered

**Numerator:**
Patients who did not have Barium swallow test ordered

**Denominator:**
All patients aged 18 years and older seen for an initial evaluation of GERD

**Exclusion(s):**

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3142F</td>
<td>Barium swallow test ordered</td>
</tr>
</tbody>
</table>

#### Footnotes

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12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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## Gastroesophageal Reflux Disease (GERD)

### Brief Description of Performance Measure & Source and Reporting Instructions:

<table>
<thead>
<tr>
<th>Documentation of medical reason(s) for ordering a Barium swallow test</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients aged 18 years and older seen for an initial evaluation of GERD who did not have a Barium swallow test ordered</td>
<td>3200F</td>
<td>Barium swallow test not ordered</td>
</tr>
</tbody>
</table>

**Reporting Instructions:**
- If barium swallow test was ordered at initial evaluation for GERD, report 3142F. If barium swallow was not ordered at initial evaluation, report 3200F.
- If there is documentation that supports the reason for ordering a barium swallow, report 3142F with modifier 1P.

### Gastroesophageal Reflux Disease (GERD) Continuous Medication Therapy - Assessment of GERD Symptoms

Whether or not the patient aged 18 years and older with a diagnosis of GERD who has been prescribed continuous proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H2RA) therapy had an annual assessment of his/her GERD symptoms after 12 months of therapy

| 1118F | GERD symptoms assessed after 12 months of therapy |

**Footnotes**

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</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Patients who had an annual assessment of their GERD symptoms after 12 months of therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of GERD who have been prescribed continuous proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H2RA) therapy*</td>
<td>4185F</td>
<td>Continuous (12-months) therapy with proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H2RA) received</td>
</tr>
<tr>
<td>*Continuous therapy is defined as proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H2RA) therapy lasting twelve months or more to treat GERD</td>
<td>4186F</td>
<td>No continuous (12-months) therapy with either proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H2RA) received</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not assessing GERD symptoms</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with the diagnosis of GERD who have been prescribed continuous proton pump inhibitor (PPI) or histamine H2 receptor antagonist (H2RA) therapy who received an annual assessment of their GERD symptoms after 12 months of therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4185F or 4186F for each patient. If patient is receiving continuous (12-months) proton pump inhibitor (PPI) or histamine H2 receptor antagonist</td>
<td></td>
<td></td>
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6. **The Society of Thoracic Surgeons at** [www.sts.org](http://www.sts.org) and **National Quality Forum,** [www.qualityforum.org](http://www.qualityforum.org)
# Gastroesophageal Reflux Disease (GERD)

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<tr>
<td>(H2RA) therapy and has had GERD symptoms assessed annually after 12 months of therapy, report 1118F. For patient with appropriate exclusion criteria use 1118F with modifier 1P.</td>
<td></td>
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## Footnotes

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### Geriatrics (GER)

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<tbody>
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<td><strong>Medication Reconciliation</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
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</tr>
<tr>
<td>Whether or not the patient aged 65 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented</td>
<td>1111F</td>
<td>Discharge medications reconciled with the current medication list in outpatient medical record</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented</td>
<td>1110F</td>
<td>Patient discharged from an inpatient facility (eg hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 65 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s): None</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 65 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)
4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.
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### Geriatrics (GER)

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</thead>
<tbody>
<tr>
<td>discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: Report only for patients who were discharged from an inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) within the last 60 days. If there is documentation of reconciliation of discharge medications with the current medication list, report 1111F. There are no performance exclusions; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Advance Care Plan</strong>: Whether or not the patient aged 65 years and older has 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</td>
<td></td>
<td></td>
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<td><strong>CPT Category II Code(s)</strong></td>
<td><strong>Code Descriptor(s)</strong></td>
</tr>
<tr>
<td><strong>Numerator:</strong> 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</td>
<td>1123F</td>
<td>Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record</td>
</tr>
<tr>
<td>Definition: For the purposes of this measure, “documentation that patient did not wish or was not able to name a surrogate decision 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</td>
<td>1124F</td>
<td>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</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 65 years and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> 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 patient did not</td>
<td></td>
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<tr>
<td>wish or was not able to name a surrogate decision maker or provide an advance care plan</td>
<td></td>
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</table>

**Reporting Instructions**

Report 1123F or 1124F for each patient. If patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, report 1124F. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.

The reporting physician does not need to be the physician who documented or discussed advance care planning with the patient but it must be in the medical record at the time of reporting.

Note: This measure applies to all healthcare settings (eg, inpatient, 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.

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

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org).
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<tr>
<td>Whether or not the female patient aged 65 years and older was assessed for the presence or absence of urinary incontinence within 12 months <strong>Numerator</strong>: Patients who were assessed for the presence or absence of urinary incontinence within 12 months Urinary incontinence is defined as any involuntary leakage of urine <strong>Denominator</strong>: All female patients aged 65 years and older <strong>Exclusion(s)</strong>: Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence <strong>Percentage</strong> of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months <strong>Reporting Instructions</strong>: For patient with appropriate exclusion criteria, report 1090F with modifier 1P.</td>
<td>1090F</td>
<td>Presence or absence of urinary incontinence assessed</td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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<tbody>
<tr>
<td><strong>Characterization of Urinary Incontinence in Women Aged 65 Years and Older</strong></td>
<td>1091F</td>
<td>Urinary incontinence characterized (eg frequency, volume, timing, type of symptoms, how bothersome)</td>
</tr>
<tr>
<td>Whether or not the female patient aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients whose urinary incontinence was characterized (may include one or more of the following: frequency, volume, timing, type of symptoms or how bothersome to the patient) at least once within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All female patients aged 65 years and older with a diagnosis of urinary incontinence</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
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</tr>
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**Footnotes**

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</table>
| **Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older**<sup>5</sup>  
Whether or not the female patient aged 65 years and older with a diagnosis of urinary incontinence had a documented plan of care for urinary incontinence at least once within 12 months  
**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, modifications or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy  
**Exclusion(s):** None  
**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 | 0509F | Urinary incontinence plan of care documented |

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**Footnotes**

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</thead>
<tbody>
<tr>
<td><strong>Screening for Future Fall Risk</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td>1100F</td>
<td>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</td>
</tr>
<tr>
<td>Whether or not the patient aged 65 years and older was screened for future fall risk (2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong>:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical reason(s) for not screening for future fall risk (eg, patient is not ambulatory)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 65 years and older who were screened for future fall risk at least once within 12 months</td>
<td></td>
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</tr>
</tbody>
</table>

Footnotes

<sup>1</sup>Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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<sup>7</sup>Optum, [www.optum.com](http://www.optum.com).


<sup>10</sup>American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

<sup>11</sup>American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

<sup>12</sup>American College of Gastroenterology (AG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

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## Geriatrics (GER)

### Brief Description of Performance Measure & Source and Reporting Instructions:

**Reporting Instructions:** For patient with appropriate exclusion criteria, report either 1100F or 1101F with modifier 1P.

**Risk Assessment for Falls**

- Whether or not the patient aged 65 years and older with a history of falls had a risk assessment for falls completed within 12 months
- **Numerator:** Patients who had a risk assessment for falls completed within 12 months
- **Risk assessment is comprised of:**
  - Balance/gait
  - Postural blood pressure
  - Vision
  - Home fall hazards
  - Documentation on whether medications are a contributing factor or not to falls

### CPT Category II Code(s) | Code Descriptor(s)
--- | ---
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
3288F | Falls risk assessment documented

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### Footnotes

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<tr>
<td>1100F</td>
<td>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</td>
</tr>
<tr>
<td>1101F</td>
<td>Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year</td>
</tr>
</tbody>
</table>

### Brief Description of Performance Measure & Source and Reporting Instructions:

Within the past 12 months (Note: all components do not need to be completed during one patient visit)

**Definition:** A fall is defined as 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.

**See technical specifications for detailed requirements for each component**

**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)

**Exclusion(s):** Documentation of medical reason(s) for not completing a risk assessment for falls

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

**Reporting Instructions:** Report 1100F or 1101F for each patient. If patient has a history of falls (1100F) and there is a

### Footnotes

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
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<tr>
<td>risk assessment for falls, also report 3288F. For patient with appropriate exclusion criteria, report 3288F with modifier 1P.</td>
<td>0518F</td>
<td>Falls plan of care documented</td>
</tr>
</tbody>
</table>
| **Geriatrics (GER)**  
**Plan of Care for Falls**⁵  
Whether or not the patient aged 65 years and older with a history of falls had a plan of care for falls documented within 12 months  
*Plan of care must include:*  
- consideration of appropriate assistance device AND  
- balance, strength, and gait training  
**Definition:** A fall is defined as 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. | | |
| **Denominator Codes** | 1100F | Patient screened for future fall risk; documentation of two or more falls in the past year or any |

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**Footnotes**

⁵**Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

⁶**National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®)**, [www.ncqa.org](http://www.ncqa.org)

⁷**The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

⁸**National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

⁹Joint measure from **The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

¹⁰**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

¹¹**Optum**, [www.optum.com](http://www.optum.com)

¹²**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com


¹⁴**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

¹⁵**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

¹⁶**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
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<tbody>
<tr>
<td><strong>Denominator</strong>: 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) <strong>Exclusion(s)</strong>: Documentation of medical reason(s) why a plan of care is not documented <strong>Percentage</strong> of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months <strong>Reporting Instructions</strong>: Report 1100F or 1101F for each patient. If patient has a history of falls (1100F) and there is a plan of care for falls documented, also report 0518F. For patient with appropriate exclusion criteria, report 0518F with modifier 1P.</td>
<td>1101F</td>
<td>fall with injury in the past year Patient screened for future fall risk; documentation of no falls in the past year or only one fall without injury in the past year</td>
</tr>
</tbody>
</table>

Footnotes

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org

3The Joint Commission, https://www.jointcommission.org

4National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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7Optum, www.optum.com

8American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


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## Heart Failure (HF)

### Brief Description of Performance Measure & Source and Reporting Instructions:

<table>
<thead>
<tr>
<th>Measure Description</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Left Ventricular Ejection Fraction (LVEF) Assessment (Outpatient)^1 (#1)</td>
<td>3021F</td>
<td>Left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function.</td>
</tr>
<tr>
<td></td>
<td>3022F</td>
<td>Left ventricular ejection fraction (LVEF) greater than or equal to 40% or documentation as normal or mildly depressed left ventricular systolic function.</td>
</tr>
</tbody>
</table>

### Numerator:

Patients for whom the quantitative or qualitative results of a recent or prior (any time in the past) LVEF assessment documented.

### Denominator:

All patients aged 18 years and older with a diagnosis of heart failure.

---

**Footnotes**

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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 3021F OR 3022F to indicate availability of LVEF assessment result. If the patient has ever had a left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function, report 3021F. <strong>There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Left Ventricular Ejection Fraction (LVEF) Assessment (Inpatient)</strong>&lt;sup&gt;1&lt;/sup&gt; (#2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

Footnotes

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

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12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with a principal diagnosis of heart failure has a result of LVEF assessment available in hospital medical record or LVEF assessment planned after discharge</td>
<td><strong>For complete measure language with definitions, please reference the measure worksheets at <a href="http://www.physicianconsortium.org">www.physicianconsortium.org</a></strong></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with documentation in the hospital record of the results of an LVEF assessment that was performed either before arrival or during hospitalization OR documentation in the hospital record that LVEF assessment is planned for after discharge</td>
<td>3021F</td>
<td>Left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a principal discharge diagnosis of heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not documenting the results of an LVEF assessment OR that LVEF assessment is not planned for after discharge (eg,</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

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<th>Heart Failure (HF)</th>
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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>patients who expired, patients who left against medical advice, other medical reason(s))</td>
<td>3022F</td>
<td>Left ventricular ejection fraction (LVEF) greater than or equal to 40% or documentation as normal or mildly depressed left ventricular systolic function</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report this measure for each hospitalization. Report 3021F OR 3022F to indicate presence of LVEF result. If the patient has ever had a left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function, report 3021F. If LVEF result is not available, report 3019F if LVEF assessment is planned after patient is discharged from the hospital. For the patient with appropriate exclusion criteria, report 3019F, with modifier 1P. Modifier 2P or 3P may not be used.</td>
<td>3019F</td>
<td>Left ventricular ejection fraction (LVEF) assessment planned post discharge</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Symptom and Activity Assessment¹</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whether or not the patient aged 18 years and older with a diagnosis of heart failure has quantitative results of an evaluation of both current level of activity and clinical symptoms is documented at each visit</strong></td>
<td>3115F</td>
<td>Quantitative results of an evaluation of current level of activity and clinical symptoms</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td>3118F</td>
<td>New York Heart Association (NYHA) Class documented</td>
</tr>
<tr>
<td>Patient visits with quantitative results of an evaluation of both current level of activity AND clinical symptoms documented</td>
<td>3117F</td>
<td>Heart Failure disease specific structured assessment tool completed</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patient visits for those patients aged 18 years and older with a diagnosis of heart failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>♦ Documentation of medical reason(s) for not evaluating both current level of activity and clinical symptoms (eg, severe cognitive or functional impairment, other medical reason(s))</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
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</tr>
</tbody>
</table>

Footnotes

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⁷Optum, [www.optum.com](http://www.optum.com).


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For each patient aged 18 years of age and older with a diagnosis of heart failure, report 3115F or 3118F or 3117F.

For the patient with appropriate exclusion criteria, report 3115F, with modifier 1P. Modifier 2P or 3P may not be used for this measure.
Symptom Management

Whether or not the patient aged 18 years and older with a diagnosis of heart failure with quantitative results of an evaluation of both level of activity AND clinical symptoms documented which symptoms have improved or remained consistent with treatment goals OR symptoms demonstrate clinically important deterioration and have a plan of care

**For complete measure language with definitions, please reference the measure worksheets at [www.physicianconsortium.org](http://www.physicianconsortium.org)**

**Numerator:** Patient visits in which patient symptoms have improved or remained consistent with treatment goals since last assessment OR patient symptoms have demonstrated clinically important deterioration since last assessment with a documented plan of care

**Denominator:** All patient visits for those patients aged 18 years and older with a diagnosis of heart failure and with quantitative results of an evaluation of both level of activity AND clinical symptoms documented

**Exclusion(s): None**

<table>
<thead>
<tr>
<th>Denominator Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1450F</td>
</tr>
<tr>
<td>1451F</td>
</tr>
<tr>
<td>0555F</td>
</tr>
<tr>
<td>3115F</td>
</tr>
<tr>
<td>3118F</td>
</tr>
<tr>
<td>3117F</td>
</tr>
</tbody>
</table>

Symptoms improved or remained consistent with treatment goals since last assessment

Symptoms demonstrated clinically important deterioration since last assessment

Symptom management plan of care documented

Quantitative results of an evaluation of level of activity and clinical symptoms

New York Heart Association (NYHA) Class documented

Heart Failure disease specific structured assessment tool completed

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**Footnotes**

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**Reporting Instructions**: If quantitative results of an evaluation of level of activity and clinical symptoms are present, report 3115F OR 3118F OR 3117F. Otherwise, report 3119F. If symptoms improved or remained consistent with treatment goals since last assessment, report 1450F. If symptoms have demonstrated clinically important deterioration since last assessment and there is a documented plan of care, report 1451F AND 0555F.

There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.

**3119F**

No evaluation of level of activity or clinical symptoms
## Heart Failure (HF)

**Brief Description of Performance Measure & Source and Reporting Instructions:**

<table>
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<tr>
<th>Performance Measure</th>
<th>Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Patient Self-Care Education¹</td>
<td></td>
<td>4450F</td>
</tr>
</tbody>
</table>

**Patient Self-Care Education¹**

Whether or not the patient aged 18 and older with a diagnosis of heart failure was provided self-care education on three or more elements of education

**For complete measure language with definitions, please reference the measure worksheets at [www.physicianconsortium.org**

**Numerator:**

Patients who were provided with self-care education on three or more elements of education

**Denominator:**

All patients aged 18 years and older with a diagnosis of heart failure

**Exclusion(s):**

None

---

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<td></td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each patient aged 18 years and older with a diagnosis of heart failure who was provided with self-care education on three or more elements of education, report 4450F. There are no performance exclusions for this measure; modifiers 1P, or 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Back to New Measure Table</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (Outpt and Inpt Setting)**¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 and older with a diagnosis of heart failure with a current or prior LVEF &lt; 40% was prescribed beta-blocker therapy <strong>For complete measure language with definitions, please reference the measure worksheets at <a href="http://www.physicianconsortium.org">www.physicianconsortium.org</a></strong></td>
<td>4008F</td>
<td>Beta-Blocker therapy prescribed or currently being taken</td>
</tr>
</tbody>
</table>

Footnotes

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<tbody>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients who were prescribed beta-blocker therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF &lt; 40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td>Denominator Codes</td>
<td></td>
</tr>
<tr>
<td>Documentation of medical (eg, low blood pressure, fluid overload, asthma, patients recently treated with an intravenous positive inotropic agent, other medical reason(s)), patient (eg, patient declined, other patient reason(s)), or system (eg, other reason(s) attributable to the health care system) reason(s) for not prescribing beta-blocker therapy</td>
<td>3021F</td>
<td>Left ventricular ejection fraction (LVEF) &lt; 40% or documentation of moderately or severely depressed left ventricular systolic function</td>
</tr>
<tr>
<td></td>
<td>3022F</td>
<td>Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>This measure is paired with measure #7- Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

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</tr>
<tr>
<td>Dysfunction. Implementers of this measure should not use this measure without the Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction measure. Report 3021F OR 3022F to indicate LVEF result. If the patient has ever had a left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F), report 4008F if prescribed beta-blocker or if currently taking beta-blocker. For patient with appropriate exclusion criteria, report 4008F with modifier 1P, or 2P, or 3P. If ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F) AND was prescribed or currently taking beta-blocker therapy, report 4008F in addition. In the event that patient has CAD with a prior MI and LVEF &lt; 40% and was prescribed or currently taking beta-blocker therapy, report 3021F AND 4008F.</td>
</tr>
<tr>
<td><strong>CPT Category II Code(s)</strong></td>
</tr>
<tr>
<td><strong>Code Descriptor(s)</strong></td>
</tr>
</tbody>
</table>

Footnotes

1**Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2**National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3**The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4**National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

6**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)


8**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com).


10**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality).


12**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org).
## Heart Failure (HF)

### Brief Description of Performance Measure & Source and Reporting Instructions:

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4010F</td>
<td>Angiotensin converting enzyme (ACE) inhibitor or Angiotensin Receptor Blocker (ARB) therapy prescribed or currently being taken</td>
</tr>
<tr>
<td>Denominator Codes</td>
<td></td>
</tr>
<tr>
<td>3021F</td>
<td>Left ventricular ejection fraction (LVEF) &lt; 40% or documentation of moderately or severely depressed left ventricular systolic function</td>
</tr>
<tr>
<td>3022F</td>
<td>Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function</td>
</tr>
</tbody>
</table>

For patient with appropriate exclusion criteria report 4008F with modifier 1P, 2P, or 3P.

**Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting)**

Whether or not the patient aged 18 and older with a diagnosis of heart failure with a current or prior LVEF < 40% was prescribed an ACE inhibitor or ARB therapy

**For complete measure language with definitions, please reference the measure worksheets at [www.physicianconsortium.org](http://www.physicianconsortium.org)***

**Numerator:**

Patients who were prescribed ACE inhibitor or ARB therapy

**Denominator:**

<table>
<thead>
<tr>
<th>Denominator Codes</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3021F</td>
<td>Left ventricular ejection fraction (LVEF) &lt; 40% or documentation of moderately or severely depressed left ventricular systolic function</td>
</tr>
<tr>
<td>3022F</td>
<td>Left ventricular ejection fraction (LVEF) ≥ 40% or documentation as normal or mildly depressed left ventricular systolic function</td>
</tr>
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---

**Footnotes**

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2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)
4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.
5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).
## Heart Failure (HF)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF &lt; 40%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Exclusion(s):**

Documentation of medical reason(s) (eg, hypotensive patients who are at immediate risk of cardiogenic shock, hospitalized patients who have experienced marked azotemia, other medical reason(s)), patient (eg, other patient reason(s)), or system (eg, other system reason(s)) reason(s) for not prescribing ACE inhibitor or ARB therapy

**Reporting Instructions:**

This measure is paired with measure #6- Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting). Implementers of this measure should not use this measure without the Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting) measure.

---

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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### Heart Failure (HF)

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report 3021F OR 3022F to indicate LVEF result. If the patient has ever had a left ventricular ejection fraction (LVEF) less than 40% or documentation of moderately or severely depressed left ventricular systolic function (3021F), report 4010F ACE inhibitor or ARB therapy is prescribed or currently being taken. For patient with appropriate exclusion criteria, report 4010F with modifier 1P, or 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling regarding Implantable Cardioverter-Defibrillator (ICD) Implantation for Patients with Left Ventricular Systolic Dysfunction on Combination Medical Therapy¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of heart failure with a current LVEF ≤ 35% despite ACE/ARB therapy and beta-blocker therapy for 3 months was counseled regarding implantable cardioverter-defibrillator (ICD) implantation as a treatment option for the prophylaxis of sudden death</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

¹Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷Optum, [www.optum.com](http://www.optum.com)

⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)

¹²American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org)

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Last Updated June 23, 2023
## Heart Failure (HF)

### Brief Description of Performance Measure & Source and Reporting Instructions:

**For complete measure language with definitions, please reference the measure worksheets at www.physicianconsortium.org**

### Numerator:

Patients who were counseled regarding ICD implantation as a treatment option for the prophylaxis of sudden death

### Denominator:

All patients aged 18 years and older with a diagnosis of heart failure with current LVEF ≤ 35% despite ACE inhibitor/ARB and beta-blocker therapy for at least three months

### Exclusion(s):

Documentation of medical reasons for not counseling regarding ICD implantation as a treatment option for the prophylaxis of sudden death (eg, patients with an ICD or CRT-

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4470F</td>
<td>Implantable Cardioverter-Defibrillator (ICD) counseling provided</td>
</tr>
<tr>
<td>Denominator Codes</td>
<td></td>
</tr>
<tr>
<td>3055F</td>
<td>Left ventricular ejection fraction (LVEF) less than or equal to 35%</td>
</tr>
<tr>
<td>3056F</td>
<td>Left ventricular ejection fraction (LVEF) greater than 35% or no LVEF result available</td>
</tr>
<tr>
<td>4480F</td>
<td>Patient receiving ACE Inhibitor/ARB Therapy and Beta-Blocker Therapy for 3 months or longer</td>
</tr>
<tr>
<td>4481F</td>
<td>Patient receiving ACE Inhibitor/ARB Therapy and Beta-Blocker Therapy for less than 3 months or patient not</td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **Physician Consortium for Performance Improvement (PCPI)** and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


### Heart Failure (HF)

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<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions:</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>D device, multiple or significant comorbidities, limited life expectancy, other medical reason(s))</td>
<td></td>
<td>receiving ACE Inhibitor/ARB Therapy and Beta-Blocker Therapy</td>
</tr>
</tbody>
</table>

**Reporting Instructions:**

Report 3055F or 3056F to indicate current LVEF result AND report 4480F or 4481F to indicate duration of ACE/ARB therapy and beta-blocker therapy. If LVEF less than or equal to 35% (3055F) AND patient receiving ACE Inhibitor/ARB Therapy and Beta-Blocker Therapy for three months or longer (4480F), also report 4470F if Implantable Cardioverter-Defibrillator (ICD) counseling provided to patient.

For the patient with appropriate exclusion criteria, report 4470F with modifier 1P; modifier 2P or 3P may not be reported.

---

**Footnotes**

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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and [National Quality Forum](http://www.qualityforum.org)


<table>
<thead>
<tr>
<th>Hematology (HEM)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Myelodysplastic Syndrome (MDS) and Acute Leukemias-Baseline cytogenetic testing performed on bone marrow¹</td>
<td>3155F</td>
<td>Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment</td>
</tr>
</tbody>
</table>

**Footnotes**

⁠¹**Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²**National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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⁷**Optum**, [www.optum.com](http://www.optum.com)

⁸**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com


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¹¹**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

¹²**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients with a medical reason for not performing cytogenetic testing (e.g., no liquid bone marrow or fibrotic marrow), report 3155F with modifier 1P. For patients with a patient reason for not performing cytogenetic testing (e.g., at time of diagnosis receiving palliative care or not receiving treatment as defined above), report 3155F with modifier 2P. For patients with a system reason for not performing cytogenetic testing (e.g., patient previously treated by another physician at the time cytogenetic testing performed), report 3155F with modifier 3P.</td>
<td>3160F</td>
<td>Documentation of iron stores prior to initiating erythropoietin therapy</td>
</tr>
</tbody>
</table>

Myelodysplastic Syndrome (MDS)-Documentation of iron stores in patients receiving erythropoietin therapy

Whether or not the patient aged 18 years and older with a diagnosis of MDS who is receiving erythropoietin therapy had documentation of iron stores prior to initiating erythropoietin therapy

**Numerator:** Patients with documentation of iron stores prior to initiating erythropoietin therapy

Documentation includes either:

- Bone marrow examination including iron stain

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### Hematology (HEM)

**Brief Description of Performance Measure & Source and Reporting Instructions**

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serum iron measurement by ferritin or serum iron and total iron binding capacity (TIBC)</td>
<td>Denominator Codes</td>
<td>Patient receiving erythropoietin therapy</td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy</td>
<td>4090F</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy</td>
<td>4095F</td>
<td>Patient not receiving erythropoietin therapy</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reporting Instructions**: If using CPT II codes to report the denominator, report either 4090F or 4095F for each patient. Otherwise report the appropriate drug administration code and the appropriate drug code for the erythropoietin. If patient is receiving erythropoietin therapy and iron stores were documented prior to initiating erythropoietin therapy, also report 3160F. If patient was started on erythropoietin therapy under the care of another physician, is responding to erythropoietin therapy, and there is no documentation of iron stores, report 3160F with modifier 3P.

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<th>CPT Category II Code(s)</th>
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</thead>
<tbody>
<tr>
<td><strong>Multiple Myeloma: Treatment with bisphosphonates</strong>¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of multiple myeloma, not in remission, was prescribed or is receiving intravenous bisphosphonate therapy within the 12-month reporting period</td>
<td><strong>4100F</strong></td>
<td>Bisphosphonate therapy, intravenous, ordered or received</td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(For a listing of intravenous bisphosphonates that qualify for reporting 4100F please see the measure technical specifications.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for not prescribing bisphosphonates; Documentation of patient reason(s) for not prescribing bisphosphonates</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12-month reporting period</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: For patient with appropriate exclusion criteria, report 4100F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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### Chronic Lymphocytic Leukemia (CLL)-Baseline Flow Cytometry

Whether or not the patient aged 18 years and older with a diagnosis of CLL had baseline flow cytometry studies performed.

**Numerator:** Patients who had baseline flow cytometry studies performed and documented in the chart.

Baseline refers to testing that is performed at time of diagnosis or prior to initiating treatment (ie antineoplastic therapy) for that diagnosis.

**Denominator:** All patients aged 18 years and older, seen within a 12-month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL).

**Percentage** of patients aged 18 years and older, seen within a 12-month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart.

**Reporting Instructions:** Treatment may include antineoplastic therapy.

For patients with a medical reason for not performing baseline flow cytometry studies, report 3170F with modifier 1P.

For patients with a patient reason for not performing cytogenetic testing (eg, receiving palliative care or not)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3170F</td>
<td>Baseline flow cytometry studies performed at time of diagnosis or prior to initiating treatment</td>
</tr>
</tbody>
</table>

---

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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<table>
<thead>
<tr>
<th>Hematology (HEM)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>receiving treatment as defined above), report 3170F with modifier 2P. For patients with a system reason for not performing cytogenetic testing (eg, patient previously treated by another physician at the time baseline flow cytometry studies were performed), report 3170F with modifier 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hepatitis C (HEP C)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Testing for Chronic Hepatitis C: Confirmation of Hepatitis C Viremia (HCV)</strong></td>
<td>3265F</td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of hepatitis C seen for an initial evaluation had HCV RNA testing ordered or previously performed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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### Hepatitis C (HEP C)

#### Brief Description of Performance Measure & Source

**Numerator:** Patients for whom HCV RNA testing was ordered or previously performed  
**Denominator:** All patients aged 18 years and older with a diagnosis of hepatitis C seen for initial evaluation  
**Exclusion(s):** Documentation of medical or patient reason(s) for not ordering or performing HCV RNA  
**Percentage** of patients aged 18 years and older with a diagnosis of hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed

**Reporting Instructions:** If this measure is reported on the same claim as an E/M service for “new patient” (99201-99205), the denominator code (1119F or 1121F) does not need to be reported.  
If reporting an established patient code or consultation code, (99212-99215 or 99241-99245), the reporting physician should use 1119F to report initial evaluation for condition or 1121F to denote a subsequent evaluation.  
If 1119F is reported and RNA testing for Hepatitis C viremia is ordered or was previously performed and results are documented, also report 3265F. For patients with appropriate exclusion criteria report 3265F with modifier 1P or 2P.

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator Codes</td>
<td></td>
</tr>
<tr>
<td>1119F</td>
<td>Initial evaluation for condition</td>
</tr>
<tr>
<td>1121F</td>
<td>Subsequent evaluation for condition</td>
</tr>
</tbody>
</table>

**RIBONUCLEIC ACID (RNA) TESTING FOR HEPATITIS C VIREMIA ORDERED OR RESULTS DOCUMENTED**

**Footnotes**

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### Hepatitis C (HEP-C)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis C Ribonucleic Acid (RNA) Testing Before Initiating Treatment ¹</td>
<td>3218F</td>
<td>RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C</td>
</tr>
</tbody>
</table>

**Footnotes**

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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⁷Optum, [www.optum.com](http://www.optum.com).


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

¹²American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

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<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>testing was performed within 12 months prior to initiation of antiviral treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td>4150F</td>
<td>Patient receiving antiviral treatment for Hepatitis C</td>
</tr>
<tr>
<td>Report this measure only once.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 4150F or 4151F for each patient aged 18 years and older with a diagnosis of chronic Hepatitis C. If patient is receiving antiviral therapy and received RNA testing for Hepatitis C within 12 months prior to initiation of antiviral treatment, also report 3218F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the patient with appropriate exclusion criteria, report 3218F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If patient is first seen by physician after initiation of treatment, report 3218F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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6**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and [National Quality Forum](http://www.qualityforum.org).


8**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com).


10**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality).


12**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org).
## Hepatitis C (HEP-C)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **HCV Genotype Testing Prior to Treatment**  
Whether or not the patient aged 18 years and older with a diagnosis of chronic Hepatitis C, who is receiving antiviral treatment had HCV genotype testing performed prior to initiation of antiviral treatment  
**Numerator:** Patients for whom HCV genotype testing was performed prior to initiation of antiviral treatment  
**Denominator:** All patients aged 18 years and older with a diagnosis of chronic Hepatitis C who are receiving antiviral treatment  
**Exclusion(s):** None | 4151F | Patient did not start or is not receiving antiviral treatment for Hepatitis C during the measurement period |
| | 3266F | Hepatitis C genotype testing documented as performed prior to |

### Footnotes

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### Hepatitis C (HEP-C)<sup>1</sup>

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of chronic Hepatitis C who are receiving antiviral treatment for whom HCV genotype testing was performed prior to initiation of antiviral treatment</td>
<td>Denominator Codes</td>
<td>initiation of antiviral treatment for Hepatitis C</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report this measure only once. Report 4150F or 4151F for each patient aged 18 years and older with a diagnosis of chronic Hepatitis C. If patient is receiving antiviral treatment and had Hepatitis C genotype testing performed prior to initiation of antiviral treatment, also report 3266F. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td>4150F</td>
<td>Patient receiving antiviral treatment for Hepatitis C</td>
</tr>
<tr>
<td><strong>Antiviral Treatment Prescribed</strong>&lt;sup&gt;1&lt;/sup&gt; Whether or not the patient aged 18 years and older with a diagnosis of chronic Hepatitis C was prescribed peginterferon and ribavirin therapy within the 12-month reporting period</td>
<td>4151F</td>
<td>Patient did not start or not receiving antiviral treatment for Hepatitis C during the measurement period</td>
</tr>
</tbody>
</table>

---

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong>: Patients who were prescribed peginterferon and ribavirin therapy within the 12-month reporting period</td>
<td>4153F</td>
<td>Combination peginterferon and ribavirin therapy prescribed</td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with a diagnosis of chronic Hepatitis C</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for not prescribing peginterferon and ribavirin therapy (eg, patient was not a candidate for therapy, could not tolerate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of chronic Hepatitis C who were prescribed peginterferon and ribavirin therapy within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: For the patient with appropriate exclusion criteria, report 4153F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

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### Hepatitis C (HEP-C)¹

<table>
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<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Patients for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment</td>
<td>3220F</td>
<td>Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of chronic Hepatitis C who are receiving antiviral treatment</td>
<td>4150F</td>
<td>Patient receiving antiviral treatment for Hepatitis C</td>
</tr>
<tr>
<td><strong>Denominator Codes</strong></td>
<td>4151F</td>
<td>Patient did not start or is not receiving antiviral treatment for Hepatitis C</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not performing quantitative HCV RNA at 12 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not performing quantitative HCV RNA at 12 weeks</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of patients aged 18 years and older with a diagnosis of chronic Hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 4150F or 4151F for each patient aged 18 years and older with a diagnosis of chronic Hepatitis C. If the patient is receiving antiviral treatment for Hepatitis C and Hepatitis C quantitative RNA testing is documented as performed at 12 weeks from initiation of antiviral treatment, also report 3220F.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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### Hepatitis C (HEP-C)

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<thead>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patient with appropriate exclusion criteria, report 3220F with modifier 1P. <strong>Note:</strong> Technical specifications for this measure allow for testing to be completed between treatment weeks 11-13. The date the test was performed should be documented in the patient's medical record.</td>
<td></td>
<td>Hepatitis C during the measurement period</td>
</tr>
</tbody>
</table>

### Hepatitis A Vaccination

Whether or not the patient aged 18 years and older with a diagnosis of Hepatitis C received at least one injection of Hepatitis A vaccine, or has documented immunity to Hepatitis A

**Numerator:** Patients who have received at least or who have documented immunity to Hepatitis A

**Denominator:** All patients aged 18 years and older with a diagnosis of Hepatitis C

**Exclusion(s):** Documentation of medical reason(s) for not receiving at least one injection of Hepatitis A vaccine

| | 4148F | Hepatitis A vaccine injection administered or previously received |

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## Hepatitis C (HEP-C)\(^1\)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of Hepatitis C who have received at least one injection of Hepatitis A vaccine, or who have documented immunity to Hepatitis A</td>
<td>3215F</td>
<td>Patient has documented immunity to Hepatitis A</td>
</tr>
</tbody>
</table>

**Reporting Instructions:**

Report code 4148F if the patient has received at least one injection of Hepatitis A vaccine, **or** report code 3215F, if the patient has documented immunity to Hepatitis A.

For the patient with appropriate exclusion criteria, report 4148F with modifier 1P.

**Note:** If patient has previously received complete Hepatitis A vaccination series (both doses), code 4155F may be reported.

### Hepatitis B Vaccination\(^2\)

Whether or not the patient aged 18 years and older with a diagnosis of Hepatitis C received at least one injection of Hepatitis B vaccine, or has documented immunity to Hepatitis B

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4149F</td>
<td>Hepatitis B vaccine injection administered or previously received</td>
</tr>
</tbody>
</table>

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<tr>
<th>Hepatitis C (HEP-C)¹</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Patients who have received at least one injection of Hepatitis B vaccine, or who have documented immunity to Hepatitis B</td>
<td>3216F</td>
<td>Patient has documented immunity to Hepatitis B</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of Hepatitis C</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not receiving at least one injection of Hepatitis B vaccine</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of Hepatitis C who have received at least one injection of Hepatitis B vaccine, or who have documented immunity to Hepatitis B</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report code 4149F, if patient has received at least one injection of Hepatitis B vaccine, or code 3216F, if patient has documented immunity to Hepatitis B.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For the patient with appropriate exclusion criteria report, 4149F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> If patient has previously received complete Hepatitis B vaccination series (all 3 doses), code 4157F may be reported.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)


¹⁰American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org/quality).

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

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<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instruction</th>
<th>CPT Category II Code(s)</th>
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</tr>
</thead>
</table>
| **Counseling Regarding Risk of Alcohol Consumption**  
Whether or not the patient aged 18 years and older with a diagnosis of Hepatitis C was counseled about the risks of alcohol consumption at least once within the 12 month reporting period  
**Numerator:** Patients who were counseleda about the risks of alcohol use at least once in the 12 month reporting period  
**Denominator:** All patients aged 18 years and older with a diagnosis of Hepatitis C  
**Exclusion(s):** None  
**Percentage** of patients aged 18 years and older with a diagnosis of Hepatitis C who were counseled about the risks of alcohol use at least once in the 12 month reporting period | 4158F | Patient counseled about risks of alcohol use |

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1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**


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## Hepatitis C (HEP-C)¹

### Brief Description of Performance Measure & Source and Reporting Instruction

Counseling Regarding Use of Contraception Prior to Antiviral Therapy¹

Whether or not the female patient aged 18 to 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment received counseling regarding contraception prior to the initiation of treatment.

**Numerator:** Patients who were counseled regarding contraception prior to the initiation of treatment

**Denominator:** All women aged 18 to 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

**Exclusion(s):** Documentation of medical reason(s) for not counseling patient regarding contraception

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4159F</td>
<td></td>
</tr>
</tbody>
</table>

### Reporting Instructions:

There are no performance exclusions for code 4158F. Do not report modifiers 1P, 2P, or 3P with this code.

---

Footnotes

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<tr>
<th>Hepatitis C (HEP-C)*</th>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong> of female patients aged 18 to 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment who were counseled regarding contraception prior to the initiation of treatment</td>
<td></td>
<td>Counseling regarding contraception received prior to initiation of antiviral treatment</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4150F or 4151F for each patient. If patient is receiving antiviral treatment for Hepatitis C and patient received counseling regarding contraception, also report 4159F. For patient with appropriate exclusion criteria, report 4159F with modifier 1P. If patient is first seen by physician after initiation of treatment, report 3218F with modifier 1P.</td>
<td>Denominator Codes</td>
<td>Patient receiving antiviral treatment for Hepatitis C, Patient did not start or is not receiving antiviral treatment for</td>
</tr>
</tbody>
</table>

**Footnotes**

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<tbody>
<tr>
<td></td>
<td></td>
<td>hepatitis C during the measurement period</td>
</tr>
</tbody>
</table>

## HIV/AIDS (HIV)

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<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>CD4+ Cell Count⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of HIV/AIDS had a CD4+ cell count or CD4+ cell percentage performed at least once every six months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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| **HIV/AIDS (HIV)** |  |
|-------------------|---|---|
| **Brief Description of Performance Measure & Source and Reporting Instruction** | **CPT Category II Code(s)** | **Code Descriptor(s)** |
| **Numerator:** Patients who had a CD4+ cell count or CD4+ cell percentage performed at least once every six months | 3500F | CD4+ cell count or CD4+ cell percentage documented as performed |
| **Denominator:** All patients aged 6 months and older with a diagnosis of HIV/AIDS |  |
| **Exclusion(s):** None |  |
| **Percentage** of patients aged 6 months and older with a diagnosis of HIV/AIDS for whom a CD4+ cell count or CD4+ cell percentage was performed at least once every 6 months |  |
| **Reporting Instructions:** Report 3500F each time the CD4+ cell count or percentage is performed. |  |
| There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used. |  |
| Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation. |  |

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### HIV/AIDS (HIV)

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</tr>
</thead>
<tbody>
<tr>
<td>Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **HIV RNA Control for Patients After Six Months of Potent Antiretroviral Therapy** 5  
Whether or not the patient with a diagnosis of HIV/AIDS who is receiving potent antiretroviral therapy has a viral load below limits of quantification after at least 6 months of potent antiretroviral therapy OR who does not have a viral load below limits of quantification after at least 6 months of potent antiretroviral therapy and has documentation of a plan of care  
**Numerator:**  
Patients who have viral load below limits of quantification* OR patients who do not have viral load below limits of quantification AND who have a documented plan of care**  
*Limits of quantification using laboratory cutoff for reference laboratory used by that clinic or provider  
**Denominator Code**  
Patients receiving potent antiretroviral therapy for 6 months or longer | 3503F | HIV RNA viral load not below limits of quantification |
| | 3502F | HIV RNA viral load below limits of quantification |
| | 0575F | HIV RNA control plan of care, documented |
| | 4270F | |
| | 4271F | |

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### HIV/AIDS (HIV)

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</thead>
<tbody>
<tr>
<td><strong>A plan of care may include: altering the therapy regimen, reaffirming to the patient the importance of high adherence to the regimen, or reassessment of viral load at a specified future date</strong>&lt;br&gt;<strong>Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials</strong>&lt;br&gt;Note: For potent antiretroviral therapy recommendations refer to current DHHS guidelines available at <a href="http://www.aidsinfo.nih.gov/Guidelines">www.aidsinfo.nih.gov/Guidelines</a>&lt;br&gt;<strong>Denominator:</strong> All patients aged 13 years and older with a diagnosis of HIV/AIDS who have received potent antiretroviral therapy* for at least 6 months</td>
<td></td>
<td>Patient receiving potent antiretroviral therapy for less than 6 months or not receiving potent antiretroviral therapy</td>
</tr>
<tr>
<td><strong>Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS who are receiving potent antiretroviral therapy AND who have a viral load below limits of quantification after at least 6 months of potent antiretroviral therapy OR who do not have a viral load below limits of</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
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**HIV/AIDS (HIV)**

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
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</thead>
<tbody>
<tr>
<td>quantification after at least six months of potent antiretroviral therapy and have a documented plan of care during the measurement year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For all patients aged 13 years and older with a diagnosis of HIV/AIDS, report 4270F if patient has received potent antiviral therapy for at least 6 months, or 4271F if patient has received potent antiretroviral therapy for less than 6 months or is not receiving potent antiretroviral therapy. When reporting 4270F, also report 3503F if HIV RNA viral load is not below limits of quantification or 3502F if HIV RNA viral load is below limits of quantification. When reporting 3503F, also report 0575F if HIV RNA control plan is documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation.</td>
<td></td>
<td></td>
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<tbody>
<tr>
<td>Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tuberculosis (TB) Screening</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of HIV/AIDS has documentation of a tuberculosis (TB) screening test performed and results interpreted at least once since the diagnosis of HIV infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who have documentation of a tuberculosis (TB) screening test performed and results interpreted at least once since the diagnosis of HIV infection</td>
<td>3510F</td>
<td>Documentation that tuberculosis (TB) screening test performed and results interpreted</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 3 months and older with a diagnosis of HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not performing tuberculosis (TB) screening test (eg, patients with a history of positive PPD or treatment for TB); documentation</td>
<td></td>
<td></td>
</tr>
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</thead>
<tbody>
<tr>
<td>Brief Description of Performance Measure &amp; Source and Reporting Instruction</td>
<td>3510F</td>
<td>Chlamydia and gonorrhea screenings documented as performed</td>
</tr>
<tr>
<td>of patient reason for not performing TB screening test (e.g., patient declined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 3 months and older with a diagnosis of HIV/AIDS for whom there is documentation that a tuberculosis (TB) screening test was performed and results interpreted at least once since the diagnosis of HIV infection.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patient with appropriate exclusion criteria, report 3510F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit.</td>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong>: Patients who have Chlamydia and gonorrhea screenings performed at least once since the diagnosis of HIV infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 13 years and older with a diagnosis of HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of patient reason(s) for not performing Chlamydia and gonorrhea screenings (eg, patient refusal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom Chlamydia and gonorrhea screenings were performed at least once since the diagnosis of HIV infection.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: For patient with appropriate exclusion criteria, report 3511F with modifier 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit,</td>
<td></td>
<td></td>
</tr>
</tbody>
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### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

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### HIV/AIDS (HIV)

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<tr>
<td>will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sexually Transmitted Diseases – Syphilis Screening</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of HIV/AIDS has a syphilis screening performed</td>
<td>3512F</td>
<td>Syphilis screening documented as performed</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who have a syphilis screening performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 13 years and older with a diagnosis of HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of patient reason(s) for not performing a syphilis screening (eg, patient declined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom a syphilis screening was performed during the measurement year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 3512F with modifier 2P.</td>
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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

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<td>Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other Infectious Diseases – Hepatitis B Screening

Whether or not the patient with a diagnosis of HIV/AIDS has a Hepatitis B screening performed at least once since the diagnosis of HIV infection, or has documented immunity

**Numerator:** Patients who had a Hepatitis B screening performed at least once since the diagnosis of HIV infection, or who have documented immunity

**Denominator:** All patients aged 6 months and older with a diagnosis of HIV/AIDS

**Exclusion(s):** Documentation of patient reason for not performing Hepatitis B screening (e.g., patient declined)

**Percentage** of patients aged 6 months and older with a diagnosis of HIV/AIDS who had a Hepatitis B screening

<table>
<thead>
<tr>
<th></th>
<th>3513F</th>
<th>Hepatitis B screening documented as performed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3216F</td>
<td>Patient has documented immunity to Hepatitis B</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>permed at least once since the diagnosis of HIV infection, or for whom there was documented immunity.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| **Reporting Instructions:**  
  Report 3513F or 3216F for each patient with a diagnosis of HIV/AIDS. For patient with appropriate exclusion criteria, report 3513F with modifier 2P.  
  Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit. | 3514F | Hepatitis C screening documented as performed |
| | 3515F | |

### Other Infectious Diseases – Hepatitis C Screening

Whether or not the patient with a diagnosis of HIV/AIDS had a Hepatitis C screening performed at least once since the diagnosis of HIV infection, or has documented immunity

**Numerator:** Patients who had a Hepatitis C screening performed at least once since the diagnosis of HIV infection, or who have documented immunity

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
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<tbody>
<tr>
<td>3514F</td>
<td>Hepatitis C screening documented as performed</td>
</tr>
<tr>
<td>3515F</td>
<td></td>
</tr>
</tbody>
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12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All patients 13 years of age and older with a diagnosis of HIV/AIDS</td>
<td><strong>%</strong></td>
<td>Patient has documented immunity to Hepatitis C</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of patient reason for not performing Hepatitis C screening (eg, patient refusal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients 13 years of age and older with a diagnosis of HIV/AIDS who had a Hepatitis C screening performed at least once since the diagnosis of HIV infection, or for whom there was documented immunity.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 3514F or 3515F for each patient with a diagnosis of HIV/AIDS. For patient with appropriate exclusion criteria, report 3514F with modifier 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit.</td>
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<tbody>
<tr>
<td><strong>Influenza Immunization</strong></td>
<td>4274F</td>
<td>Influenza immunization administered or previously received</td>
</tr>
</tbody>
</table>

**Numerator:** Patients administered or documented to have previously received an influenza immunization during the current influenza season

**Denominator:** All patients age 6 months and older with a diagnosis of HIV/AIDS

**Exclusion(s):** Documentation of medical reason for patient not receiving an influenza immunization (e.g., patient allergic history, potential adverse drug interaction); documentation of patient reason for patient not receiving influenza immunization (e.g., patient refusal); documentation of system reason for

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</thead>
<tbody>
<tr>
<td>patient not receiving an influenza immunization (e.g., vaccine unavailable)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients age 6 months and older with a diagnosis of HIV/AIDS who were administered or documented to have previously received an influenza immunization during the current influenza season.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 4274F with modifier 1P, 2P or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit.</td>
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</table>

**Pneumococcal Immunization**

Whether or not the patient with a diagnosis of HIV/AIDS was administered or documented to have previously received a...

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# HIV/AIDS (HIV)

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<tbody>
<tr>
<td>Pneumococcal vaccine at least once since the diagnosis of HIV infection</td>
<td>4040F</td>
<td>Pneumococcal vaccine administered or previously received</td>
</tr>
</tbody>
</table>

### Reporting Instructions:

**Numerator**: Patients administered or previously received a pneumococcal vaccine at least once since the diagnosis of HIV infection

**Denominator**: All patients aged 2 years and older with a diagnosis of HIV/AIDS

**Exclusion(s)**: Documentation of medical reason for patient not receiving a pneumococcal vaccine (e.g., patient allergic history, potential adverse drug interaction); documentation of patient reason for patient not receiving a pneumococcal vaccine (e.g., patient declined)

**Percentage** of patients aged 2 years and older with a diagnosis of HIV/AIDS who were administered or documented to have previously received a pneumococcal vaccine at least once since the diagnosis of HIV infection.

### Footnotes

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<tbody>
<tr>
<td>For patient with appropriate exclusion criteria, report 4040F with modifier 1P.</td>
<td>4191F</td>
<td>Hepatitis B vaccine injection administered or previously received</td>
</tr>
<tr>
<td>Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit.</td>
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<tr>
<td><strong>Hepatitis B Vaccination</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of HIV/AIDS has ever received at least one injection of Hepatitis B vaccine, or who has documented immunity</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who have ever received at least one injection of Hepatitis B vaccine or who have documented immunity</td>
<td>4191F</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 6 months and older with a diagnosis of HIV/AIDS</td>
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<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for patient not receiving at least one inject of Hepatitis B vaccine (e.g., patient has documented HBV infection); documentation of patient reason(s) for patient not receiving at least one injection of Hepatitis B vaccine (e.g., patient refusal)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 6 months and older with a diagnosis of HIV/AIDS who have ever received at least one injection of Hepatitis B vaccine, or who have documented immunity during the measurement year.</td>
<td>3216F</td>
<td>Patient has documented immunity to Hepatitis B</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4191F or 3216F for each patient with HIV/AIDS. For patient with appropriate exclusion criteria, report 4191F with modifier 1P or 2P. Note: If patient has previously received complete Hepatitis B vaccination series (all 3 doses), code 4157F may be reported. Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit,</td>
<td></td>
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**HIV/AIDS (HIV)**

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<td>will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
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</tr>
</tbody>
</table>

**Screening for Injection Drug Use**

Whether or not the patient with a diagnosis of HIV/AIDS was screened for injection drug use at least once within 12 months

**Numerator:** Patients who were screened* for injection drug use at least once within 12 months

*Screening is defined as documentation that a discussion regarding injection drug use took place, or documentation that a standardized written or verbal tool for assessing injection drug use was used

**Denominator:** All patients aged 13 years and older with a diagnosis of HIV/AIDS

Footnotes

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<tbody>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 13 years and older with a diagnosis of HIV/AIDS who were screened for injection drug use at least once within 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to the measure specifications for a definition of medical visit.</td>
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3**The Joint Commission**,[https://www.jointcommission.org](https://www.jointcommission.org)

4**National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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10**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality).


12**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org).

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### HIV/AIDS (HIV)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening for High Risk Sexual Behaviors</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td>4293F</td>
<td>Patient screened for high risk sexual behavior</td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of HIV/AIDS was screened for high-risk sexual behaviors at least once within 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were screened* for high-risk sexual behaviors at least once within 12 months.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Screening is defined as documentation that a discussion regarding injection drug use took place, or documentation that a standardized written or verbal tool for assessing injection drug use was used</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients 13 years of age and older with a diagnosis of HIV/AIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients 13 years of age and older with a diagnosis of HIV/AIDS who were screened for high-risk sexual behaviors at least once within 12 months.</td>
<td></td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td><strong>Pneumocystis jiroveci pneumonia (PCP) Prophylaxis – Adults and Children ≥6 Years</strong></td>
<td>4280F</td>
<td>Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count or percentage</td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of HIV/AIDS and a CD4+ cell count &lt;200 cells/mm³ had pneumocystis jiroveci pneumonia (PCP) prophylaxis prescribed within 3 months of low CD4+ cell count</td>
<td>3494F</td>
<td>CD4+ cell count &lt;200 cells/mm³</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who had pneumocystis jiroveci pneumonia (PCP) prophylaxis prescribed within 3 months of low CD4+ cell count</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used. Note: Patients who have at least two medical visits during the measurement year, with at least 60 days between each visit, will be included in the measure calculation. Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
<td></td>
</tr>
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<tbody>
<tr>
<td><strong>Denominator:</strong> All patients aged 6 years and older with a diagnosis of HIV/AIDS whose CD4+ cell count &lt;200 cells/mm3</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason for not prescribing PCP prophylaxis (ie, patient’s CD4+ cell count ≥200 cells/mm3 within 3 months after CD4+ cell count &lt;200 cells/mm3, indicating that the patient’s CD4+ levels are within an acceptable range and the patient does not require PCP prophylaxis)</td>
<td>3495F</td>
<td>CD4+ cell count 200 – 499 cells/mm3</td>
</tr>
<tr>
<td><strong>Percentage of patients aged 6 years and older with a diagnosis of HIV/AIDS and a CD4+ cell count &lt;200 cells/mm3 for whom pneumocystis jiroveci pneumonia (PCP) prophylaxis was prescribed within 3 months of low CD4+ cell count.</strong></td>
<td>3496F</td>
<td>CD4+ cell count ≥500 cells/mm3</td>
</tr>
</tbody>
</table>

**Reporting Instructions:**

For all patients aged 6 years and older with a diagnosis of HIV/AIDS, report 3494F, 3495F or 3496F each time a CD4+ cell count is performed.

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<tbody>
<tr>
<td>When reporting 3494F, also report if pneumocystis jiroveci pneumonia (PCP) prophylaxis is prescribed within 3 months of low CD4+ cell count. For patient with appropriate exclusion criterion (a subsequent CD4+ cell count ≥200 cells/mm³ within 3 months after a CD4+ cell count &lt;200 cells/mm³), report 4280F with modifier 1P. Note: It is anticipated that the measure will be reported by the physician providing ongoing HIV care. Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumocystis jiroveci pneumonia (PCP) Prophylaxis – Children 1–5 Years&lt;sup&gt;5&lt;/sup&gt; Whether or not the patient with a diagnosis of HIV/AIDS and a CD4+ cell count &lt;500 cells/mm³ or a CD4+ cell percentage &lt;15% had pneumocystis jiroveci pneumonia (PCP) prophylaxis prescribed within 3 months of low CD4+ cell count.</td>
<td>4280F</td>
<td>Pneumocystis jiroveci pneumonia prophylaxis prescribed within 3 months of low CD4+ cell count.</td>
</tr>
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</table>

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<tbody>
<tr>
<td>prescribed within 3 months of low CD4+ cell count or percentage <strong>Numerator:</strong> Patients who had pneumocystis jiroveci pneumonia (PCP) prophylaxis prescribed within 3 months of low CD4+ cell count or percentage <strong>Denominator:</strong> All patients aged 1–5 years with a diagnosis of HIV/AIDS whose CD4+ cell count &lt;500 cells/mm3 or CD4+ cell percentage &lt;15% <strong>Exclusion(s):</strong> Documentation of medical reason for not prescribing PCP prophylaxis (i.e., patient’s CD4+ cell count ≥500 cells/mm3 or CD4+ cell percentage ≥15% within 3 months after CD4+ cell count &lt;500 cells/mm3 or CD4+ cell percentage &lt;15%, indicating that the patient’s CD4+ levels are within an acceptable range and the patient does not require PCP prophylaxis) <strong>Percentage</strong> of patients aged 1–5 years with a diagnosis of HIV/AIDS and a CD4+ cell count &lt;500 cells/mm3 or CD4+ cell percentage &lt;15% for whom pneumocystis jiroveci pneumonia prescribed within 3 months of low CD4+ cell count or percentage</td>
<td>Denominator Codes</td>
<td>CD4+ cell count &lt;200 cells/mm3</td>
</tr>
<tr>
<td>3495F</td>
<td>months of low CD4+ cell count or percentage</td>
<td></td>
</tr>
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<tbody>
<tr>
<td>(PCP) prophylaxis was prescribed within 3 months of low CD4+ cell count or percentage</td>
<td>3496F</td>
<td>CD4+ cell count 200 – 499 cells/mm3</td>
</tr>
<tr>
<td></td>
<td>3497F</td>
<td>CD4+ cell count ≥500 cells/mm3</td>
</tr>
<tr>
<td></td>
<td>3498F</td>
<td>CD4+ cell percentage &lt;15%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>CD4+ cell percentage ≥15%</td>
</tr>
</tbody>
</table>

**Reporting Instructions:**

For all patients aged 1–5 years with a diagnosis of HIV/AIDS, report 3494F, 3495F, 3496F, 3497F or 3498F each time the patient’s CD4+ cell count or percentage is performed.

When reporting 3494F, 3495F or 3497F, also report 4280F if pneumocystis jiroveci pneumonia (PCP) prophylaxis is prescribed within 3 months of low CD4+ cell count or percentage.

For patient with appropriate exclusion criterion (a subsequent CD4+ cell count ≥500 cells/mm3 or CD4+ cell percentage ≥15% within 3 months after a CD4+ cell count <500 cells/mm3 or CD4+ cell percentage <15%), report 4280F with modifier 1P.

Note: It is anticipated that the measure will be reported by the physician providing ongoing HIV care.

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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)


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<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instruction</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pneumocystis jiroveci pneumonia (PCP) Prophylaxis – Infants ≥6 Weeks to &lt;12 Months</strong> 5</td>
<td>4279F</td>
<td>Pneumocystis jiroveci pneumonia prophylaxis prescribed</td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of HIV/AIDS or who is HIV indeterminate had pneumocystis jiroveci pneumonia (PCP) prophylaxis prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were prescribed pneumocystis jiroveci pneumonia (PCP) prophylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged ≥6 weeks and &lt;12 months with a diagnosis of HIV/AIDS or who are HIV indeterminate*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*For the purposes of this measure, HIV indeterminate is defined as infants of undetermined HIV status born of HIV-infected mothers as determined by medical record review</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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7**Optum, [www.optum.com](http://www.optum.com).**

8**American Academy of Neurology. [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**


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<tbody>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td>Denominator Codes</td>
<td>HIV indeterminate (infants of undetermined HIV status born of HIV-infected mothers)</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged ≥6 weeks to &lt;12 months with a diagnosis of HIV/AIDS or who are HIV indeterminate for whom pneumocystis jiroveci pneumonia (PCP) prophylaxis was prescribed</td>
<td>3491F</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patients ≥6 weeks to &lt;12 months diagnosed with HIV (using ICD-9 codes) and prescribed PCP prophylaxis, report 4279F. For patients ≥6 weeks to &lt;12 months who are HIV indeterminate (infants born of HIV-infected mothers), report 3491F. If pneumocystis jiroveci pneumonia (PCP) prophylaxis is prescribed, also report 4279F. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used. It is anticipated that this measure will be reported by the physician providing ongoing HIV care. Refer to the measure</td>
<td></td>
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<tbody>
<tr>
<td>specifications for a definition of medical visit and other requirements for inclusion in measure calculation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adolescent and Adult Patients with HIV/AIDS who are Prescribed Potent Antiretroviral Therapy</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of HIV/AIDS and:</td>
<td>4276F</td>
<td>Potent antiretroviral therapy prescribed</td>
</tr>
<tr>
<td>• nadir CD4+ cell count &lt;350 cells/mm³, OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• a history of an AIDS-defining condition, OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• is pregnant, had potent antiretroviral therapy prescribed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were prescribed potent antiretroviral therapy*</td>
<td></td>
<td></td>
</tr>
</tbody>
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Last Updated June 23, 2023
**HIV/AIDS (HIV)**

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<tbody>
<tr>
<td><em>Potent antiretroviral therapy is described as any antiretroviral therapy that has demonstrated optimal efficacy and results in durable suppression of HIV as shown by prior clinical trials</em></td>
<td>Denominator Codes</td>
<td>History of nadir CD4+ cell count &lt;350 cells/mm³</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td>History of AIDS-defining condition</td>
</tr>
<tr>
<td>• All patients aged 13 years and older with a diagnosis of HIV/AIDS who have a history of a nadir** CD4+ cell count &lt;350 cells/mm³; OR</td>
<td>3492F</td>
<td>No history of nadir CD4+ cell count &lt;350 cells/mm³ AND no history of AIDS-defining condition</td>
</tr>
<tr>
<td>• All patients aged 13 years and older with a diagnosis of HIV/AIDS who have a history of an AIDS-defining condition***, regardless of CD4+ cell count; OR</td>
<td>3490F</td>
<td></td>
</tr>
<tr>
<td>• All patients with a diagnosis of HIV/AIDS who are pregnant, regardless of CD4+ cell count or age</td>
<td>3493F</td>
<td></td>
</tr>
<tr>
<td><strong>Nadir (lowest ever) CD4+ cell count may be the present count</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>***For AIDS-defining conditions refer to measure specification</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
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**Percentage** of patients with a diagnosis of HIV/AIDS: aged 13 years and older who have a history of a nadir CD4+ count <350 cells/mm³

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); **and American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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<table>
<thead>
<tr>
<th>HIV/AIDS (HIV)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Description of Performance Measure &amp; Source and Reporting Instruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cells/mm3; aged 13 years and older who have a history of an AIDS-defining condition, regardless of CD4+ cell count; or who are pregnant, regardless of CD4+ cell count or age, who were prescribed potent antiretroviral therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patients diagnosed with HIV/AIDS who are pregnant (using ICD-9 codes) and prescribed potent antiretroviral therapy (ART), report 4276F. For patients aged 13 years and older diagnosed with HIV/AIDS and a history of a nadir CD4+ cell count &lt;350 cells/mm3, report 3492F. If potent ART is prescribed, also report 4276F. For patients aged 13 years and older diagnosed with HIV/AIDS and a history of an AIDS-defining condition, report 3490F. If potent ART is prescribed, also report 4276F. For patients aged 13 years and older diagnosed with HIV/AIDS and no history of a nadir CD4+ cell count &lt;350 cells/mm3 AND no history of an AIDS-defining condition, report 3493F.</td>
<td></td>
<td></td>
</tr>
</tbody>
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Footnotes

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7Optum, www.optum.com

8American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


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<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instruction</strong></td>
<td><strong>CPT Category II Code(s)</strong></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
</tr>
<tr>
<td>Note: It is anticipated that the measure will be reported by the physician providing ongoing HIV care.</td>
<td></td>
</tr>
<tr>
<td>Refer to the measure specifications for a definition of medical visit.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hypertension</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source</strong></td>
<td><strong>CPT Category II Code(s)</strong></td>
</tr>
<tr>
<td><strong>Blood Pressure Control</strong>**</td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of hypertension has a blood pressure reading less than 140 mm Hg systolic and less than 90 mm Hg diastolic OR a blood pressure reading greater than or equal to 140 mm Hg systolic and greater than or equal to 90 mm Hg diastolic.</td>
<td></td>
</tr>
</tbody>
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6The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7Optum, [www.optum.com](http://www.optum.com)

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3074F</td>
<td>Most recent systolic blood pressure &lt; 130 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3075F</td>
<td>Most recent systolic blood pressure 130 to 139 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3077F</td>
<td>Most recent systolic blood pressure ≥ 140 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3078F</td>
<td>Most recent diastolic blood pressure &lt; 80 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3079F</td>
<td>Most recent diastolic blood pressure 80 – 89 mm Hg</td>
</tr>
<tr>
<td></td>
<td>3080F</td>
<td>Most recent diastolic blood pressure ≥ 90 mm Hg</td>
</tr>
<tr>
<td></td>
<td>4145F</td>
<td>Most recent systolic blood pressure &lt; 130 mm Hg</td>
</tr>
</tbody>
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7. [Optum](http://www.optum.com).


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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>reason(s) for not prescribing 2 or more anti-hypertensive medications</td>
<td>4145F</td>
<td>Two or more anti-hypertensive agents</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For the systolic blood pressure value, report</td>
<td></td>
<td>taken</td>
</tr>
<tr>
<td>one of the three systolic codes; for the diastolic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>blood pressure value, report one of the three diastolic codes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If 3077F or 3080F are reported AND two or more anti-hypertensive agents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>are prescribed or currently taking, also report 4145F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patient with appropriate exclusion criteria report 4145F with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inflammatory Bowel Disease (IBD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IBD Preventive Care: Corticosteroid Sparing Therapy(^\text{10})</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>Whether or not patient aged 18 years and older with a diagnosis of inflammatory bowel disease who has been managed by corticosteroid* greater than or equal to 10mg/day for 60 or greater consecutive days was prescribed corticosteroid sparing therapy in the last measurement year.</td>
<td>4142F</td>
<td>Corticosteroid sparing therapy prescribed</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients managed with corticosteroids* greater than or equal to 10mg/day for 60 or greater consecutive days AND prescribed a corticosteroid sparing therapy (e.g. thiopurines, methotrexate, or anti-TNF agents).</td>
<td>3750F</td>
<td>Patient not receiving dose of corticosteroids greater than or equal to 10mg/day for 60 or greater consecutive days</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients aged 18 years and older with a diagnosis of inflammatory bowel disease.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical reason(s) for not treating with corticosteroid sparing therapy (e.g., benefits of continuing steroid therapy outweigh the risk of weaning patient off)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>steroids, initiating steroid sparing therapy or patient refuses to initiate steroid sparing therapy).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patients with appropriate exclusion criteria, report code 4142F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Prednisone equivalents can be determined using the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IBD Preventive Care: Corticosteroid Related Iatrogenic Injury –Bone Loss Assessment</strong>&lt;sup&gt;10&lt;/sup&gt;</td>
<td>3096F</td>
<td>Central Dual-energy X-Ray Absorptiometry (DXA) ordered</td>
</tr>
<tr>
<td>Whether or not patient aged 18 years and older with a diagnosis of inflammatory bowel disease who has received dose of corticosteroids greater than or equal to 10 mg/day for</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>60 or greater consecutive days was assessed for risk of bone loss once per reporting year.</td>
<td>3095F</td>
<td>Dual-energy X-Ray Absorptiometry (DXA) results documented</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who have received dose of corticosteroids* greater than or equal to 10mg/day for 60 or greater consecutive days who were assessed** for risk of bone loss.</td>
<td>4005F</td>
<td>Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of inflammatory bowel disease.</td>
<td>3750F</td>
<td>Patient not receiving dose of corticosteroids greater than or equal to 10mg/day* for 60 or greater consecutive days</td>
</tr>
</tbody>
</table>

**Exclusion(s):** None

*Prednisone equivalents can be determined using the following:

1 mg of prednisone = 1 mg of prednisolone; 5 mg of cortisone; 4 mg of hydrocortisone; 0.8 mg of triamcinolone; 0.8 mg of methylprednisolone; 0.15 mg of dexamethasone; 0.15 mg of betamethasone

** Documentation of an assessment for risk of bone loss has been performed or ordered includes central DXA

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<tbody>
<tr>
<td>measurement ordered or performed or pharmacologic therapy prescribed within 12 months.</td>
<td>4035F</td>
<td>Influenza immunization recommended</td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td>4037F</td>
<td>Influenza immunization ordered or administered</td>
</tr>
<tr>
<td>There are no exclusions for this measure; modifiers 1P, 2P, and 3P may not be used for this measure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Back to IBD Measure Table</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IBD Preventive Care: Influenza Immunization10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not patient aged 18 years and older with inflammatory bowel disease had influenza immunization recommended, administered or had previously received influenza immunization during the reporting year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients for whom influenza immunization was recommended, administered, or previously received.</td>
<td></td>
<td></td>
</tr>
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<tbody>
<tr>
<td>Denominator: All patients aged 18 years and older with a diagnosis of inflammatory bowel disease.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s): Documentation of medical reason(s) (eg, patient allergic reaction, potential adverse drug reaction), patient reasons (eg, patient refusal), systems reasons (eg, vaccine not available) for not recommending, administering or having previously received influenza immunization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: For patients with appropriate exclusion criteria, report code 4037F or 4035F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To report previous administration of influenza vaccine, report 4037F with modifier 1P.</td>
<td></td>
</tr>
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</table>
| **Assessment of Hepatitis B status before initiating anti-TNF therapy**<sup>10</sup> | 3216F  
4149F  
3517F  
6150F | Patient has documented immunity to Hepatitis  
Hepatitis B vaccine injection administered or previously received  
Hepatitis B Virus (HBV) status assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy.  
Patient not receiving a first course of anti-TNF (tumor necrosis factor) therapy |
| Whether or not patients aged 18 years and older with a diagnosis of inflammatory bowel disease (IBD) had Hepatitis B Virus (HBV) status assessed and results interpreted within one year prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy. | | |

*Assessed by one of the following:

- 87340: HBsAG
- 87341: HBsAG neutralization
- 86704: HBcAb, total
- 86705: HBcAB, IgM

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<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>86706: HBsAB</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Denominator:** All patients aged 18 years and older with a diagnosis of inflammatory bowel disease.

**Exclusion(s):**
Documentation of medical reason(s) (e.g., potential drug interaction, potential for allergic reaction) or patient reason(s) (e.g., patient declined) for not assessing for Hepatitis B Virus (HBV) status within one year prior to first course of anti-TNF therapy.

**Reporting Instructions:**
For patients with appropriate exclusion criteria, report code 3517F with modifier 1P or 2P.

**IBD: Testing for latent TB before initiating anti-TNF therapy**
Whether or not patients aged 18 years and older with a diagnosis of inflammatory bowel disease for whom a tuberculosis (TB) screening was performed and results

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Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and [National Quality Forum](http://www.qualityforum.org)


10. **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org) or [quality@aan.com](mailto:quality@aan.com).


## Inflammatory Bowel Disease (IBD)

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</tr>
</thead>
<tbody>
<tr>
<td>interpreted within 6 months prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy. <strong>Numerator:</strong> Patients for whom a TB screening was performed and results interpreted, within six months prior to receiving a first course of anti-TNF (tumor necrosis factor) therapy. <strong>Denominator:</strong> All patients aged 18 years and older with a diagnosis of inflammatory bowel disease. <strong>Exclusion(s):</strong> Documentation of medical reason(s) (eg, patient positive for TB and documentation of past treatment; patient recently completed course of anti-TB therapy) or patient reason(s) (eg, patient declined) for not screening for TB within six months prior to first course of anti-TNF therapy. <strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria, report code 3510F with modifier 1P or 2P.</td>
<td>3510F</td>
<td>Documentation that Tuberculosis (TB) screening test performed and results interpreted</td>
</tr>
<tr>
<td></td>
<td>6150F</td>
<td>Patient not receiving a first course of anti-TNF (tumor necrosis factor) therapy</td>
</tr>
</tbody>
</table>

### Footnotes

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Inflammatory Bowel Disease (IBD)

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</tr>
</thead>
</table>
| **Prophylaxis for Venous Thromboembolism-Inpatient measure**<sup>10</sup>  
Whether or not a patient aged 18 years and older with a diagnosis of inflammatory bowel disease (IBD) hospitalized for any reason received prophylaxis<sup>*</sup> for venous thromboembolism prevention.  
**Numerator:**  
Patients who receive prophylaxis<sup>*</sup> for venous thromboembolism prevention.  
*Definition: For purposes of this measure, DVT prophylaxis can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), intravenous heparin, low-dose subcutaneous heparin, or intermittent pneumatic compression devices when pharmacological prophylaxis is contraindicated. Mechanical prophylaxis does not include anti-embolism stockings such as TED hose. (See category II code 4070F)* | 4069F | Venous thromboembolism (VTE) prophylaxis received |

Footnotes

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### Inflammatory Bowel Disease (IBD)

#### Brief Description of Performance Measure & Source

| Denominator: | All patients aged 18 years and older with a diagnosis of IBD (inflammatory bowel disease) hospitalized for any reason. |
| Exclusion(s): | None |
| Reporting Instructions: | There are no exclusions for this measure; modifiers 1P, 2P, and 3P may not be reported for this measure. |

#### Type, anatomic location, and activity assessed<sup>10</sup>

Whether or not a patient 18 years and older with a diagnosis of inflammatory bowel disease was assessed for disease type, anatomic location and activity, at least once during the reporting year.

**Numerator:**

Patients with documented assessment of:

- Type of Inflammatory Bowel Disease (Crohn’s, Ulcerative Colitis or IBD-unclassified);

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</thead>
</table>
| b. Anatomic location of disease based on current or historical endoscopic and/or radiologic data;  
c. Luminal Disease activity (quiescent, mild, moderate, severe), and presence of extraintestinal manifestations | 1052F | Type, anatomic location and activity all assessed |

**Denominator:** All patients aged 18 years and older with a diagnosis of inflammatory bowel disease.

**Exclusion(s):**

Documentation of patient reason(s) for not performing assessment (e.g., patient refuses endoscopic and/or radiologic assessment)

**Reporting Instruction:**

For patients with appropriate exclusion criteria report code 1052F with modifier 2P.

### Pneumococcal Immunization

Whether or not patient aged 18 years and older with a diagnosis of inflammatory bowel disease received

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7. [Optum](https://www.optum.com).

8. [American Academy of Neurology](https://www.aan.com/practice/neuromuscular-quality-measures), [www.aan.com](http://www.aan.com) or [quality@aan.com](mailto:quality@aan.com).


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Last Updated June 23, 2023
### Inflammatory Bowel Disease (IBD)

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</tr>
</thead>
<tbody>
<tr>
<td>pneumococcal vaccination administered or previously received</td>
<td>4040F</td>
<td>Pneumococcal vaccine administered or previously received</td>
</tr>
</tbody>
</table>

**Numerator:**
Patients for whom pneumococcal vaccination was administered or previously received.

**Denominator:**
All patients aged 18 years and older with a diagnosis of inflammatory bowel disease.

**Exclusion(s):**
Documentation of medical (eg, patient allergic reaction, potential adverse drug reaction), and patient (eg, patient refusal) reasons for not administering or previously receiving pneumococcal vaccination

**Reporting Instructions:**
For patients with appropriate exclusion criteria, report code 4040F with modifier 1P or 2P.

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12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
<table>
<thead>
<tr>
<th>Inflammatory Bowel Disease (IBD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
</tr>
<tr>
<td>Testing for <em>Clostridium difficile</em> - Inpatient Measure&lt;sup&gt;10&lt;/sup&gt;</td>
</tr>
<tr>
<td>Whether or not patient aged 18 years and older with a diagnosis of inflammatory bowel disease hospitalized (for any reason) who has refractory diarrhea at the time of hospitalization or who develops diarrhea during hospitalization is tested for <em>Clostridium difficile</em>.</td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
</tr>
<tr>
<td>Patients who are tested for <em>Clostridium difficile</em>.</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
</tr>
<tr>
<td>All patients with aged 18 years and older with a diagnosis of inflammatory bowel disease hospitalized (for any reason)</td>
</tr>
</tbody>
</table>

Footnotes

<sup>1</sup>Physician Consortium for Performance Improvement®(PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement<sup>®</sup> (PCPI), see the appropriate Payor website.

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<sup>7</sup>Optum, [www.optum.com](http://www.optum.com).


<sup>10</sup>American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

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<sup>12</sup>American College of Gastroenterology (AG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
## Inflammatory Bowel Disease (IBD)

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</thead>
<tbody>
<tr>
<td>who have refractory diarrhea at the time of hospitalization or who develop diarrhea during hospitalization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Documentation of medical reason(s) for not testing for <em>Clostridium difficile</em> (eg, testing completed within 2 weeks of admission to hospital or patient had resection of colon).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patients with appropriate exclusion criteria, report code 3520F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Tobacco Use: Screening &amp; Cessation Intervention</strong>&lt;sup&gt;10&lt;/sup&gt;</td>
<td>4004F, 1036F</td>
<td>Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user.</td>
</tr>
<tr>
<td>Whether or not patient aged 18 years and older with a diagnosis of inflammatory bowel disease was screened for tobacco use at least once during the one-year measurement period AND who received cessation counseling intervention if identified as a tobacco user.</td>
<td></td>
<td>Current tobacco non-user</td>
</tr>
</tbody>
</table>

### Footnotes

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## Inflammatory Bowel Disease (IBD)

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</tr>
</thead>
<tbody>
<tr>
<td>Patients who were screened for tobacco use* at least once during the one-year measurement period AND who received tobacco cessation counseling intervention** if identified as a tobacco user</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Includes use of any type of tobacco</td>
<td></td>
<td></td>
</tr>
<tr>
<td>** Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients aged 18 years and older with a diagnosis of inflammatory bowel disease.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Reporting Instructions

Footnotes

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Inflammatory Bowel Disease (IBD)

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<tbody>
<tr>
<td>For patients with appropriate exclusion criteria, report code 4004F with modifier 1P.</td>
<td></td>
<td></td>
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Footnotes

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# Lung Cancer/Esophageal Cancer (Lung/Esop Cx)

<table>
<thead>
<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pulmonary function testing</strong>[6]**</td>
<td>3038F</td>
<td>Pulmonary function test performed within 12 months prior to surgery</td>
</tr>
<tr>
<td>Whether or not a patient, ≥ 18 years of age, undergoing a major lung resection had a pulmonary function test within 12 months prior to surgery. <strong>Numerator:</strong> Patients who had a pulmonary function test performed within 12 months prior to surgery. <strong>Denominator:</strong> All patients ≥ 18 years of age, undergoing a major lung resection. <strong>Exclusion(s):</strong> Documentation of medical reasons for not performing pulmonary function tests within 12 months prior to surgery (eg, patients who were unable to perform pulmonary function testing and those with urgent/emergent need of lung resection (lung abscess, massive hemoptysis, bronchopleural fistula, etc.) <strong>Percentage</strong> of patients, ≥ 18 years of age, undergoing a major lung resection who had a pulmonary function test performed within 12 months prior to surgery. <strong>Reporting Instructions:</strong> For the patient with appropriate exclusion criteria, report 3038F with modifier 1P.</td>
<td></td>
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</tbody>
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9. [College of American Pathologists (CAP)](https://www.cap.org/advocacy/quality-payment-program-for-pathologists/mips-for-pathologists/2023-pathology-quality-standards), or quality@aan.com
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<tbody>
<tr>
<td><strong>Recording of Performance Status</strong>&lt;sup&gt;6&lt;/sup&gt;&lt;br&gt;Whether or not a patient, ≥ 18 years of age, undergoing resection for lung or esophageal cancer had performance status documented and reviewed within 2 weeks prior to the surgery date.</td>
<td>3328F</td>
<td>Performance status documented and reviewed within 2 weeks prior to surgery</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who had their performance status documented and reviewed within 2 weeks prior to surgery. <strong>Definition:</strong> Performance status is a general measure of a patient's physiologic status, taking into account the cancer and its associated effects along with other concurrent medical problems, such as cardiac or pulmonary disease. Examples of appropriate scales include Zubrod, Karnofsky, WHO, and ECOG.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients, ≥ 18 years of age, undergoing resection for lung or esophageal cancer who had performance status documented and reviewed within 2 weeks prior to surgery.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Footnotes**

1. *Physician Consortium for Performance Improvement® (PCPI)* - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. *National Committee on Quality Assurance (NCQA)*, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)


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# Lung Cancer/Esophageal Cancer (Lung/Esop Cx)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>status documented and reviewed within 2 weeks prior to the surgery date</td>
<td></td>
<td>Clinical tumor, node and metastases (TNM) staging documented and reviewed prior to surgery</td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recording of Clinical Stage</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not a patient, aged 18 years and older, undergoing resection for lung or esophageal cancer had clinical tumor, node and metastases (TNM) staging documented and reviewed prior to surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who had clinical TNM staging documented and reviewed prior to surgery</td>
<td>3323F</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older undergoing resection for lung or esophageal cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients, aged 18 years and older, undergoing resection for lung or esophageal cancer who had clinical TNM staging provided prior to surgery</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

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</thead>
<tbody>
<tr>
<td>Reporting Instructions: There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Major Depressive Disorder (MDD)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression Screening and Assessment in High Risk Patients&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not a patient who is 18 years and older and is identified in a high risk category (ie age or condition) has a documented result from a depression screen or assessment during the measurement year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td>Negative screen for depressive symptoms as categorized by using a standardized depression screening/assessment tool</td>
</tr>
<tr>
<td>Documented results of depression screen or assessment during the measurement year.</td>
<td>3351F</td>
<td></td>
</tr>
<tr>
<td>Note: Patients who are screened positive for depressive symptoms who do not receive further assessment of</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<sup>6</sup>*The Society of Thoracic Surgeons* at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

<sup>7</sup>Optum, [www.optum.com](http://www.optum.com)


<sup>10</sup>American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

<sup>11</sup>American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)

<sup>12</sup>American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org)
### Major Depressive Disorder (MDD)

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</thead>
</table>
| depressive symptoms with a standardized tool do not count toward the numerator. Documentation of any one of the following counts toward this measure:  
  - Negative screen for depressive symptoms using a standardized tool**  
  - No significant depressive symptoms using a standardized tool**  
  - Mild to moderate depressive symptoms using a standardized tool**  
  - Clinically significant depressive symptoms using a standardized tool**  
*Note: Measure specifications should be referred to determine criteria to meet any of the listed risk categories (i.e., the denominators.)  
**Note: Measure specifications should be referred to identify acceptable standardized tools for screening and assessment. ** | 3352F | No significant depressive symptoms as categorized by using a standardized depression assessment tool |
| | 3353F | Mild to moderate depressive symptoms as categorized by using a standardized depression screening/assessment tool |
| | 3354F | Clinically significant depressive symptoms as categorized by using a standardized depression screening/assessment tool |

**Denominator:**
Adults, 18 years and older, who have been identified in one or more of following the high risk categories (i.e. age or condition)*:

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<table>
<thead>
<tr>
<th>Major Depressive Disorder (MDD)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source</strong></td>
</tr>
<tr>
<td>- Patients with diabetes</td>
</tr>
<tr>
<td>- Patients with cardiovascular disease including acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA)</td>
</tr>
<tr>
<td>- Two methods can be used to identify the eligible population: 1) a cardiac event or 2) an ischemic vascular disease (IVD) diagnosis. For the cardiac event (AMI, CABG, or PTCA) the look back is from January 1 through November 1 of the year prior to the measurement year; for the IVD diagnosis the look back is the measurement and the year prior to the measurement year.</td>
</tr>
<tr>
<td>- Patients with persistent asthma</td>
</tr>
<tr>
<td>- Patients with chronic obstructive pulmonary disease (COPD)</td>
</tr>
<tr>
<td>- Patients with low back pain</td>
</tr>
<tr>
<td>- Patients who are 65 years and older</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
</tr>
<tr>
<td>Report code 3351F, 3352F, 3353F, or 3354F for patients identified as high risk when acceptable screening or assessment has been documented. There are no</td>
</tr>
</tbody>
</table>

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**Major Depressive Disorder (MDD)**

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</tr>
</thead>
<tbody>
<tr>
<td>performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used. <strong>Note: Measure specifications should be referred to identify acceptable standardized tools for screening and assessment.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Evaluation</strong>¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not a patient aged 18 years and older with a new diagnosis or recurrent episode of MDD met the DSM-IV™ criteria during the visit in which the new diagnosis or recurrent episode was identified during the reporting year</td>
<td>1040F</td>
<td>DSM-5 criteria for major depressive disorder documented at the initial evaluation</td>
</tr>
<tr>
<td>Numerator: Patients with documented evidence that they met the DSM-IV™ criteria* [At least 5 elements (<strong>must</strong> include: 1) depressed mood or 2) loss of interest or pleasure) with symptom duration of two weeks or longer] during the visit in which the new diagnosis of an initial or recurrent episode was identified during the reporting year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*DSM-IV™ criteria includes presence of depressed mood, marked diminished interest/pleasure, significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, diminished ability to concentrate and recurrent suicidal ideation.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷Optum, [www.optum.com](http://www.optum.com)

⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

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## Major Depressive Disorder (MDD)

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<tr>
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> Patients aged 18 years and older with a new diagnosis or recurrent episode of MDD</td>
<td>Denominator Codes</td>
<td>Documentation of new diagnosis of initial or recurrent episode of major depressive disorder</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD with documented evidence of having met DSM-IV™ criteria during the visit in which the new diagnosis or recurrent episode was identified during the reporting year</td>
<td>3093F</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 3093F for each patient with a new diagnosis of an initial or recurrent episode of MDD. Report 1040F where DSM-5 criteria documented</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who had a suicide risk assessment at each visit during the reporting year</td>
<td>3085F</td>
<td>Suicide risk assessed</td>
</tr>
</tbody>
</table>

### Footnotes

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### Major Depressive Disorder (MDD)

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</thead>
<tbody>
<tr>
<td>Denominator: Patients aged 18 years and older with a new diagnosis of an initial or recurrent episode of MDD</td>
<td>3093F</td>
<td>Documentation of new diagnosis of initial or recurrent episode of major depressive disorder</td>
</tr>
<tr>
<td>Exclusion: Documentation that patient is in remission (no longer meeting DSM-IV™ criteria)</td>
<td>3092F</td>
<td>Major depressive disorder, in remission</td>
</tr>
<tr>
<td>Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who had a suicide risk assessment completed at each visit during the reporting year</td>
<td>3085F</td>
<td>For patient with appropriate exclusion criteria, report 3092F.</td>
</tr>
<tr>
<td>Reporting Instructions: Report 3093F for each patient with a new, confirmed diagnosis of MDD. Report 3085F for assessment of suicide risk. For patient with appropriate exclusion criteria, report 3092F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severity Classification at Initial Visit¹</td>
<td>3090F</td>
<td>Major depressive disorder, without psychotic features</td>
</tr>
<tr>
<td>Whether or not a patient aged 18 years and older was classified for severity of his/her MDD during the visit in which the new diagnosis or recurrent episode was identified during the reporting year</td>
<td>3091F</td>
<td>Major depressive disorder, severe without psychotic features</td>
</tr>
<tr>
<td>Numerator: Patients whose severity of MDD was classified during the visit in which the new diagnosis or recurrent episode was identified during the reporting year</td>
<td>3088F</td>
<td>Major depressive disorder, mild</td>
</tr>
<tr>
<td>Denominator: All patients aged 18 years and older with a new diagnosis of an initial or recurrent episode of MDD</td>
<td>3089F</td>
<td>Major depressive disorder, moderate</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source</strong></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Exclusion: None</td>
</tr>
<tr>
<td>Percentage of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD whose severity of MDD was classified during the visit in which the new diagnosis or recurrent episode was identified during the reporting year. There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
</tr>
<tr>
<td>Reporting Instructions: Report 3093F for each patient with a new diagnosis of an initial or recurrent episode of MDD during the reporting year. Also report 3088F or 3089F or 3090F or 3091F or 3092F for the corresponding severity classification.</td>
</tr>
<tr>
<td>Numerator: Patients who received therapy appropriate to their classification during the reporting year. Appropriate treatment for corresponding severity classification:</td>
</tr>
<tr>
<td>Mild MDD:</td>
</tr>
<tr>
<td>Treatment: Psychotherapy, Medication Management, and/or Electroconvulsive Therapy (ECT)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
</thead>
<tbody>
<tr>
<td>Psychotherapy OR Antidepressant medication</td>
<td>4065F</td>
<td>Antipsychotic pharmacotherapy prescribed</td>
</tr>
<tr>
<td>Moderate MDD: Psychotherapy OR Antidepressant medication OR Psychotherapy and antidepressant medication</td>
<td>4066F</td>
<td>Electroconvulsive Therapy (ECT) provided</td>
</tr>
<tr>
<td>Severe MDD without psychotic features: Antidepressant medications OR Psychotherapy and antidepressant medications</td>
<td>4067F</td>
<td>Patient referral for electroconvulsive therapy (ECT) documented</td>
</tr>
<tr>
<td>Severe MDD with psychotic features: Antidepressant medication and antipsychotic medication OR ECT</td>
<td>90870</td>
<td>Electroconvulsive therapy</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with a new diagnosis of an initial or recurrent episode of MDD</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical, patient, or system reason(s) for not prescribing treatment.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a new diagnosis or recurrent episode of MDD who received therapy</td>
<td>3088F</td>
<td>Major depressive disorder, mild</td>
</tr>
<tr>
<td></td>
<td>3089F</td>
<td>Major depressive disorder, moderate</td>
</tr>
<tr>
<td></td>
<td>3090F</td>
<td></td>
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<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>appropriate to their severity classification during the reporting year</td>
<td>3091F</td>
<td>Major depressive disorder, severe without psychotic features</td>
</tr>
<tr>
<td><strong>Mild MDD: Report 3088F and:</strong></td>
<td>3092F</td>
<td>Major depressive disorder, severe with psychotic features</td>
</tr>
<tr>
<td>(a) Psychotherapy- 4060F or 4062F</td>
<td>Denominator Code:</td>
<td>Major depressive disorder, in remission</td>
</tr>
<tr>
<td>(b) Antidepressant medication- 4064F</td>
<td>3093F</td>
<td>Documentation of new diagnosis of initial or recurrent episode of major depressive disorder</td>
</tr>
<tr>
<td><strong>Moderate MDD: Report 3089F and:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(c) Psychotherapy- 4060F or 4062F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(d) Antidepressant medication- 4064F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(e) Psychotherapy and antidepressant medication- 4060F or 4062F AND 4064F</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Severe MDD without psychotic features: Report 3090F and:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(f) Antidepressant medications – 4064F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(g) Psychotherapy and antidepressant medications- 4060F or 4062F AND 4064F</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes:

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Last Updated June 23, 2023
## Major Depressive Disorder (MDD)

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</thead>
<tbody>
<tr>
<td>Severe MDD with psychotic features: Report 3091F and:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(h) Antidepressant medication and antipsychotic medication-4064F and 4065F</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(i) ECT- 4066F or 4067F or 90870</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

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<tr>
<th>Major Depressive Disorder—Child and Adolescent (MDD ADOL)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Interview of Adolescent or Child</strong>¹ Back to Top</td>
<td>2060F</td>
<td>Patient interviewed directly by evaluating clinician on or before date of diagnosis of major depressive disorder</td>
</tr>
<tr>
<td><strong>Brief Description of Performance Measure and Source</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 6 through 17 years with a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnosis of major depressive disorder was interviewed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>directly by the evaluating clinician on or before the date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were interviewed directly by the evaluating clinician on or before the date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 6 through 17 years with a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>diagnosis of major depressive disorder who were</td>
<td></td>
<td></td>
</tr>
<tr>
<td>interviewed directly by the evaluating clinician on or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>before the date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s): None</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 6 through 17 years with a diagnosis of major depressive disorder who were interviewed directly by the evaluating clinician on or before the date of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Last Updated June 23, 2023
## Major Depressive Disorder—Child and Adolescent (MDD ADOL)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 6 through 17 years with a diagnosis of major depressive disorder has documented evidence that they met the DSM-IV criteria during the visit in which the new diagnosis or recurrent episode was identified</td>
<td>1040F</td>
<td>DSM-5 criteria for major depressive disorder documented at the initial evaluation</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with documented evidence that they met the DSM-IV criteria [at least 5 elements with symptom duration of two weeks or longer, including 1) depressed mood (<em>can be irritable mood in children and adolescents</em>) or 2) loss of interest or pleasure] during the visit in which the new diagnosis or recurrent episode was identified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 6 through 17 years with a diagnosis of major depressive disorder</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 6 through 17 years with a diagnosis of major depressive disorder with documented evidence that they met the DSM-IV criteria [at least 5 elements (including 1) depressed mood (<em>can be irritable mood in children and adolescents</em>) or 2) loss of interest or pleasure] with symptom duration of two weeks or longer] during the visit in which the new diagnosis or recurrent episode was identified</td>
<td></td>
<td></td>
</tr>
</tbody>
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Last Updated June 23, 2023
Major Depressive Disorder—Child and Adolescent (MDD ADOL)

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</thead>
<tbody>
<tr>
<td>Reporting Instructions: There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide Risk Assessment¹</td>
<td>3085F</td>
<td>Suicide risk assessed</td>
</tr>
<tr>
<td>Whether or not the patient aged 6 through 17 years old with a diagnosis of major depressive disorder received an assessment for suicide risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Numerator: Patient visits with an assessment for suicide risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Denominator: All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s): None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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⁷Optum, [www.optum.com](http://www.optum.com).


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

¹²American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source</strong></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Psychotherapy</strong>¹</td>
</tr>
<tr>
<td>Whether or not the patient aged 6 through 17 years with a diagnosis of major depressive disorder received or was referred for psychotherapy during an episode of major depressive disorder</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who received or were referred for psychotherapy during an episode of major depressive disorder</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 6 through 17 years with a diagnosis of major depressive disorder</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason, patient reason (includes family reasons), or system reason(s) (eg, psychotherapy not regionally available) for not providing or referring for psychotherapy.</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 6 through 17 years with a diagnosis of major depressive disorder who received or were referred for psychotherapy during an episode of major depressive disorder</td>
</tr>
</tbody>
</table>

Footnotes

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⁷Optum, www.optum.com


¹⁰American Gastroenterological Association (AGA), www.gastro.org/quality.


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<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4064F</td>
<td>Antidepressant pharmacotherapy prescribed</td>
</tr>
<tr>
<td>4063F</td>
<td>Antidepressant pharmacotherapy considered and not prescribed</td>
</tr>
</tbody>
</table>

**Major Depressive Disorder—Child and Adolescent (MDD ADOL)**

**Brief Description of Performance Measure and Source**

<table>
<thead>
<tr>
<th>Reporting Instructions: For patient with appropriate exclusion criteria, report 4060F or 4062F with modifier 1P, 2P or 3P.</th>
</tr>
</thead>
</table>
| Medications Considered¹  
Whether or not the patient aged 6 through 17 years with a diagnosis of major depressive disorder was considered or prescribed an antidepressant medication during an episode of major depressive disorder  
**Numerator:** Patients for whom an antidepressant medication was considered* or prescribed during an episode of major depressive disorder  
Definition: The numerator criteria will be met if an antidepressant medication was either prescribed or there is documentation that the antidepressant medication was not prescribed for documented reasons.  
**Denominator:** All patients aged 6 through 17 years with a diagnosis of major depressive disorder  
**Exclusion(s):** None |

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⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷Optum, [www.optum.com](http://www.optum.com)

⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com)


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)

¹²American College of Gastroenterology (AG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org)
| Major Depressive Disorder—Child and Adolescent (MDD ADOL) |
|----------------------------------|------------------|------------------|
| **Brief Description of Performance Measure and Source** | **CPT Category II Code(s)** | **Code Descriptor(s)** |
| Percentage of patients aged 6 through 17 years with a diagnosis of major depressive disorder for whom an antidepressant medication was considered or prescribed during an episode of major depressive disorder | | |
| **Reporting Instructions:** Report 4064F if antidepressant pharmacotherapy was prescribed. If antidepressant pharmacotherapy was not prescribed but there is documentation that it was considered, report 4063F. There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used. | 0545F | Plan for follow-up care for major depressive disorder, documented |
| **Follow-up Care**<sup>1</sup> | | |
| Whether or not patient aged 6 through 17 years with a diagnosis of major depressive disorder has a plan for follow-up care documented | | |
| **Numerator:** Patient visits with a plan for follow-up care documented | | |
| **Denominator:** All patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder | | |
| **Exclusion(s): None** | | |

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7. **Optum**, www.optum.com

8. **American Academy of Neurology**, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


10. **American Gastroenterological Association (AGA)**, www.gastro.org/quality

11. **American Society of Anesthesiologists (ASA)**, www.asahq.org

12. **American College of Gastroenterology (AGC)**, www.gi.org; **American Gastroenterological Association (AGA)**, www.gastro.org; **American Society for Gastrointestinal Endoscopy (ASGE)**, www.asge.org
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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure and Source</strong></td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with a plan for follow-up care documented</td>
</tr>
</tbody>
</table>

**Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.

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# Brief Description of Performance Measure & Source and Reporting Instructions

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<thead>
<tr>
<th>Melanoma Follow Up Measures⁵</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient with a new diagnosis of melanoma or a history of melanoma received all of the following aspects of care within the 12 month reporting period: (1) Patient was asked specifically if he/she had any new and changing moles <strong>AND</strong> (2) A complete physical skin examination was performed and the morphology, size, and location of new or changing pigmented lesions were noted <strong>AND</strong> (3) Patient was counseled to perform a monthly self skin examination</td>
<td>0015F</td>
<td>Melanoma follow up completed</td>
</tr>
<tr>
<td></td>
<td>1050F</td>
<td></td>
</tr>
</tbody>
</table>

**Numerator:** Patients who received all of the following aspects of care at least once within the 12 month reporting period: (1) Patient was asked specifically if he/she had any new or changing moles **AND** (2) A complete physical skin examination* was performed and the morphology, size, and location of new or changing pigmented lesions were noted **AND** (3) Patient was counseled to perform a monthly self-skin examination

*Complete physical skin exam includes: head (including the face), neck, chest (including the axillae), abdomen, back, and |

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8. **American Academy of Neurology**, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com
11. **American Society of Anesthesiologists (ASA)**, www.asahq.org
## Melanoma (ML)

**Brief Description of Performance Measure & Source and Reporting Instructions**

- **Denominator:** All patients with a new diagnosis of melanoma or a history of melanoma.
- **Exclusion(s):** Documentation of system reason(s) for not performing the follow up service (e.g., another physician performed the service)
- **Percentage:** Of patients with a new diagnosis of melanoma or a history of melanoma who received all of the following aspects of care within the 12 month reporting period: (1) Patient was asked specifically if he/she had any new and changing moles AND (2) A complete physical skin examination was performed and the morphology, size, and location of new or changing pigmented lesions were noted AND (3) Patient was counseled to perform a monthly self-skin examination.
- **Reporting Instructions:** If all three components of the numerator are performed, report composite code 0015F for this measure.

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2029F</td>
<td>History obtained regarding new or changing moles</td>
</tr>
<tr>
<td>5005F</td>
<td>Complete physical skin exam performed</td>
</tr>
<tr>
<td></td>
<td>Patient counseled to perform a monthly self-skin examination</td>
</tr>
</tbody>
</table>

### Footnotes

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3. **The Joint Commission,** [https://www.jointcommission.org](https://www.jointcommission.org)
4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.
5. Joint measure from [The Physician Consortium for Performance Improvement (PCPI)](https://www.pcpi.org) and [National Committee on Quality Assurance (NCQA)](http://www.ncqa.org) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).
6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum,** [www.qualityforum.org](http://www.qualityforum.org)
7. **Optum,** [www.optum.com](http://www.optum.com)
8. **American Academy of Neurology,** [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures) or [quality@aan.com](mailto:quality@aan.com)
10. **American Gastroenterological Association (AGA),** [www.gastro.org/quality](http://www.gastro.org/quality)
11. **American Society of Anesthesiologists (ASA),** [www.asahq.org](http://www.asahq.org)
12. **American College of Gastroenterology (ACG),** [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA),** [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE),** [www.asge.org](http://www.asge.org)

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<table>
<thead>
<tr>
<th>Melanoma Continuity</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient, regardless of age, with a current diagnosis of melanoma or a history of melanoma had information entered, at least once within a 12 month period, into a recall system that includes: the target date for the next complete physical skin exam specified, AND a process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment</td>
<td>7010F</td>
<td>Patient information entered into a recall system that includes: target date for the next exam specified and a process to follow up with patients regarding missed or unscheduled appointments</td>
</tr>
</tbody>
</table>

**Numerator:** Patients whose information was entered, at least once within a 12 month period, into a recall system* that includes:

- A target date for the next complete physical skin exam, AND

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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

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<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
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</tr>
</thead>
<tbody>
<tr>
<td>- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment *To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum: patient identifier, patient contact information, cancer diagnosis(es), dates(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam. <strong>Denominator</strong>: All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma. <strong>Exclusion(s)</strong>: Documentation of system reason for not entering patient's information into a recall system (e.g., melanoma being monitored by another physician provider) <strong>Percentage</strong> of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose...</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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7Optum, www.optum.com


10American Gastroenterological Association (AGA), www.gastro.org/quality

11American Society of Anesthesiologists (ASA), www.asahq.org

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</thead>
</table>
| information was entered, at least once within a 12 month period, into a recall system that includes:  
• A target date for the next complete physical skin exam, AND  
• A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment | 5050F |  |

**Melanoma Coordination of Care**

Whether or not the patient diagnosed with a new episode of melanoma has a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

**Numerator:** Patients who have a treatment plan* documented in the chart that was communicated** to the physician(s) providing continuing care within one month of diagnosis

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<table>
<thead>
<tr>
<th>Melanoma (ML)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
</tr>
<tr>
<td>Treatment plan communicated to provider(s) managing continuing care within one month of diagnosis</td>
</tr>
<tr>
<td><strong>Denominator</strong></td>
</tr>
<tr>
<td>All patients, regardless of age, diagnosed with a new occurrence of melanoma</td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of patient reason(s) for not communicating treatment plan (eg, patient asks that treatment plan not be communicated physician(s) providing continuing care)</td>
</tr>
<tr>
<td>Documentation of system reason(s) for not communicating treatment plan to the PCP(s) (eg, patient does not have a PCP or referring physician)</td>
</tr>
</tbody>
</table>

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Footnotes

1. Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement®, see the appropriate Payor website.

2. National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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## Melanoma (ML)

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong> of patients diagnosed with a new episode of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions For patient with appropriate exclusion criteria, report 5050F with modifier 2P or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Appropriate Use of Imaging Studies in Stage 0-IA Melanoma</strong></td>
<td>3319F</td>
<td>One of the following diagnostic imaging studies ordered: chest X-ray, CT, Ultrasound, MRI, PET, or nuclear medicine scans</td>
</tr>
<tr>
<td>Whether or not the patient, regardless of age, with Stage 0 or IA melanoma, without signs or symptoms, did not have imaging studies ordered</td>
<td>3320F</td>
<td>None of the following diagnostic imaging studies ordered: chest X-ray, CT, Ultrasound, MRI, PET, and nuclear medicine scans</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies were ordered (ie, chest x-ray [CXR], computed tomography [CT], Ultrasound, magnetic resonance imaging [MRI], positron emission tomography [PET], or nuclear medicine scans)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients, regardless of age, with stage 0 or IA melanoma</td>
<td></td>
<td></td>
</tr>
</tbody>
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## Melanoma (ML)

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for ordering diagnostic imaging studies (eg, patient has signs or symptoms that justify imaging studies) Documentation of system reason(s) for ordering diagnostic imaging studies (eg, requirement for clinical trial enrollment, ordered by another provider). <strong>Percentage</strong> of patients, regardless of age, with stage 0 or IA melanoma, without signs or symptoms, for whom no imaging studies were ordered <strong>Reporting Instructions:</strong> Report 3319F or 3320F for each patient with a diagnosis of melanoma. For the patient with Stage 0 or IA melanoma, also report 3321F or 3322F. If there is a valid medical or system reason for ordering diagnostic imaging studies, report 3319F with modifier 1P or 3P; 1P, 2P or 3P may not be used with 3320F.</td>
<td>Denominator Codes</td>
<td>3321F</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3322F</td>
</tr>
</tbody>
</table>

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7Optum, www.optum.com

8American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


10American Gastroenterological Association (AGA), www.gastro.org/quality

11American Society of Anesthesiologists (ASA), www.asahq.org

12American College of Gastroenterology (AGC), www.gi.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org

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<tr>
<th>Nuclear Medicine (NUC_MED)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nuclear Medicine (NUC_MED): Correlation With Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy</strong>¹</td>
<td>3570F</td>
<td>Final report for bone scintigraphy study includes correlation with existing relevant imaging studies (eg, x-ray, MRI, CT) corresponding to the same anatomical region in question</td>
</tr>
</tbody>
</table>

**Footnotes**

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

⁵Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


⁷Optum, [www.optum.com](http://www.optum.com).


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

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**Nuclear Medicine (NUC_MED)**

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</tr>
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<tbody>
<tr>
<td>existing relevant imaging study available, patient did not have a previous relevant imaging study) <strong>Percentage</strong> of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.) that were performed</td>
<td>5100F</td>
<td>Potential risk for fracture communicated to the referring physician</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For the patient with appropriate exclusion criteria, report 3570F with modifier 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>Communication to the referring physician within 24 hours of completion of the imaging study</td>
<td><strong>Denominator Codes</strong>&lt;br&gt;3572F&lt;br&gt;3573F</td>
<td>Physician within 24 hours of completion of the imaging study</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients with documentation of direct communication(^a) to the referring physician within 24 hours of completion of the imaging study&lt;br&gt;&lt;br&gt;(^a)Direct communication is defined as communication by the diagnostic imager or a designee to the treating or referring physician or his/her representative with confirmed receipt of the findings (verbal communication, certified letter, or by any electronic transmission with receipt or documentation that the communication was received.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients, regardless of age, undergoing bone scintigraphy, considered to be potentially at risk for fracture in a weight-bearing site(^a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^a)Examples of this would include: location of a lesion, new lesion in a weight-bearing region, increasing intensity and/or area of a previously noted lesion, etc.</td>
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</tbody>
</table>

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<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Medical reason for not documenting direct communication to the referring physician within 24 hours of completion of the imaging study (eg, previously reported prior lesion in same location with no evidence of progression or regression, negative scan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients, regardless of age, undergoing bone scintigraphy considered to be potentially at risk for fracture in a weight-bearing site for whom there is documentation of direct communication to the referring physician within 24 hours of completion of the imaging study</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 3572F or 3573F for each patient undergoing bone scintigraphy. If the patient is considered to be potentially at risk for fracture in a weight-bearing site and has documentation of direct communication to the referring physician within 24 hours of completion of the imaging study, also report 5100F.</td>
<td></td>
<td></td>
</tr>
</tbody>
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7. **Optum**, www.optum.com


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<tbody>
<tr>
<td>For patient with appropriate exclusion criteria, report 5100F with modifier 1P.</td>
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### Oncology (ONC)

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</tr>
</thead>
</table>
| **Cancer Stage Documented**<sup>1</sup> Whether or not the patient with a diagnosis of breast, colon, or rectal cancer who is receiving chemotherapy or radiation therapy had either a baseline American Joint Committee on Cancer (AJCC) cancer stage or documentation that the cancer is metastatic in the medical record  
**Numerator:** Patients who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period  
Cancer stage refers to stage at diagnosis | 3300F 3301F | American Joint Committee on Cancer (AJCC) stage documented and reviewed |

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### Oncology (ONC)

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator</strong>: All patients with a diagnosis of breast, colon, or rectal cancer seen in the ambulatory setting</td>
<td></td>
<td>Cancer stage documented in medical record as metastatic and reviewed</td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients with a diagnosis of breast, colon, or rectal cancer seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting</td>
<td>4179F</td>
<td>Tamoxifen or aromatase inhibitor (AI) prescribed</td>
</tr>
</tbody>
</table>

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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)


10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

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### Oncology (ONC)

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>progesterone receptor (PR) positive breast cancer was prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period</td>
<td>3370F</td>
<td>AJCC Breast Cancer Stage 0, documented</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were prescribed tamoxifen or aromatase inhibitor (AI) within the 12 month reporting period</td>
<td>3372F</td>
<td>AJCC Breast Cancer Stage I: T1mic, T1a or T1b (tumor size ≤ 1 cm), documented</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer</td>
<td>3374F</td>
<td>AJCC Breast Cancer Stage I: T1c (tumor size &gt; 1 cm to 2 cm), documented</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not prescribing tamoxifen or an aromatase inhibitor (eg, patient’s disease has progressed to metastatic; eg, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is receiving radiation or chemotherapy, patient diagnosis date was ≥ 5 years from reporting date)</td>
<td>3376F</td>
<td>AJCC Breast Cancer Stage II, documented</td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not prescribing tamoxifen or an aromatase inhibitor (eg, patient refusal)</td>
<td>3378F</td>
<td>AJCC Breast Cancer Stage III, documented</td>
</tr>
<tr>
<td>Documentation of system reason(s) for not prescribing tamoxifen or an aromatase inhibitor (eg, patient is currently enrolled in a clinical trial)</td>
<td>3380F</td>
<td>AJCC Breast Cancer Stage IV, documented</td>
</tr>
<tr>
<td></td>
<td>3315F</td>
<td>Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td><strong>Percentage</strong> of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period</td>
<td>3316F</td>
<td>Estrogen receptor (ER) and progesterone receptor (PR) negative breast cancer</td>
</tr>
</tbody>
</table>

**Reporting Instructions:**

Report an appropriate cancer staging code from the 3370F-3380F series for each patient aged 18 years and older with a diagnosis of breast cancer. For patients with Stage T1c through Stage III (3374F-3378F) also report 3315F or 3316F. If patient with Stage T1c through Stage III is estrogen receptor (ER) or progesterone receptor (PR) positive (3315F), and tamoxifen or an aromatase inhibitor (AI) is prescribed, also report 4179F.

For patient with appropriate exclusion criteria, report 4179F with modifier 1P, 2P, or 3P. If reporting exclusion and cancer stage at diagnosis or ER/PR status unknown, it is not required to report one of the codes for AJCC Cancer Stage.

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<tbody>
<tr>
<td><strong>Chemotherapy for Stage IIIA through IIIC Colon Cancer patients</strong>¹</td>
<td>4180F</td>
<td>Adjuvant chemotherapy referred, prescribed, or previously received for Stage III colon cancer</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with Stage IIIA through IIIC colon cancer was referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy or previously received adjuvant chemotherapy within the 12 month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy or previously received adjuvant chemotherapy* within the 12 month reporting period</td>
<td>3382F</td>
<td>AJCC colon cancer, Stage 0, documented</td>
</tr>
<tr>
<td>*According to current NCCN guidelines, the following therapies are recommended: 5-fluorouracil/leucovorin or capecitabine, or 5-fluorouracil/leucovorin/oxaliplatin</td>
<td>3384F</td>
<td>AJCC colon cancer, Stage I, documented</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with Stage IIIA through IIIC colon cancer</td>
<td>3386F</td>
<td>AJCC colon cancer, Stage II, documented</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, medical comorbidities, diagnosis date more than 5 years prior)</td>
<td>3388F</td>
<td>AJCC colon cancer, Stage III, documented</td>
</tr>
<tr>
<td></td>
<td>3390F</td>
<td>AJCC colon cancer, Stage IV, documented</td>
</tr>
</tbody>
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7. **Optum,** [www.optum.com](http://www.optum.com)


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<tbody>
<tr>
<td>to the current visit date; patient's cancer has metastasized, medical contraindication/allergy, poor performance status) Documentation of patient reason(s) for not referring for adjuvant chemotherapy or prescribing adjuvant chemotherapy (eg, patient refusal) Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy) <strong>Percentage</strong> of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy or who have previously received adjuvant chemotherapy within the 12-month reporting period <strong>Reporting Instructions:</strong> Report an appropriate cancer staging code from the 3382F-3390F series for each patient aged 18 years and older with a diagnosis of colon cancer. For the patient with AJCC Stage III</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>Plan for Chemotherapy Documented Before Chemotherapy Administered&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of breast, colon, or rectal cancer who is receiving intravenous chemotherapy had a planned chemotherapy regimen (which includes, at a minimum: drug(s) prescribed, dose, and duration) documented prior to the initiation of a new treatment regimen</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients for whom the planned chemotherapy regimen (which includes, at a minimum: drug(s) prescribed, dose, and duration) is documented prior to initiation of a new treatment regimen</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with a diagnosis of breast, colon, or rectal cancer who are receiving intravenous chemotherapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</table>
| **Exclusion(s): None**  
Percentage of patients with a diagnosis of breast, colon, or rectal cancer who are receiving intravenous chemotherapy for whom the planned chemotherapy regimen (which includes, at a minimum: drug(s) prescribed, dose, and duration) is documented prior to the initiation of a new treatment regimen | 0519F | Planned chemotherapy regimen, including at a minimum: drug(s) prescribed, dose, and duration, documented prior to initiation of a new treatment regimen |

**Treatment Summary Communication – Radiation Oncology**

Whether or not the patient with a diagnosis of cancer who has undergone brachytherapy or external beam radiation therapy has a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment

**Numerator:** Patients who have a treatment summary* report in the chart that was communicated to the physician(s)

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</thead>
<tbody>
<tr>
<td>Providing continuing care and to the patient within one month of completing treatment</td>
<td>5020F</td>
<td>Treatment summary report communicated to physician(s) managing continuing care and to the patient within one month of completing treatment</td>
</tr>
</tbody>
</table>

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<tr>
<td>chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reporting Instructions**: This measure is reported once at the conclusion of each course of radiation treatment. For patient with appropriate exclusion criteria, report 5020F with modifier 2P or 3P.

### Radiation Dose Limits to Normal Tissues

Whether or not the patient, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

**Numerator**: Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

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#### Brief Description of Performance Measure & Source

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<tr>
<th>Denominator: All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion(s): None</td>
<td>0520F</td>
<td>Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs</td>
</tr>
<tr>
<td>Pain Intensity Quantified-Medical Oncology and Radiation Oncology¹</td>
<td>1125F</td>
<td>Pain severity quantified; pain present</td>
</tr>
</tbody>
</table>

| Pain Intensity Quantified-Medical Oncology and Radiation Oncology¹ | 1126F | Pain severity quantified; pain present |

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<td><strong>CPT Category II Code(s)</strong></td>
<td><strong>Code Descriptor(s)</strong></td>
</tr>
<tr>
<td>Number of patient visits in which pain intensity is quantified&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
<td>Pain severity quantified; no pain present</td>
</tr>
<tr>
<td>Pain severity can be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All visits for patients with a diagnosis of cancer currently receiving chemotherapy or radiation therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of visits for patients with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 1126F if pain severity is quantified and no pain is present, or report 1125F if pain severity is quantified and pain is present. There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
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12American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

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<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visits for the patient, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who reports having pain and has a documented plan of care to address pain</td>
<td>0521F</td>
<td>Plan of care to address pain documented</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patient visits that included a documented plan of care(^a) to address pain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(^a)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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain</td>
<td>1125F</td>
<td>Pain severity quantified, pain present</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> 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</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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### Oncology (ONC)

<table>
<thead>
<tr>
<th>Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report 1125F for each patient with a diagnosis of cancer who reports pain. If a plan of care to address pain is documented, also report 0521F. There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used. If the patient reports no pain, report only 1126F.</td>
<td>1126F</td>
<td>Pain severity quantified, no pain present</td>
</tr>
</tbody>
</table>

### Pathology Report – Medical Oncology and Radiation Oncology

**Numerator:** Patients with a pathology report in the medical record that confirms malignancy prior to the initiation of therapy

**Denominator:** All patients with a diagnosis of cancer receiving chemotherapy or radiation therapy

**Exclusion(s):** Documentation of a medical reason(s) for not having a pathology report in the medical record, confirming

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3317F</td>
<td>Pathology report confirming malignancy documented in the medical record and reviewed prior to the initiation of chemotherapy</td>
</tr>
<tr>
<td>3318F</td>
<td>Pathology report confirming malignancy documented in the medical record and reviewed prior to the initiation of radiation therapy</td>
</tr>
</tbody>
</table>

---

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## Oncology (ONC)

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</tr>
</thead>
<tbody>
<tr>
<td>malignancy prior to the initiation of therapy (eg, palliative treatment for metastatic illness)</td>
<td>3317F</td>
<td>3318F</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients with a diagnosis of cancer receiving chemotherapy with a pathology report in the medical record that confirms malignancy prior to the initiation of therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: This measure is to be reported once at the beginning of treatment. Report 3317F for patient receiving chemotherapy or 3318F for patient receiving radiation therapy. For patient with appropriate exclusion criteria, report 3317F or 3318F with modifier 1P. If patient is first seen by the reporting physician after the treatment has been initiated, the pathology report should be documented before the reporting physician continues treatment. The physician continuing the treatment(s) should report as if treatment is being initiated.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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6. The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7. Optum, [www.optum.com](http://www.optum.com)


10. American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

11. American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)

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# Osteoarthritis (Adult) (OA)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Composite Codes: Osteoarthritis Assessment</strong>¹ - See individual measures listed below for:</td>
<td>0005F</td>
<td>Osteoarthritis assessed</td>
</tr>
<tr>
<td>Osteoarthritis symptoms and functional status assessed (1006F), use of anti-inflammatory or over-the-counter (OTC) analgesic medications assessed (1007F), initial examination of the involved joint(s) (includes visual inspection, palpation, range of motion) (2004F)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Symptom and Functional Assessment</strong>¹</td>
<td>1006F</td>
<td>Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as)</td>
</tr>
<tr>
<td>Patient visits with assessment for function and pain/Number of visits during the reporting year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patient visits with assessment for level of function and pain documented during the reporting year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All visits for patients aged ≥ 21 years of age with osteoarthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusions: None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of visits for patients ≥ 21 years of age with osteoarthritis who were assessed for function and pain during the reporting year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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¹**Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²**National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

³**The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴**National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

⁵Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


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¹¹**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org).

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| **Osteoarthritis (Adult) (OA)** |
|-----------------|-------------------|-----------------|
| **Brief Description of Performance Measure & Source and Reporting Instructions** | **CPT Category II Code(s)** | **Code Descriptor(s)** |
| **Reporting Instructions:** Use when osteoarthritis is addressed during the patient encounter. There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used. | | the SF-36, AAOS Hip & Knee Questionnaire) |
| **Assessment for Use of Anti-inflammatory or Analgesic OTC medications**¹ | | **1007F** |
| Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications/Number of visits during the reporting year. | | Use of anti-inflammatory or analgesic over-the-counter (OTC) medications for symptom relief assessed. |
| **Numerator:** Patient visits with assessment for use of anti-inflammatory or analgesic OTC medications documented during the reporting year. | | |
| **Denominator:** All visits for patients aged ≥ 21 years of age with osteoarthritis. | | |

Footnotes:

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³The Joint Commission, https://www.jointcommission.org

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¹⁰American Gastroenterological Association (AGA), www.gastro.org/quality.


### Osteoarthritis (Adult) (OA)

**Brief Description of Performance Measure & Source and Reporting Instructions**

- **Exclusions:** None

- **Percentage** of visits for patients ≥ 21 years of age with osteoarthritis with assessment for use of anti-inflammatory or analgesic over-the-counter (OTC) medications during the reporting year

- **Reporting Instructions:** Use when osteoarthritis is addressed during the patient encounter

  There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.

<table>
<thead>
<tr>
<th>Non-steroidal Anti-inflammatory Drug (NSAID) Risk Assessment¹</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>

- **Numerator:** Patients who were assessed for **all** of the following GI and Renal risk factors during the reporting year:
  - GI bleed
  - History of peptic ulcer disease (PUD)

### Footnotes

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### Osteoarthritis (Adult) (OA)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| • Concomitant use of glucocorticoids or anticoagulants  
• Smoking  
• Significant alcohol use  
• Age > 65 years  
• Renal disease (Cr>2.0 mg/dl)  
• Hypertension  
• Heart failure  
• Concomitant use of diuretic or angiotensin-converting enzyme (ACE) inhibitor  | 1008F | Gastrointestinal and renal risk factors assessed for patients on prescribed or OTC non-steroidal anti-inflammatory drug (NSAID) |

**Denominator:** All patients ≥ 21 years of age with osteoarthritis on a prescribed or OTC NSAID

**Exclusions:** None

**Percentage** of patients ≥ 21 years of age with osteoarthritis on prescribed or OTC NSAIDs who were assessed for gastrointestinal and renal risk factors during the reporting year

**Reporting Instructions:**

There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.

---

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Osteoarthritis (Adult) (OA)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physical Examination of the Involved Joint</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
<td>Initial examination of the involved joint(s) (includes visual inspection, palpation, range of motion)</td>
</tr>
<tr>
<td>Whether or not a physical examination of the involved joint was performed during the initial visit during the reporting year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients for whom a physical examination of the involved joint was performed during the initial visit during the reporting year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients ≥ 21 years of age with osteoarthritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusions:</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients ≥ 21 years of age with osteoarthritis for whom a physical examination of the involved joint was performed during the initial visit during the reporting year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instruction:</strong> Use only for initial osteoarthritis visit or for visits for new joint involvement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
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### Osteoarthritis (Adult) (OA)

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<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Anti-inflammatory/Analgesic Therapy</strong>¹</td>
<td>4016F</td>
<td>Anti-inflammatory/analgesic agent prescribed</td>
</tr>
</tbody>
</table>

**Footnotes**

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## Osteoarthritis (Adult) (OA)

### Brief Description of Performance Measure & Source and Reporting Instructions

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<tr>
<th>CPT Category II Code(s)</th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gastrointestinal prophylaxis for NSAID use prescribed</td>
</tr>
</tbody>
</table>

| denominator exclusions, but rather demonstrate that therapy was considered and are included in the numerator when calculating the measure. |

### Gastrointestinal Prophylaxis

<table>
<thead>
<tr>
<th>Patient visits during which GI prophylaxis was considered/Number of visits during the reporting year</th>
</tr>
</thead>
</table>

**Numerator:** Patient visits during which GI prophylaxis was considered during the reporting year

**Denominator:** All visits for patients aged ≥ 21 years of age with osteoarthritis on a prescribed or OTC NSAID

**Numerator Inclusion(s):** Documentation that GI prophylaxis was prescribed; documentation of medical or patient reason(s) for not prescribing GI prophylaxis

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## Osteoarthritis (Adult) (OA)

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</tr>
</thead>
<tbody>
<tr>
<td>Percentage of visits for patients ≥ 21 years of age with osteoarthritis during which GI prophylaxis was considered during the reporting year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4017F alone or with modifier (1P if medical reason for not prescribing GI prophylaxis was documented or 2P modifier if patient reason for not prescribing GI prophylaxis was documented). For this measure, the modifiers do not act as denominator exclusions, but rather demonstrate that therapy was considered and are included in the numerator when calculating the measure.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Therapeutic Exercise for the Involved Joint

- **Numerator:** Patient visits during which therapeutic exercise for the knee or hip was considered/Number of visits during the reporting year
- **Denominator:** All visits for patients ≥ 21 years of age with osteoarthritis of the hip or knee

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<tr>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator Inclusion(s):</strong> Documentation of medical or patient reason(s) for not instructing therapeutic exercise or prescribing physical therapy for the hip or knee (eg, economic, social, religious); documentation that therapeutic exercise for the hip or knee was instructed; documentation that physical therapy for the hip or knee was prescribed.</td>
<td><strong>4018F</strong></td>
<td>Therapeutic exercise for the involved joint(s) instructed or physical or occupational therapy prescribed</td>
</tr>
<tr>
<td><strong>Percentage of visits for patients ≥ 21 years of age with osteoarthritis of the hip or knee during which therapeutic exercise for the hip or knee (therapeutic exercise instructed or physical therapy prescribed) was considered during the reporting year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 4018F alone or with modifier (1P if medical reason for not instructing therapeutic exercise or prescribing physical therapy was documented; 2P if patient reason for not instructing therapeutic exercise or prescribing physical therapy was documented). For this measure, the modifiers do not act as denominator exclusions, but rather demonstrate that therapy was considered and are included in the numerator when calculating the measure.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2. **National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)**
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7. **Optum, [www.optum.com](http://www.optum.com).**
8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**
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### Osteoporosis (OP)

<table>
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<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Communication with the Physician Managing On-going Care Post Fracture**<sup>5</sup>  
Whether or not the patient aged 50 years and older treated for a hip, spine or distal radial fracture had documentation of communication to 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  
Communication may include:  
Documentation in the medical record indicating that the physician treating the fracture communicated (eg, verbally, by letter, DEXA report was sent with the physician 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. | 5015F | Documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis |

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<th><strong>Code Descriptor(s)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong>&lt;br&gt;&lt;br&gt;<strong>Denominator</strong>: All patients aged 50 years and older treated for hip, spine or distal radial fracture&lt;br&gt;&lt;br&gt;<strong>Exclusion(s)</strong>:&lt;br&gt;Documentation of medical or patient reason(s) for not communicating with the physician managing the patient’s ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis&lt;br&gt;&lt;br&gt;<strong>Percentage</strong> of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient’s ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis&lt;br&gt;&lt;br&gt;- If the physician treating the fracture is the same physician who is providing the ongoing care, report 5015F&lt;br&gt;- For patient with appropriate exclusion criteria report 5015F with modifier 1P or 2P.&lt;br&gt;- Communication to the physician managing the ongoing care of the patient must occur within 3 months of treatment for the fracture to allow reporting of 5015F.</td>
<td></td>
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<td></td>
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</tr>
</tbody>
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</thead>
<tbody>
<tr>
<td><strong>Screening or Therapy for Women Aged 65 Years and Older</strong>&lt;sup&gt;5&lt;/sup&gt; Whether or not the female patient aged 65 years and older who had a central DXA measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months <strong>Numerator:</strong> Patients who had a central DXA measurement ordered or results documented at least once since age 60 or pharmacologic therapy prescribed within 12 months <strong>Denominator:</strong> All female patients aged 65 years and older <strong>Exclusion(s):</strong> Documentation of medical, patient, or system reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy <strong>Percentage</strong> of female patients aged 65 years and older who have a central DXA measurement ordered or results documented at least once since age 60 or pharmacologic therapy prescribed within 12 months <strong>Reporting Instructions:</strong></td>
<td>3095F</td>
<td>Central Dual-energy X-Ray Absorptiometry (DXA) results documented</td>
</tr>
<tr>
<td></td>
<td>3096F</td>
<td>Central Dual-energy X-Ray Absorptiometry (DXA) ordered</td>
</tr>
<tr>
<td></td>
<td>4005F</td>
<td>Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed</td>
</tr>
</tbody>
</table>

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</thead>
</table>
| -Report 3095F if patient has documentation of being tested since age 60  
-Report 3096F If Central DXA was ordered  
Report 4005F if patient was treated using pharmacologic agents for osteoporosis  
-For patient with appropriate exclusion criteria report either 3095F, 3096F, or 4005F with modifier 1P, 2P or 3P. | | |
| **Management Following Fracture**  
Whether or not the patient aged 50 years and older with a fracture of the hip, spine or distal radius had a central DXA measurement ordered or results documented or pharmacologic therapy prescribed  
**Numerator:** Patients who had a central DXA measurement ordered or results documented or pharmacologic therapy prescribed  
**Denominator:** All patients aged 50 years and older with a fracture of the hip, spine or distal radius | 3095F | |

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<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical, patient, or system reason(s) for not ordering or performing a central DXA measurement or not prescribing pharmacologic therapy</td>
<td>3096F</td>
<td>Central Dual-energy X-Ray Absorptiometry (DXA) results documented</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 50 years and older with a fracture of the hip, spine or distal radius who had a central DXA measurement ordered or performed or pharmacologic therapy prescribed</td>
<td>4005F</td>
<td>Central Dual-energy X-Ray Absorptiometry (DXA) ordered</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td>Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed</td>
</tr>
<tr>
<td>-Report either 3095F or 4005F if patient has documentation of being tested or treated for osteoporosis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Report 3096F if Central DXA was ordered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-For patient with appropriate exclusion criteria report either 3095F, 3096F or 4005F with modifier 1P, 2P or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-The management (DXA ordered or performed or pharmacologic therapy prescribe) should occur within 3 months of notification of the fracture from the physician treating the fracture.</td>
<td></td>
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</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>Brief Description of Performance Measure &amp; Source and Reporting Instructions</td>
<td>CPT Category II Code(s)</td>
</tr>
<tr>
<td>Pharmacologic Therapy&lt;sup&gt;5&lt;/sup&gt;</td>
<td>4005F</td>
</tr>
<tr>
<td>Whether or not the patient aged 50 years and older with a diagnosis of osteoporosis was prescribed pharmacologic therapy within 12 months</td>
<td></td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who were prescribed pharmacologic therapy&lt;sup&gt;*&lt;/sup&gt; within 12 months</td>
<td></td>
</tr>
<tr>
<td>*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).</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 50 years and older with the diagnosis of osteoporosis</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical, patient, or system reason(s) for not prescribing pharmacologic therapy</td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months</td>
<td></td>
</tr>
</tbody>
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<tr>
<td><strong>Osteoporosis (OP)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria report 4005F with modifier 1P, 2P or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Counseling for Vitamin D and Calcium Intake and Exercise</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td>4019F</td>
<td>Documentation of receipt of counseling on exercise AND either both calcium and vitamin D use or</td>
</tr>
<tr>
<td>Whether or not the patient, regardless of age, with a diagnosis of osteoporosis is either receiving both calcium and vitamin D or had documented counseling regarding both calcium and vitamin D intake, and exercise at least once within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who are either receiving both calcium and vitamin D or have been counseled regarding both calcium and vitamin D intake, and exercise at least once within 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients, regardless of age, with the diagnosis of osteoporosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for patient not receiving both calcium and vitamin D and not needing counseling regarding both calcium and vitamin D intake, and</td>
<td></td>
<td></td>
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</tbody>
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<tbody>
<tr>
<td>exercise (eg, patient has dementia and is unable to receive counseling)</td>
<td></td>
<td>counseling regarding both calcium and vitamin D use</td>
</tr>
</tbody>
</table>

**Percentage** of patients, regardless of age, with a diagnosis of osteoporosis who either received both calcium and vitamin D or had documented counseling regarding both calcium and vitamin D intake, and exercise at least once within 12 months

**Reporting Instructions:**
- Report 4019F if there is documentation that patient is either receiving both calcium and vitamin D or was counseled regarding calcium and vitamin D use; and also counseled on exercise within 12 months
- For patient with appropriate exclusion criteria report 4019F with modifier 1P.

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Palliative/End of Life Care (Pall Cr)

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</thead>
<tbody>
<tr>
<td><strong>Advance Care Planning</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td>1123F, 1124F</td>
<td>Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record</td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with advanced chronic or serious life threatening illness has 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</td>
<td></td>
<td>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</td>
</tr>
<tr>
<td><strong>Numerator:</strong> 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</td>
<td>1150F</td>
<td>Denominator Codes</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• substantial risk of death within one year, based on the physician’s clinical judgment integrating the patient’s co-morbidities, health status, social and other factors OR</td>
<td></td>
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<tbody>
<tr>
<td>• patients with advanced disease whose goals of care prioritize comfort OR • patients with incurable cancer, organ system failure, or severe progressive neurological conditions*</td>
<td>1151F</td>
<td>Documentation that a patient has a substantial risk of death within one year</td>
</tr>
<tr>
<td>* Note: See specifications for ICD-9 code list to identify patients with incurable cancer, organ system failure, or severe progressive neurological conditions</td>
<td>1152F</td>
<td>Documentation that a patient does not have a substantial risk of death within one year</td>
</tr>
<tr>
<td></td>
<td>1153F</td>
<td>Documentation of advanced disease diagnosis, goals of care prioritize comfort</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Documentation of advanced disease diagnosis, goals of care do not prioritize comfort</td>
</tr>
</tbody>
</table>

**Exclusion(s):** None

**Percentage** of patients 18 years and older with an advanced chronic or serious life-threatening illness 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 during the measurement year

**Reporting Instructions:**

Report either 1123F or 1124F for each patient aged 18 years and older with incurable cancer, organ system failure, or severe progressive neurological conditions (identified using 1151F, 1152F, or 1153F).

- Documentation of advanced disease diagnosis
- Goals of care prioritize comfort
- Goals of care do not prioritize comfort

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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


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<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-9 codes) who has advance care planning discussed and documented.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 1150F or 1151F or 1152F or 1153F for each patient aged 18 years and older. If patient has substantial risk of death within one year (1150F) or the patient’s goals of care prioritize comfort (1152F), and advance care planning was discussed and documented, also report 1123F or 1124F. There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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3The Joint Commission, https://www.jointcommission.org

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# Palliative/End of Life Care (Pall Cr)

## Palliative/End of Life Care (Pall Cr)

### Brief Description of Performance Measure & Source and Reporting Instructions

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3450F</td>
<td>Dyspnea screened, no dyspnea or mild dyspnea</td>
</tr>
<tr>
<td>3451F</td>
<td>Dyspnea screened, moderate or severe dyspnea</td>
</tr>
<tr>
<td>1150F</td>
<td>Documentation that a patient has a substantial risk of death within one year</td>
</tr>
<tr>
<td>1152F</td>
<td>Documentation that a patient does not have a substantial risk of death within one year</td>
</tr>
<tr>
<td>1153F</td>
<td>Documentation of advanced disease diagnosis, goals of care prioritize comfort</td>
</tr>
</tbody>
</table>

### Dyspnea Screening

Whether or not the patient aged 18 years and older with advanced chronic or serious life-threatening illness has a documented result from a dyspnea screening.

#### Numerator:
Patients who are screened for dyspnea.

#### Denominator:
All patients aged 18 years and older with:

- with incurable cancer, organ system failure, or severe progressive neurological conditions* AND
  - substantial risk of death within one year, based on the physician's clinical judgment integrating the patient's co-morbidities, health status, social and other factors OR
  - with advanced disease whose goals of care prioritize comfort
- Note: See specifications for ICD-9 code list to identify patients with incurable cancer, organ system failure, or severe progressive neurological conditions

* Note: See specifications for ICD-9 code list to identify patients with incurable cancer, organ system failure, or severe progressive neurological conditions

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### Footnotes

1. [Physician Consortium for Performance Improvement®](https://www.pcpi.org) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. [National Committee on Quality Assurance (NCQA)](https://www.ncqa.org), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. [The Joint Commission](https://www.jointcommission.org)

4. [National Diabetes Quality Improvement Alliance (NDQIA)](https://www.ncqa.org), The Physician Consortium for Performance Improvement (PCPI), and [National Committee on Quality Assurance (NCQA)](https://www.ncqa.org) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

5. [The Society of Thoracic Surgeons](https://www.sts.org) and [National Quality Forum](https://www.qualityforum.org).

6. [Optum](https://www.optum.com).


9. [American Gastroenterological Association (AGA)](https://www.gastro.org), or quality@aan.com.


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</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td>Documentation of advanced disease diagnosis, goals of care do not prioritize comfort</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients 18 years and older with an advanced chronic or serious life-threatening illness who have a documented result from a dyspnea screening</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 1150F or 1151F or 1152F or 1153F for each patient aged 18 years and older with incurable cancer, organ system failure, or severe progressive neurological conditions (identified using ICD-9 codes). If patient has substantial risk of death within one year (1150F) or the patient's goals of care prioritize comfort (1152F), and dyspnea screening was performed, also report 3450F or 3451F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Footnotes**

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8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**


10. **American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org)**

11. **American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)**

12. **American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).**
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</tr>
</thead>
</table>
| **Dyspnea Management**<sup>5</sup>  
Whether or not the patient aged 18 years and older with advanced chronic or serious life-threatening illness and a documented diagnosis of moderate or severe dyspnea from a dyspnea screening has a documented plan of care to manage dyspnea symptoms | 0535F  
**Denominator Codes**  
3450F  
3451F  
3452F  
1150F  
1151F | Dyspnea management plan of care, documented  
Dyspnea screened, no dyspnea or mild dyspnea  
Dyspnea screened, moderate or severe dyspnea  
Dyspnea not screened  
Documentation that a patient has a substantial risk of death within one year |

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<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
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</tbody>
</table>
| - patients with incurable cancer, organ system failure, or severe progressive neurological conditions* AND  
  - substantial risk of death within one year, based on the physician’s clinical judgment integrating the patient’s co-morbidities, health status, social and other factors OR  
  - patients with advanced disease whose goals of care prioritize comfort  
  - screened for dyspnea and diagnosed with moderate or severe dyspnea  
  * Note: See specifications for ICD-9 code list to identify patients with incurable cancer, organ system failure, or severe progressive neurological conditions |
| **Percentage** of patients 18 years and older with an advanced chronic or serious life threatening illness who have a documented result of moderate or severe dyspnea from a dyspnea screening and have a documented plan of care to manage dyspnea symptoms |
| **CPT Category II Code(s)** |
| 1152F |
| 1153F |
| **Code Descriptor(s)** |
| Documentation that a patient does not have a substantial risk of death within one year |
| Documentation of advanced disease diagnosis, goals of care prioritize comfort |
| Documentation of advance disease diagnosis, goals of care do not prioritize comfort |

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**Reporting Instructions:**

Report 1150F or 1151F or 1152F or 1153F for each patient aged 18 years and older with incurable cancer, organ system failure, or severe progressive neurological conditions (identified using ICD-9 codes). If patient has substantial risk of death within one year (1150F) or patient's goals of care prioritize comfort (1152F), also report 3450F or 3451F or 3452F. If patient has moderate or severe dyspnea (3451F), and a dyspnea management plan of care is documented, also report 0535F.

There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.

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**Footnotes**

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### Annual Parkinson’s Disease Diagnosis Reviewed

Whether or not patient with a diagnosis of Parkinson’s disease had their Parkinson’s disease diagnosis reviewed, including a review of current medications (eg medications that can produce Parkinson-like signs or symptoms) and the presence of atypical features (eg 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:** Patients who had their Parkinson’s disease diagnosis reviewed, including a review of current medications (eg medications that can produce Parkinson-like signs or symptoms) and the presence of atypical features (eg 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.

**Denominator:** All patients with a diagnosis of Parkinson’s disease.

**Exclusion(s):** None.

**Reporting Instructions:**

| 1400F | Parkinson’s disease diagnosis reviewed |

---

**Footnotes**

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<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
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<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
</tr>
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Footnotes

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<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
</tr>
<tr>
<td><strong>Psychiatric Disorders or Disturbances Assessment</strong>&lt;sup&gt;8&lt;/sup&gt;</td>
</tr>
<tr>
<td>Whether or not the patient with a diagnosis of Parkinson’s disease was assessed for psychiatric disorders or disturbances (eg psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually.</td>
</tr>
<tr>
<td>**Numerator:**Patients who were assessed for psychiatric disorders or disturbances (eg psychosis, depression, anxiety disorder, apathy, or impulse control disorder) at least annually.</td>
</tr>
<tr>
<td>**Denominator:**All patients with a diagnosis of Parkinson’s disease.</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None.</td>
</tr>
<tr>
<td>**Reporting Instructions:**There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
</tr>
<tr>
<td><strong>CPT Category II Code(s)</strong></td>
</tr>
<tr>
<td><strong>3700F</strong></td>
</tr>
<tr>
<td><strong>Code Descriptor(s)</strong></td>
</tr>
<tr>
<td>Psychiatric disorders or disturbances assessed</td>
</tr>
</tbody>
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Footnotes

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## Parkinson's Disease (Prkns)

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<tbody>
<tr>
<td><strong>Cognitive Impairment or Dysfunction Assessment</strong>(^8) Whether or not the patient with a diagnosis of Parkinson’s disease was assessed for cognitive impairment or dysfunction at least annually. <strong>Numerator:</strong> Patients who were assessed for cognitive impairment or dysfunction at least annually. <strong>Denominator:</strong> All patients with a diagnosis of Parkinson’s disease. <strong>Exclusion(s):</strong> None. <strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td>3720F</td>
<td>Cognitive impairment or dysfunction assessed</td>
</tr>
</tbody>
</table>

### Footnotes

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\(^10\)American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).


\(^12\)American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
### Querying about Symptoms of Autonomic Dysfunction

Whether or not the patient with a diagnosis of Parkinson’s disease (or caregiver(s), as appropriate) was queried about symptoms of autonomic dysfunction (e.g., orthostatic hypotension, constipation, urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, or persistent erectile failure) at least annually.

**Numerator:** Patients (or caregiver(s), as appropriate) who were queried about symptoms of autonomic dysfunction (e.g., orthostatic hypotension, constipation, urinary urgency/incontinence and fecal incontinence, urinary retention requiring catheterization, or persistent erectile failure) at least annually.

**Denominator:** All patients with a diagnosis of Parkinson’s disease.

**Exclusion(s):** Documentation of medical reason(s) for not querying patient (or caregiver) about symptoms of autonomic dysfunction at least annually (e.g., patient is unable to respond and no informant is available)

**Reporting Instructions:** For the patient with appropriate exclusion criteria report 4326F with modifier 1P.

| 4326F | Patient (or caregiver) queried about symptoms of autonomic dysfunction |

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3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

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5. Joint measure from [The Physician Consortium for Performance Improvement (PCPI)](https://www.pcpip.org) and [National Committee on Quality Assurance (NCQA)](http://www.ncqa.org) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


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## Parkinson’s Disease (Prkns)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Querying about Sleep Disturbances**<sup>8</sup>  
Whether or not the patient with a diagnosis of Parkinson’s disease (or caregiver(s), as appropriate) was queried about sleep disturbances at least annually.  
**Numerator:** Patients (or caregiver(s), as appropriates) who were queried about sleep disturbances at least annually.  
**Denominator:** All patients with a diagnosis of Parkinson’s disease.  
**Exclusion(s):** Documentation of medical reason(s) for not querying patient (or caregiver) about sleep disturbances at least annually (eg patient is unable to respond and no informant is available)  
**Reporting Instructions:** For the patient with appropriate exclusion criteria report 4328F with modifier 1P. | 4328F | Patient (or caregiver) queried about sleep disturbances |
|  
---  

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.  
2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)  
3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)  
4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.  
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11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)  

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<table>
<thead>
<tr>
<th>Parkinson's Disease (Prkns)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Description of Performance Measure &amp; Source and Reporting Instructions</td>
</tr>
<tr>
<td>Querying about Falls$^8$</td>
</tr>
</tbody>
</table>

Whether or not the patient with a diagnosis of Parkinson’s disease (or caregiver(s), as appropriate) was queried about falls at least annually.

**Numerator:** Patients (or caregiver(s), as appropriate) who were queried about falls at least annually.

**Denominator:** All patients with a diagnosis of Parkinson’s disease.

**Exclusion(s):** Documentation of medical reason(s) for not querying patient (or caregiver) about falls at least annually (eg patient is unable to respond and no informant is available)

**Reporting Instructions:** For the patient with appropriate exclusion criteria report 6080F with modifier 1P

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**Footnotes**

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org) or [quality@aan.com](mailto:quality@aan.com).


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### Parkinson's Disease Rehabilitative Therapy Options

Whether or not the patient with a diagnosis of Parkinson’s disease (or caregiver(s), as appropriate) had rehabilitative therapy (e.g., physical, occupational, or speech therapy) options 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.

**Denominator:** All patients with a diagnosis of Parkinson’s disease.

**Exclusion(s):** Documentation of medical reason(s) for not discussing rehabilitative therapy options with the patient (or caregiver) at least annually (e.g., patient has no known physical disability due to Parkinson’s disease; patient is unable to respond and no informant is available)

**Reporting Instructions:** For the patient with appropriate exclusion criteria, report 4400F with modifier 1P.

### Parkinson's Disease-Related Safety Issues Counseling

Whether or not the patient with a diagnosis of Parkinson’s disease (or caregiver(s), as appropriate) was counseled about context-specific safety issues appropriate to the patient’s

4400F  
Rehabilitative therapy options discussed with patient (or caregiver)

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2. **National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)**

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5. **Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).**


7. **Optum, [www.optum.com](http://www.optum.com).**

8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**


10. **American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).**

11. **American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).**

12. **American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).**

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# Parkinson's Disease (Prkns)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>stage of disease (eg injury prevention, medication management, or driving) at least annually</td>
<td>6090F</td>
<td>Patient (or caregiver) counseled about safety issues appropriate to patient’s stage of disease</td>
</tr>
</tbody>
</table>

**Numerator:** Patients (or caregiver(s), as appropriate) who were counseled about context-specific safety issues appropriate to the patient’s stage of disease (eg injury prevention, medication management, or driving) at least annually

**Denominator:** All patients with a diagnosis of Parkinson’s disease

**Exclusion(s):** Documentation of medical reason for not counseling the patient (or caregiver) about context-specific safety issues appropriate to the patient’s stage of disease (eg patient is unable to comprehend and no informant is available)

**Reporting Instructions:** For the patient with appropriate exclusion criteria, report 6090F with modifier 1P.

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Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®)**, [www.ncqa.org](http://www.ncqa.org)

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<table>
<thead>
<tr>
<th><strong>Querying about Parkinson's Disease Medication Related Motor Complications</strong></th>
<th><strong>4324F</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not at the visit for the patient with a diagnosis of Parkinson's disease the patient (or caregiver(s), as appropriate) was queried about Parkinson's disease medication-related motor complications (eg wearing off, dyskinesia, or off-time).</td>
<td>Patient (or caregiver) queried about Parkinson's disease medication related motor complications</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patient visits with patient (or caregiver(s), as appropriate) queried about Parkinson's disease medication-related motor complications (eg wearing off, dyskinesia, or off-time).</td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All visits for patients with a diagnosis of Parkinson's disease.</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason for not querying patient (or caregiver) about Parkinson's disease medication-related motor complications (eg patient is not on a Parkinson's disease medication; the patient is unable to respond and no informant is available)</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For the patient with appropriate exclusion criteria report 4324F with modifier 1P.</td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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# Parkinson's Disease Medical and Surgical Treatment Options Reviewed

Whether or not the patient with a diagnosis of Parkinson’s disease (or caregiver(s), as appropriate) had the Parkinson’s disease treatment options reviewed (eg non-pharmacological treatment, pharmacological treatment or surgical treatment) at least once annually

**Numerator:** Patients (or caregiver(s), as appropriate) who had the Parkinson’s disease treatment options reviewed (eg non-pharmacological treatment, pharmacological treatment or surgical treatment) at least once annually

**Denominator:** All patients with a diagnosis of Parkinson’s disease.

**Exclusion(s):** Documentation of medical reason for not querying patient (or caregiver) about Parkinson’s disease medication related motor complications (eg the patient is unable to respond and no informant is available)

**Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.

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<table>
<thead>
<tr>
<th>Footnotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>¹<strong>Physician Consortium for Performance Improvement® (PCPI)</strong> - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.</td>
</tr>
<tr>
<td>²<strong>National Committee on Quality Assurance (NCQA)</strong>, Health Employer Data Information Set (HEDIS®), <a href="http://www.ncqa.org">www.ncqa.org</a></td>
</tr>
<tr>
<td>³<strong>The Joint Commission</strong>, <a href="https://www.jointcommission.org">https://www.jointcommission.org</a></td>
</tr>
<tr>
<td>⁴<strong>National Diabetes Quality Improvement Alliance (NDQIA)</strong> - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.</td>
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<td>⁵Joint measure from <strong>The Physician Consortium for Performance Improvement (PCPI)</strong>, and <strong>National Committee on Quality Assurance (NCQA)</strong> - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at <a href="http://www.ncqa.org">www.ncqa.org</a>.</td>
</tr>
<tr>
<td>⁶<strong>The Society of Thoracic Surgeons</strong> at <a href="http://www.sts.org">www.sts.org</a> and <strong>National Quality Forum</strong>, <a href="http://www.qualityforum.org">www.qualityforum.org</a></td>
</tr>
<tr>
<td>⁷<strong>Optum</strong>, <a href="http://www.optum.com">www.optum.com</a></td>
</tr>
<tr>
<td>¹⁰<strong>American Society of Anesthesiologists (ASA)</strong>, <a href="http://www.asahq.org">www.asahq.org</a></td>
</tr>
<tr>
<td>¹¹<strong>American College of Gastroenterology (AGC)</strong>, <a href="http://www.gi.org">www.gi.org</a>; <strong>American Gastroenterological Association (AGA)</strong>, <a href="http://www.gastro.org">www.gastro.org</a>; and <strong>American Society for Gastrointestinal Endoscopy (ASGE)</strong>, <a href="http://www.asge.org">www.asge.org</a>.</td>
</tr>
<tr>
<td>Performance Measure &amp; Source and Reporting Instruction</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>Breast cancer resection pathology reporting-pT category (primary tumor) and pN (regional lymph nodes) with histologic grade¹</td>
</tr>
</tbody>
</table>

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org

³The Joint Commission, https://www.jointcommission.org

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⁷Optum, www.optum.com

⁸American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>breast cancer resection pathology report with appropriate exclusion criteria report 3260F with modifier 1P. If the specimen is not primary breast tissue (eg, liver biopsy), report only 3250F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>colorectal cancer resection pathology reporting-pT category (primary tumor) and pN category (regional lymph node) with histologic grade¹</td>
<td>3260F</td>
<td>pT category (primary tumor) and pN category (regional lymph nodes) and histologic grade documented in pathology report</td>
</tr>
</tbody>
</table>

Footnotes

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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### Pathology (PATH)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Percentage** of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN (lymph nodes) category and the histologic grade  
**Reporting Instructions:** Report this measure each time a colorectal cancer resection pathology report is prepared. For colon and rectum cancer resection pathology report with appropriate exclusion criteria report 3260F with modifier 1P. If the specimen is not primary colorectal tissue (eg, liver biopsy), report only 3250F. | 3250F | Specimen site other than anatomic location of primary tumor |
| **Esophageal Biopsies with a Diagnosis of Barrett’s Esophagus that also include a Statement on Dysplasia**  
Whether or not an esophageal biopsy report documenting the presence of Barrett’s mucosa includes a statement about dysplasia  
**Numerator:** Esophageal biopsy reports with the histologic finding of Barrett’s mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading) | 3126F | Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite, and if present, contains appropriate grading) |

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Footnotes

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All esophageal biopsy reports that document the presence of Barrett’s mucosa</td>
<td>3267F</td>
<td>Pathology report includes pT category, pN category, Gleason score</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason for not reporting the histologic finding of Barrett's mucosa (e.g., malignant neoplasm or absence of intestinal metaplasia)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 3126F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Radical Prostatectomy Report includes the pT Category, the pN Category, Gleason Score, and a Statement about Margin Status:</strong> Whether or not a radical prostatectomy pathology report includes the pT category, the pN category, the Gleason score, and a statement about margin status</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

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## Pathology (PATH)

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score, and a statement about margin status</td>
<td></td>
<td>score and statement about margin status</td>
</tr>
</tbody>
</table>

**Denominator:**  
All radical prostatectomy pathology reports

**Exclusion(s):**  
Documentation of medical reason for not including pT category, pN category, Gleason score, and statement about margin status in the pathology report (eg, specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, or transurethral resection of the prostate [TURP]).

**Reporting Instructions:**  
For patient with appropriate exclusion criteria, report 3267F with modifier 1P.

### Turn Around Time (TAT) for Routine Non-Gynecologic Cytopathology Specimens

Whether or not a cytopathology report on a routine non-gynecologic specimen was finalized within two working days of the time of accession in the laboratory

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<table>
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<tr>
<th>Pathology (PATH)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reports on routine non-gynecologic cytopathology specimens are finalized within two working days from the time of accession in the laboratory.</td>
<td>0550F</td>
<td>Cytopathology report on routine non-gynecologic specimen finalized within two working days of accession date</td>
</tr>
<tr>
<td></td>
<td>0551F</td>
<td>Cytopathology report on non-gynecologic specimen with documentation that the specimen was non-routine</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All routine non-gynecologic cytopathology reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For reports provided for routine non-gynecologic specimens that are finalized within two working days, use code 0550F; for all non-routine specimens, use code 0551F.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no performance exclusions for this measure. Do not report modifiers 1P, 2P, or 3P with these codes.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Quantitative HER2 Evaluation by Immunohistochemistry (IHC) Uses the System Recommended by the ASCO/CAP Guidelines</strong>&lt;sup&gt;9&lt;/sup&gt;</td>
<td>3394F</td>
<td>Quantitative HER2 Immunohistochemistry (IHC) evaluation of breast cancer consistent with the scoring system defined in the ASCO/CAP guidelines</td>
</tr>
<tr>
<td>Whether or not a quantitative HER2 immunohistochemistry (IHC) evaluation was consistent with the scoring system defined in the ASCO/CAP guidelines</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


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<table>
<thead>
<tr>
<th>Pathology (PATH)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong></td>
<td>Breast cancer patients receiving quantitative breast tumor HER2 Immunohistochemistry (IHC) evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in Table 4 of the ASCO/CAP guideline</td>
<td>3395F</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>All breast cancer patients with quantitative breast tumor evaluation by HER2 Immunohistochemistry (IHC)</td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td>There are no performance exclusions for this measure. Do not report modifiers 1P, 2P, or 3P with these codes.</td>
<td></td>
</tr>
</tbody>
</table>

**Bone Marrow and Fine Needle Aspiration (FNA)/Direct Specimen Acquisition Timeout Procedure**

Whether or not the patient undergoing fine needle aspiration or bone marrow aspiration or biopsy received a proper timeout

---

Footnotes

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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### Pathology (PATH)

<table>
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<tr>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>procedure to verify correct patient/correct site/correct procedure</td>
<td>6100F</td>
<td>Timeout to verify correct patient and correct site and correct procedure, documented</td>
</tr>
</tbody>
</table>
| **Numerator:**  
Patients for whom there is documentation of a timeout procedure to verify correct patient/correct site/correct procedure | | |
| **Denominator:**  
All patients who had fine needle aspiration or bone marrow aspiration and/or biopsy. | | |
| **Exclusion(s):**  
None | | |
| **Reporting Instructions:**  
There are no performance exclusions for code 6100F. Do not report modifier 1P, 2P, or 3P with this code. | | |

---

**Footnotes**

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7. **Optum, [www.optum.com](http://www.optum.com).**

8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures) or quality@aan.com.**


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### Pediatric Acute Gastroenteritis (PAG)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Documentation of Hydration Status**<sup>1</sup>  
Whether or not a patient 1 month through 5 years of age with a diagnosis of acute gastroenteritis had a documented hydration status  
**Numerator:** Patients with documented hydration status  
**Denominator:** Patients 1 month through 5 years of age with the diagnosis of acute gastroenteritis  
**Exclusions:** None  
**Percentage** of patients 1 month through 5 years of age with a diagnosis of acute gastroenteritis who had hydration status documented  
**Report Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used. | 2030F | Hydration status documented, normally hydrated |
| | 2031F | Hydration status documented, dehydrated |
| **Weight Measurement**<sup>1</sup>  
Whether or not patient 1 month through 5 years of age with a diagnosis of acute gastroenteritis had weight measurement recorded | 2001F | Weight recorded |

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<sup>1</sup>Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

<sup>2</sup>National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

<sup>3</sup>The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

<sup>4</sup>National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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<sup>7</sup>Optum, [www.optum.com](http://www.optum.com).


<sup>10</sup>American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

<sup>11</sup>American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

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### Pediatric Acute Gastroenteritis (PAG)

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</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Patients who had their weight measurement recorded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> Patients 1 month through 5 years of age with a diagnosis of acute gastroenteritis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients 1 month through 5 years of age with a diagnosis of acute gastroenteritis who had weight measurement recorded</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Recommendation of Appropriate Oral Rehydration Solution¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not an appropriate oral rehydration solution was recommended for the patient 1 month through 5 years of age with a diagnosis of acute gastroenteritis</td>
<td>4056F</td>
<td>Appropriate oral rehydration solution recommended</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients for whom an appropriate oral rehydration solution was recommended</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> Patients 1 month through 5 years of age with the diagnosis of acute gastroenteritis, treated in ambulatory settings (eg, physician office or treated in the emergency department and discharged to home)</td>
<td>2030F</td>
<td>Hydration status documented, normally hydrated</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients 1 month through 5 years of age with the diagnosis of acute gastroenteritis for whom an appropriate oral rehydration solution was recommended</td>
<td>2031F</td>
<td>Hydration status documented, dehydrated</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 2030F or 2031F for all patients. Report 4056F with 2031F. There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org

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⁷Optum, www.optum.com

⁸American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


¹⁰American Gastroenterological Association (AGA), www.gastro.org/quality

¹¹American Society of Anesthesiologists (ASA), www.asahq.org

¹²American College of Gastroenterology (AGG), www.gi.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org
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</thead>
<tbody>
<tr>
<td><strong>Education</strong>¹</td>
<td>4058F</td>
<td>Pediatric gastroenteritis education provided to caregiver</td>
</tr>
</tbody>
</table>

**Pediatric Acute Gastroenteritis (PAG)**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Education</strong>¹</td>
<td>Whether or not a patient’s caregiver received education on diet and on when to contact the physician for a patient 1 month through 5 years of age with a diagnosis of acute gastroenteritis</td>
<td>4058F</td>
</tr>
<tr>
<td><strong>Numerator</strong>:</td>
<td>Patients whose caregiver received education regarding diet and when to contact the physician</td>
<td>Pediatric gastroenteritis education provided to caregiver</td>
</tr>
<tr>
<td><strong>Denominator</strong>:</td>
<td>All patients 1 month through 5 years of age with the diagnosis of acute gastroenteritis, treated in ambulatory settings (physician office or treated in the emergency room and discharged to home)</td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients 1 month through 5 years of age with a diagnosis of acute gastroenteritis whose caregiver received education regarding diet and on when to contact the physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>:</td>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used</td>
<td></td>
</tr>
</tbody>
</table>

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⁶**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum**, [www.qualityforum.org](http://www.qualityforum.org)

⁷**Optum**, [www.optum.com](http://www.optum.com)


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<thead>
<tr>
<th>Plan of Care for Inadequate Hemodialysis¹</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of calendar months during which a patient aged 17 years and younger with a diagnosis of ESRD receiving hemodialysis has Kt/V ≥1.2 OR has Kt/V &lt;1.2 with a documented plan of care*</td>
<td>0505F</td>
<td>Hemodialysis plan of care documented</td>
</tr>
<tr>
<td></td>
<td>3082F</td>
<td>Kt/V less than 1.2 (Clearance of urea (Kt)/volume (V))</td>
</tr>
<tr>
<td></td>
<td>3083F</td>
<td>Kt/V equal to or greater than 1.2 and less than 1.7 (Clearance of urea (Kt)/volume (V))</td>
</tr>
<tr>
<td></td>
<td>3084F</td>
<td>Kt/V greater than or equal to 1.7 (Clearance of urea (Kt)/volume (V))</td>
</tr>
</tbody>
</table>

* A documented plan of care may include checking for adequacy of the AV access, increasing the blood flow, increasing the dialyzer size, increasing the time of dialysis sessions, increasing the number of days of dialysis, documenting residual renal function, documenting that patient has an inborn error of metabolism or is undergoing an alternate hemodialysis modality.

Footnotes

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### Pediatric End Stage Renal Disease (P-ESRD)

**Denominator**: Patient calendar months for all patients aged 17 years and younger with a diagnosis of ESRD and receiving hemodialysis

**Exclusion(s)**: None

**Percentage** of calendar months during the 12-month reporting period in which patients aged 17 years and younger with a diagnosis of ESRD receiving hemodialysis have a single-pool Kt/V ≥1.2 or have a single-pool Kt/V <1.2 with a documented plan of care for inadequate hemodialysis

**Reporting Instructions**: Report this measure during each calendar month a patient is receiving hemodialysis. Report 3082F or 3083F or 3084F for the corresponding Kt/V measurement.

If Kt/V < 1.2 (3082F) and patient has a plan of care for inadequate hemodialysis, also report 0505F. There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Influenza Immunization</strong>¹</td>
<td>4274F</td>
<td>Influenza immunization administered or previously received</td>
</tr>
</tbody>
</table>

Footnotes

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<tr>
<th>Pediatric End Stage Renal Disease (P-ESRD)</th>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not receiving influenza immunization (eg, patient allergy, other contraindication)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not receiving the influenza immunization (eg, patient/caregiver declined)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of system reason(s) for not receiving the influenza immunization (eg, vaccine not available)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 6 months through 17 years with a diagnosis of ESRD and receiving dialysis seen for a visit between November 1 and February 15 of the one-year measurement period who have documented administration of influenza immunization OR patient reported receipt of an influenza immunization from another provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report this measure only at visits occurring between November 1 and February 15. For patient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td>with appropriate exclusion criteria, report 4274F with modifier 1P, 2P of 3P.</td>
<td></td>
<td></td>
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</tbody>
</table>

### Pediatric Pharyngitis (PHAR)

<table>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Appropriate Testing for Children with Pharyngitis**<sup>2</sup>  
Whether or not children 2 – 18 years of age (inclusive) who were diagnosed with pharyngitis and dispensed or prescribed an antibiotic received a group A strep test.  
**Numerator:** Patients who received a group A streptococcus (strep) test  
**Denominator:** All patients aged 2-18 years with the diagnosis of pharyngitis who were dispensed or prescribed antibiotic treatment | 3210F  
4120F | Group A Strep Test Performed  
Antibiotic prescribed or dispensed |

### Footnotes

1. **Physician Consortium for Performance Improvement**® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


### Pediatric Pharyngitis (PHAR)

<table>
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<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exclusion(s): Medical or patient reasons for not performing Group A Strep Tests. <strong>Percentage</strong> of children 2 – 18 years of age (inclusive) diagnosed with pharyngitis and dispensed or prescribed an antibiotic who received a group A strep test for the visit. <strong>Reporting Instructions:</strong> Note: Because this measure is being specified for physician reporting, the instructions request physicians to report prescribing or dispensing of medication. For Medical or patient reasons for not performing a Group A Strep Test, report code 3210F with modifier 1P or 2P. There are no performance measure exclusions for codes 4120F and 4124F for children with pharyngitis. Do not report modifiers 1P, 2P, or 3P with these codes for this condition.</td>
<td>4124F</td>
<td>Antibiotic neither prescribed nor dispensed</td>
</tr>
</tbody>
</table>

**Footnotes**

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**Perioperative Care 2 (PERI 2)**

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</tr>
</thead>
</table>
| **Timing of Prophylactic Antibiotics – Ordering Physician**<sup>5</sup> Whether or not the surgical patient aged 18 years and older undergoing a procedure with the indications for prophylactic parenteral antibiotics had an order for an antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)  
**Numerator:** Surgical patients who have an order for an antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)  
**Denominator:** All surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics  
(List of procedures is available in measure specifications)  
**Exclusion(s):** Documentation of medical reason(s) for not ordering an antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)  
**Percentage** of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics | 4047F | Documentation of order for prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required) |
| | 4048F | Documentation that administration of prophylactic parenteral antibiotic was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered |

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**Footnotes**

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8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com.**
10. **American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).**
11. **American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).**
12. **American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).**

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</tr>
</thead>
</table>
| parenteral antibiotics who have an order for an antibiotic to be given within one hour (if vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)  
**Reporting Instructions:** It is anticipated that this measure will be reported by the physician performing the procedure  
There must be documentation of an order (written, verbal or standing order/protocol) specifying that antibiotic is to be given within the specified timeframe OR documentation that antibiotic has been given within the specified timeframe.  
Report 4047F if prophylactic antibiotic was ordered or 4048F if antibiotic has been given.  
For patient meeting exclusion criteria, report 4047F with modifier 1P.                                                                                                                                                                                                                                                                                                                                                                 |                         |                   |

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</table>
| **Timely Administration of Prophylactic Parenteral Antibiotics**<sup>5</sup>  
Whether or not administration of the prophylactic parenteral antibiotic ordered was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) for the surgical patient aged 18 years and older who received an anesthetic when undergoing a procedure with the indications for prophylactic parenteral antibiotics  
**Numerator:** Surgical patients for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)  
**Denominator:** All surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics*  
*Anesthesia services included in denominator are associated with some surgical procedures for which prophylactic antibiotics may not be indicated. Clinicians should exclude | 4048F | Documentation that administration of prophylactic parenteral antibiotic was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered |

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 patients from denominator in instances where anesthesia services are provided but not associated with surgical procedures for which prophylactic antibiotics are indicated.

**Exclusion(s):** Documentation of medical reason(s) for not initiating administration of prophylactic antibiotics as specified (eg, contraindicated, patient already receiving antibiotics) OR antibiotic not ordered

**Percentage** of surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

**Reporting Instructions:** It is anticipated that the physician administering or responsible for the administering the prophylactic antibiotic will report this measure.

Anesthesia administration codes included in denominator are associated with some surgical procedures for which prophylactic antibiotics may not be indicated. Clinicians

<table>
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<tr>
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<tbody>
<tr>
<td>Brief Description of Performance Measure &amp; Source and Reporting Instructions</td>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin</td>
<td>4041F</td>
<td></td>
</tr>
</tbody>
</table>

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11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)


**Note:** In a pay for reporting program the “antibiotic not ordered” option may have a unique combination of CPT II codes and modifier different from what is specified here. Users of this measure in a pay for reporting program should refer to program specific specifications.

**Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin**

Whether or not the surgical patient aged 18 years and older undergoing a procedure with the indications for a first OR second generation cephalosporin should exclude patients from denominator in instances where anesthesia services are provided but not associated with surgical procedures for which prophylactic antibiotics are indicated. A surgical procedure list is not used to identify these patients.

Report 4048F where administration of the antibiotic ordered was initiated within one hour of surgical incision.

For patient with appropriate exclusion criteria, (eg, contraindicated, patient already receiving antibiotic OR antibiotic not ordered), report 4048F with modifier 1P.

Note: In a pay for reporting program the “antibiotic not ordered” option may have a unique combination of CPT II codes and modifier different from what is specified here. Users of this measure in a pay for reporting program should refer to program specific specifications.
**Perioperative Care 2 (PERI 2)**

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</tr>
</thead>
<tbody>
<tr>
<td>second generation cephalosporin had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis</td>
<td></td>
<td>Documentation of order for cefazolin OR cefuroxime for antimicrobial prophylaxis</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Surgical patients who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic (List of procedures is available in measure specifications)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not ordering cefazolin OR cefuroxime for antimicrobial prophylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| - It is anticipated that this measure will be reported by the physician performing the procedure  
- There must be documentation of an order (written, verbal or standing order/protocol) for cefazolin or cefuroxime for antimicrobial prophylaxis OR documentation that cefazolin or cefuroxime was given  
- Report 4041F if cefazolin or cefuroxime was ordered.  
- If either cefazolin or cefuroxime was administered, there is a presumption that an order existed for that administration. In this case, 4041F should be reported  
- For patient with appropriate exclusion criteria report 4041F with modifier 1P. | 4049F | Documentation that order was given to discontinue prophylactic antibiotics within 24 hours of surgical end time, non-cardiac procedure |
| **Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)** | | |
| Whether or not the non-cardiac surgical patient aged 18 years and older undergoing a procedure with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, has an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time | 4049F |  |

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7. **Optum, [www.optum.com](http://www.optum.com)**

8. **American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aan.com**


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## Perioperative Care 2 (PERI 2)

### Brief Description of Performance Measure & Source and Reporting Instructions

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<tr>
<th>Numerator:</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-cardiac surgical patients who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time</td>
<td>All non-cardiac surgical patients 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic (List of procedures is available in measure specifications)</td>
</tr>
</tbody>
</table>

**Exclusion(s):**
Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 24 hours of surgical end time

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

### Reporting Instructions:

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<tr>
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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Denominator Codes</td>
<td>Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively</td>
</tr>
<tr>
<td>4046F</td>
<td>Documentation that prophylactic antibiotics were neither given within 4 hours prior to surgical incision nor given intraoperatively</td>
</tr>
<tr>
<td>4042F</td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

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<tbody>
<tr>
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</tr>
<tr>
<td>4043F</td>
<td>Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)⁵</td>
</tr>
</tbody>
</table>

-- It is anticipated that this measure will be reported by the physician performing the procedure.

- Patients may be counted as having “received a prophylactic antibiotic” if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively

- There must be documentation of an order (written, verbal or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 24 hours of surgical end time OR specifying a course of antibiotic administration limited to that 24-hour period (eg, to be given every 8 hours for three doses) **OR** documentation that prophylactic antibiotic was discontinued within 24 hours of surgical end time

- Report either 4046F or 4042F for each patient. If patient received prophylactic antibiotics and there was an order for discontinuation within 24 hours after surgical end time, also report 4049F. For patient with appropriate exclusion criteria, report 4049F with modifier 1P.

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<tbody>
<tr>
<td>Whether or not the cardiac surgical patient aged 18 years and older undergoing a procedure with the indications for prophylactic antibiotics AND who received prophylactic antibiotics, has an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time</td>
<td>Denominator Codes</td>
<td>Documentation that an order was given to discontinue prophylactic antibiotics within 48 hours of surgical end time, cardiac procedure</td>
</tr>
<tr>
<td>Numerator: Cardiac surgical patients who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time</td>
<td>4046F</td>
<td></td>
</tr>
<tr>
<td>Denominator: All cardiac surgical patients 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic</td>
<td>4042F</td>
<td>Documentation that prophylactic antibiotics were given within 4 hours prior to surgical incision or given intraoperatively</td>
</tr>
<tr>
<td>(List of procedures available in measure specifications)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s): Documentation of medical reason(s) for not discontinuing prophylactic antibiotics within 48 hours of surgical end time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)
4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.
5. Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).
### Perioperative Care 2 (PERI 2)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time Reporting Instructions: - It is anticipated that this measure will be reported by the physician performing the procedure - Patients may be counted as having &quot;received a prophylactic antibiotic&quot; if the antibiotic was received within 4 hours prior to the surgical incision (or start of procedure when no incision is required) or intraoperatively. - There must be documentation of an order (written, verbal or standing order/protocol) specifying that prophylactic antibiotic is to be discontinued within 48 hours of surgical end time OR specifying a course of antibiotic administration limited to that 48-hour period (eg, to be given every 8 hours for three doses&quot;) OR documentation that prophylactic antibiotic was discontinued within 48 hours of surgical end time. - Report either 4046F or 4042F for each patient. If patient received prophylactic antibiotics and there was an order for discontinuation within 48 hours after surgical end time, also</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

1. Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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6. The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)


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</thead>
<tbody>
<tr>
<td>report 4043F. For patient with appropriate exclusion criteria, report 4043F with modifier 1P.</td>
<td>4044F</td>
<td>Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hrs prior to incision time or 24 hours after surgery end time</td>
</tr>
</tbody>
</table>

### Venous Thromboembolism (VTE) Prophylaxis

Whether or not the surgical patient aged 18 years and older undergoing a procedure for which VTE prophylaxis is indicated in all patients had an order for LMWH, LDUH, adjusted-dose warfarin, fondaparinux, or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

**LMWH** - Low molecular weight heparin  
**LDUH** - Low-dose unfractionated heparin

**Numerator:**  
Surgical patients who had an order for LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time

**Denominator:**  
4044F Documentation that an order was given for venous thromboembolism (VTE) prophylaxis to be given within 24 hrs prior to incision time or 24 hours after surgery end time

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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Perioperative Care 2 (PERI 2)

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<th>CPT Category II Code(s)</th>
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</thead>
<tbody>
<tr>
<td>All surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients (List of procedures available in measure specifications)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s): Documentation of medical reason(s) for patient not receiving LMWH, LDUH, adjusted-dose warfarin, fondaparinux, or mechanical prophylaxis within 24 hours prior to incision time or 24 hours after surgery end time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients who had an order for LMWH, LDUH, adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: -There must be documentation of an order (written, verbal or standing order/protocol) for VTE prophylaxis OR documentation that VTE prophylaxis was received.</td>
<td></td>
<td></td>
</tr>
</tbody>
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Footnotes

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3 The Joint Commission, https://www.jointcommission.org

4 National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5 Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at www.ncqa.org.


7 Optum, www.optum.com

8 American Academy of Neurology, https://www.aan.com/practice/neuromuscular-quality-measures, or quality@aan.com


10 American Gastroenterological Association (AGA), www.gastro.org/quality

11 American Society of Anesthesiologists (ASA), www.asahq.org

12 American College of Gastroenterology (AG), www.gi.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org
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</tr>
</thead>
<tbody>
<tr>
<td>-Report 4044F where there is documentation of an order for VTE prophylaxis or where it was given within the specified timeframe. -For patient with appropriate exclusion criteria, report 4044F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## Post-Anesthetic Transfer of Care Measure: Use of Checklist for Direct Transfer of Care from Anesthetizing Location to Critical Care Unit¹¹

Whether a patient who received an anesthesia service and was directly admitted to a critical care unit had documentation of use of a checklist for the transfer of care from the responsible anesthesia practitioner to the responsible critical care unit practitioner

### Numerator:

Patients with documented use of a checklist for the transfer of care from the responsible anesthesia practitioner to the responsible critical care unit practitioner

### Definition:

The key handoff elements that must be included in the transition of care include, but are not limited to:

1. Identification of patient
2. Identification of responsible practitioner (primary service)
3. Discussion of pertinent medical history
4. Discussion of the surgical/procedure course (procedure, reason for procedure performed)
5. Intraoperative anesthetic management and issues/concerns to include things such as airway, hemodynamic, narcotic, sedation level and paralytic management and intravenous fluids/blood products and urine output during the procedure
6. Expectations/plans for the early post-procedure period to include things such as the anticipated course (anticipatory

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0581F</td>
<td>Patient transferred directly from anesthetizing location to critical care unit</td>
</tr>
<tr>
<td>0582F</td>
<td>Patient not transferred directly from anesthetizing location to critical care unit</td>
</tr>
<tr>
<td>0583F</td>
<td>Transfer of care checklist used</td>
</tr>
<tr>
<td>0584F</td>
<td>Transfer of care checklist not used</td>
</tr>
</tbody>
</table>

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Footnotes

¹¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

²National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

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⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷Optum, [www.optum.com](http://www.optum.com)

⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com).


¹⁰American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

¹¹American College of Gastroenterology (AGA), [www.gastro.org/quality](http://www.gastro.org/quality); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

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Last Updated June 23, 2023
7. Opportunity for questions and acknowledgement of understanding of report from the receiving critical care unit team

**Denominator:**

All patients who receive an anesthesia service and are transferred directly from the anesthetizing location to a critical care unit

**Exclusion(s):** None

**Reporting Instructions:**

For all patients who receive an anesthesia service (CPT Code 00100-01969), report either 0581F or 0582F.

When 0581F is reported, also report 0583F or 0584F.

There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

**Prevention of Post-Operative Nausea and Vomiting (PONV) – Multimodal Therapy (Adults)**

| Numerator: | 4554F | Patient received inhalational anesthetic agent |

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Last Updated June 23, 2023
Patients who receive at least two prophylactic pharmacologic anti-emetic agents of different classes preoperatively and intraoperatively for the prevention of PONV

**Definition:** The recommended first- and second-line classes of pharmacologic anti-emetics for PONV prophylaxis in adults include (but are not limited to):

- 5-hydroxytryptamine (5-HT3) receptor antagonists (eg, ondansetron, dolasetron, granisetron, and tropisetron)
- steroid (eg, dexamethasone)
- phenothiazines (eg, promethazine, prochlorperazine)
- phenylethylamine (eg, ephedrine)
- butyrophenones (eg, droperidol, haloperidol)
- antihistamine (eg, dimenhydrinate, diphenhydramine)
- anticholinergic (eg, transdermal scopolamine)

**Denominator:**

All patients aged 18 years and older who receive an inhalational general anesthesia service and have three or more risk factors for post-operative nausea and vomiting (PONV)

**Denominator Criteria (Eligible Cases):**

Patients aged 18 years and older and
Who receive an anesthesia service (00100-01969)

<table>
<thead>
<tr>
<th>Denominator</th>
<th>Patient did not receive inhalational anesthetic agent</th>
</tr>
</thead>
<tbody>
<tr>
<td>4555F</td>
<td>Patient exhibits 3 or more risk factors for post-operative nausea and vomiting</td>
</tr>
<tr>
<td>4556F</td>
<td>Patient does not exhibit 3 or more risk factors for post-operative nausea and vomiting</td>
</tr>
<tr>
<td>4557F</td>
<td>Patient received at least 2 prophylactic pharmacologic anti-emetic agents of different classes preoperatively and intraoperatively</td>
</tr>
</tbody>
</table>

**Footnotes**

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)


and
4554F  Patient received inhalational anesthetic agent
and

Have three or more risk factors for PONV (4556F): (1) female
gender, (2) history of PONV or a history of motion sickness,
(3) non-smoker, and (4) intended administration of opioids for
post-operative analgesia. This includes use of opioids given
intraoperatively and whose effects extend into the post
anesthesia care unit (PACU) or post-operative period, or
opioids given in the PACU, or opioids given after discharge
from the PACU.

Exclusion(s):
Documentation of medical (eg, Contraindications/Cautions to
5HT3 antagonists such as:

- Hypersensitivity to drug/class component
- Congenital long QT syndrome
- Caution if QT prolongation risk
- Caution if hepatic impairment
- Caution if abdominal surgery)
or systems (eg, shortage/lack of availability of appropriate
class of pharmacologic anti-emetic agent) reason(s) for not
administering pharmacologic prophylaxis

Reporting Instructions:
For all patients who receive an anesthesia service (CPT Code
00100-01969), report either 4554F or 4555F and either 4556F
or 4557F.

Footnotes
1Physician Consortium for Performance Improvement®(PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
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12American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
<table>
<thead>
<tr>
<th>Maintenance of Intraoperative Normothermia¹¹</th>
<th>4559F</th>
<th>At least 1 body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>4255F</td>
<td>Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record</td>
</tr>
<tr>
<td>Patients for whom at least one body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time</td>
<td>4256F</td>
<td>Duration of general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record</td>
</tr>
<tr>
<td>Instructions: The anesthesia time used for this measure should be the anesthesia start and anesthesia end times as recorded in the anesthesia record</td>
<td>4560F</td>
<td>Anesthesia technique did not involve general or neuraxial anesthesia</td>
</tr>
<tr>
<td>Denominator:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass (Note: Cardiopulmonary bypass patients are filtered out with the CPT anesthesia codes defining the eligible population.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion(s):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of reason(s) for not achieving at least one body temperature measurement equal to or greater than 35.5 degrees Celsius (or 95.9 degrees Fahrenheit) within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time (eg, intentional hypothermia)</td>
<td></td>
<td></td>
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</tbody>
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| **Reporting Instructions:**

For all patients who receive an anesthesia service (CPT Codes 00100-01969, except when coding includes 00561, 00562, 00563, 00567, or 99116), report 4255F or 4256F or 4560F.

When 4255F is reported, also report 4559F.

For patient with appropriate medical exclusions, report 4559F with modifier 1P. |  |  |

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<table>
<thead>
<tr>
<th>Preoperative Use of Aspirin for Patients with Coronary Artery Stents</th>
<th>4561F</th>
<th>4562F</th>
<th>4563F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether the patient aged 18 years and older received aspirin within 24 hours prior to the anesthesia start time when they have a pre-existing coronary artery stent and receive an anesthesia service</td>
<td>Patient has a coronary artery stent</td>
<td>Patient does not have a coronary artery stent</td>
<td>Patient received aspirin within 24 hours prior to anesthesia start time</td>
</tr>
<tr>
<td><strong>Numerator:</strong> All patients who receive aspirin within 24 hours prior to the anesthesia start time</td>
<td>4561F</td>
<td>4562F</td>
<td>4563F</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Patients aged 18 years and older who receive an anesthesia service and have a pre-existing coronary artery stent</td>
<td>For all patients who receive an anesthesia service (CPT Code 00100-01969), report either 4561F or 4562F.</td>
<td>For patient with appropriate exclusion criteria, report 1P or 2P.</td>
<td>When 4561F is reported, also report 4563F.</td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)
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### Prenatal Care (Pre-Cr)

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</table>
| **Anti-D Immune Globulin**<sup>1</sup>  
Whether or not the D (Rh) negative and unsensitized patient who gave birth during the 12-month period, who was seen for continuing prenatal care, received anti-D immune globulin at 26-30 weeks gestation  
**Numerator:** Patients who received anti-D immune globulin at 26-30 weeks gestation  
**Denominator:** All patients who are D (Rh) negative and unsensitized who gave birth during the 12-month period, seen for continuing prenatal care | 4178F | Anti-D immune globulin received between 26 and 30 weeks gestation |

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</thead>
<tbody>
<tr>
<td>Exclusion(s): Documentation of medical reason(s) for patient not receiving anti-D immune globulin at 26-30 weeks gestation</td>
<td>Denominator Codes</td>
<td>Patient is D (Rh) negative and unsensitized</td>
</tr>
<tr>
<td>Documentation of patient reason(s) for patient not receiving anti-D immune globulin at 26-30 weeks gestation</td>
<td>3290F</td>
<td></td>
</tr>
<tr>
<td>Documentation of system reason(s) for patient not receiving anti-D immune globulin at 26-30 weeks gestation</td>
<td>3291F</td>
<td></td>
</tr>
<tr>
<td>Percentage of D (Rh) negative, unsensitized patients who gave birth during the 12-month period who received anti-D immune globulin at 26-30 weeks gestation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 3290F or 3291F for each patient. If patient is D (Rh) negative and unsensitized (3290F) and patient was administered Anti-D immune globulin between 26 and 30 weeks gestation, also report 4178F. For patients with appropriate exclusion criteria use 4178F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal ABO and Rh blood typing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the pregnant patient had an ABO and Rh blood typing during a prenatal visit</td>
<td>3293F</td>
<td>ABO and Rh blood typing documented as performed</td>
</tr>
</tbody>
</table>

**Numerator:** Pregnant patients who had an ABO and Rh blood typing performed or documented during the prenatal period

**Denominator:** All patients aged 12 years and older who have completed a full-term pregnancy

**Exclusion(s):** None

**Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.

For patients who have had ABO and Rh typing performed during the prenatal period or previously, report 3293F during the prenatal period.

### Prenatal Group B Streptococcus (GBS) screening

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the pregnant patient had a Group B Streptococcus screen during a prenatal visit</td>
<td>3294F</td>
<td>Group B Streptococcus (GBS) screening documented as performed during week 35-37 gestation</td>
</tr>
</tbody>
</table>

**Numerator:** Pregnant patients who had a Group B Streptococcus screen during week 35-37 gestation.

**Denominator:** All patients aged 12 years and older who have completed a full term pregnancy.

**Exclusion(s):** Documentation of at least one of the following medical reasons:

- previous infant with GBS disease
- maternal GBS infection during prenatal period
- patient prophylactically treated for GBS infection because screening was not performed

Documentation of the following patient reason for receiving GBS screening outside of week 35-37 of gestation:

- patient did not attend appointment during this timeframe.

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</thead>
<tbody>
<tr>
<td>Reporting Instructions: For patient with appropriate exclusion criteria, report 3294F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Screening for Human Immunodeficiency Virus (HIV)**¹</td>
<td>3292F</td>
<td>HIV testing ordered or documented and reviewed during the first or second prenatal visit</td>
</tr>
<tr>
<td>Whether or not the patient who gave birth during the 12-month period, who was seen for continuing prenatal care, was screened for HIV infection during the first or second prenatal care visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were screened for HIV infection during the first or second prenatal care visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients who gave birth during the 12-month period, seen for continuing prenatal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not screening for HIV during the first or second prenatal care visit (eg, patient has known HIV)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not screening for HIV during the first or second prenatal care visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients who gave birth during the 12-month period who were screened for HIV infection during the first or second prenatal care visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: For patient with appropriate exclusion criteria, report 3292F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Footnotes

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### Prenatal-Postpartum Care (Prenatal)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeliness of Prenatal Care¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Number of women who received a prenatal care visit as a member of the managed care organization (MCO) in the first trimester or within 42 days of enrollment in the MCO</td>
<td>0500F</td>
<td>Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period – LMP)</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Women who had live births between November 6th of the year prior to the measurement year and November 5th of the measurement year, who were continuously enrolled at least 43 days prior to delivery through 56 days after delivery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients in the denominator who received prenatal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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⁷**Optum**, [www.optum.com](http://www.optum.com)

⁸**American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com).


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</thead>
<tbody>
<tr>
<td>Prenatal Flow Sheet¹</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not patient has a prenatal flowsheet in use by the date of the first physician visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Percentage of patients with a flow sheet in use by the date of the first physician visit, which contains at a minimum: blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery</td>
<td>0501F</td>
<td>Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period – LMP (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit)</td>
</tr>
<tr>
<td><strong>Denominator:</strong> Pregnant women seen for prenatal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Patients seen for consultation only, not for continuing care</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients in the denominator with a prenatal flow sheet in use by the first physician visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of Ongoing Prenatal Care²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of women in the denominator who had an unduplicated count of less than 21%, 21%-40%, 41%-60%, 61%-80%, or greater than or equal to 81% of the expected</td>
<td>0502F</td>
<td>Subsequent prenatal care visit</td>
</tr>
</tbody>
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<tr>
<td>number of prenatal care visits, adjusted for the month of pregnancy at time of enrollment and gestational age. <strong>Denominator:</strong> Women who had live births during the measurement year. <strong>Exclusion(s):</strong> MCOs must exclude members for whom a prenatal visit is not indicated. <strong>Percentage</strong> of patients in the denominator with expected number of prenatal visits <strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Postpartum Care² <strong>Numerator:</strong> Number of women in the denominator who had a postpartum visit on or between 21 days and 56 days after delivery. <strong>Denominator:</strong> Women who had live births between November 6th of the year prior to the measurement year and November 5th of the measurement year, who were</td>
<td>0503F</td>
<td>Postpartum care visit</td>
</tr>
</tbody>
</table>

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10American Gastroenterological Association (AGA), www.gastro.org/quality

11American Society of Anesthesiologists (ASA), www.asahq.org

12American College of Gastroenterology (AGC), www.gi.org; American Gastroenterological Association (AGA), www.gastro.org; and American Society for Gastrointestinal Endoscopy (ASGE), www.asge.org
### Preventive Care & Screening (PV)

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not providing immunization; documentation of patient reason(s) for declining immunization; documentation of system reason(s) for declining immunization. <strong>Percentage</strong> of patients who received an influenza immunization <strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria use 4037F with modifier 1P, 2P, or 3P. Use 4037F with modifier 1P if previously immunized for current season.</td>
<td>4037F</td>
<td>Influenza immunization ordered or administered</td>
</tr>
<tr>
<td><strong>Adult Colorectal Cancer Screening</strong>&lt;sup&gt;1,2&lt;/sup&gt; Whether or not patient was screened for colorectal cancer during the one-year measurement period <strong>Numerator:</strong> Patients with any of the recommended colorectal cancer screening test(s) performed (fecal occult blood testing annually; flexible sigmoidoscopy every five years; annual fecal occult blood testing plus flexible sigmoidoscopy every five years; double contrast barium enema every five years; colonoscopy every ten years) <strong>Denominator:</strong> Patients who met the age criteria <strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria use 3017F with modifier 1P, 2P, or 3P. Use 3017F with modifier 1P if previously immunized for current season.</td>
<td>3017F</td>
<td>Colorectal cancer screening results documented and reviewed</td>
</tr>
</tbody>
</table>

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**Footnotes**

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2. National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

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</table>
| **Denominator:** All patients aged greater than or equal to 50 years  
**Denominator Exclusion:** Documentation of medical, patient, or system reason(s) for not providing colorectal cancer screening  
**Percentage** of patients screened for colorectal cancer  
**Reporting Instructions:** For patients with appropriate exclusion criteria, report 3017F with modifier 1P, 2P, or 3P. | 3017F | Colorectal cancer screening results documented and reviewed |
| **Colorectal Cancer Screening**  
To assess the percentage of patients 50-80 years of age who received the appropriate colorectal cancer screening.  
**Numerator:** Patients who had at least one appropriate screening for colorectal cancer during the reporting period.  
*(See measure for list of appropriate screenings)*  
**Denominator:** All patients 51-80 years of age. | | |

Footnotes

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</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Medical reasons for not providing a colorectal cancer screening (e.g., diagnosis of colorectal cancer, total colectomy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients 50-80 years of age who had the appropriate colorectal cancer screening.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report this code for a patient at least once during the measurement year for patients identified in the eligible population. For patient with appropriate exclusion criteria report 3017F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Screening Mammography</strong>¹</td>
<td>3014F</td>
<td>Screening mammography results documented and reviewed</td>
</tr>
<tr>
<td>Whether or not female patient had a mammogram performed during the two-year measurement period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Female patients who had a mammogram performed</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All female patients aged 50-69 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical, patient, or system reason(s) for declining or not performing screening mammography</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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⁷Optum, [www.optum.com](http://www.optum.com).


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

¹²American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

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</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong> of female patients who had a mammogram performed during the two-year measurement period <strong>Reporting Instructions:</strong> For patients with appropriate exclusion criteria use 3014F with modifier 1P, 2P, 3P.</td>
<td>3014F</td>
<td>Screening mammography results documented and reviewed</td>
</tr>
<tr>
<td><strong>Breast Cancer Screening</strong>&lt;sup&gt;2&lt;/sup&gt; To assess the percentage of women 40–69 years of age who had a mammogram to screen for breast cancer during the previous 24 months. <strong>Numerator:</strong> Patients who had at least one mammogram within the last 24 months. <strong>Denominator:</strong> All women 42–69 years of age. <strong>Exclusion(s):</strong> Documentation of medical reasons for not performing a screening mammogram (eg, Women who had a bilateral mastectomy or two unilateral mastectomies)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Footnotes

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<tbody>
<tr>
<td>The percentage of women 40-69 years old who have had a mammogram to screen for breast cancer during the reporting period or the year prior to the reporting period (24 months). <strong>Reporting Instructions:</strong> Report this code for a patient at least once during the measurement year for patients identified in the eligible population. For patient with appropriate exclusion criteria report 3014F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cervical Cancer Screening**

1 Whether or not the female patient aged 21 through 65 years has documentation of the performance of current cervical cancer screening with results

**Numerator:** Patients with documentation of the performance of current cervical cancer screening with results

*Current cervical cancer screening is defined as having cervical cytology testing performed at least **once** within the last three years.

**Denominator:** All female patients aged 21 through 65 years

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Cervical cancer screening results documented and reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3015F</td>
<td></td>
</tr>
</tbody>
</table>

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6 **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum,** [www.qualityforum.org](http://www.qualityforum.org)

7 **Optum,** [www.optum.com](http://www.optum.com)


10 **American Gastroenterological Association (AGA),** [www.gastro.org/quality](http://www.gastro.org/quality)

11 **American Society of Anesthesiologists (ASA),** [www.asahq.org](http://www.asahq.org)

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<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) (eg, limited life expectancy, patient has a history of complete cervix removal), patient reason(s) (eg, patient declined), or system reason(s) (eg, financial reasons) for not having cervical cancer screening performed at least once in the last three years</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of female patients aged 21 through 65 years, who have documentation of the performance of current cervical cancer screening with results during the two-year measurement period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria report 3015F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pneumococcal Vaccination for Patients 65 years and older</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To assess the percentage of patients 65 years and older who have ever received a pneumococcal vaccine.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who have ever received a pneumococcal vaccination.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
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<tbody>
<tr>
<td>All patients 65 years and older. <strong>Exclusion(s):</strong> Medical reason for not providing a pneumococcal vaccination (eg, Patients with previous anaphylactic reaction to the vaccine or any of its components) The percentage of patients 65 years and older who have received the pneumococcal vaccination. <strong>Reporting Instructions:</strong> Report this code for all patients in the denominator at least once during the measurement period.</td>
<td>4040F</td>
<td>Pneumococcal vaccine administered or previously received</td>
</tr>
<tr>
<td><strong>Pneumococcal Immunization¹</strong> Whether or not the patient aged 65 years and older has documentation of receiving a pneumococcal immunization <strong>Numerator:</strong> Patients who have documentation of receiving pneumococcal immunization*</td>
<td>4040F</td>
<td>Pneumococcal vaccine administered or previously received</td>
</tr>
<tr>
<td>*Documentation may include that the patient received the immunization during that visit OR that the patient reports having previously received the immunization since age 65 <strong>Denominator:</strong> All patients aged 65 years and older</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

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<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) (eg, patient allergy, other contraindication) or patient reason(s) (eg, patient declined) for not administering pneumococcal immunization</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 65 years and older, who have documentation of receiving pneumococcal immunization during the two-year measurement period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria report 4040F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Tobacco Use**

- Whether or not patient was queried about tobacco use one or more times

**Numerator:** Patients who were queried about tobacco use one or more times

**Denominator:** All patients aged ≥ 18 years at the beginning of the two-year measurement period

**Percentage** of patients queried about tobacco use one or more times during the two-year measurement period

<table>
<thead>
<tr>
<th>Code Descriptor(s)</th>
<th>1000F</th>
<th>1034F</th>
<th>1035F</th>
<th>1036F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco use, assessed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current tobacco smoker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smokeless tobacco user (eg, chew, snuff)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current tobacco non-user</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
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</tr>
</thead>
</table>
| **Tobacco Use Intervention**<sup>1</sup>  
Whether or not patient identified as a tobacco user received cessation intervention  
**Numerator**: Patients identified as tobacco users who received cessation intervention  
**Denominator**: All patients ≥ 18 years at the beginning of the two-year measurement period identified as tobacco users  
**Percentage** of patients identified as tobacco users who received cessation intervention during the two year measurement period  
**Reporting Instructions**: Report 1034F, 1035F or 1036F for each patient. If patient is a tobacco user (1034F or 1035F) and received cessation intervention, report 4000F or 4001F or both. | 4000F  
4001F  
**Denominator Codes**  
1034F  
1035F  
1036F | Tobacco use cessation intervention, counseling  
Tobacco use cessation intervention, pharmacologic therapy  
Current tobacco smoker  
Current smokeless tobacco user (e.g., chew, snuff)  
Current tobacco non-user |

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<tbody>
<tr>
<td>There are no performance exclusions for this measure; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
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</tbody>
</table>

## Advising Smokers to Quit

To assess the percentage of patients who have received advice to quit smoking from a doctor or other health provider during the reporting period.

<table>
<thead>
<tr>
<th>Code Descriptor(s)</th>
<th>CPT Category II Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current tobacco smoker</td>
<td>1034F</td>
</tr>
<tr>
<td>Current tobacco non-user</td>
<td>1036F</td>
</tr>
</tbody>
</table>

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<tbody>
<tr>
<td><strong>Numerator:</strong> Patients identified as current tobacco smokers and advised (cessation intervention or counseling) to quit smoking.</td>
<td>1035F&lt;br&gt;4000F&lt;br&gt;4001F</td>
<td>Current smokeless tobacco user (eg, chew)&lt;br&gt;Tobacco use cessation intervention, counseling&lt;br&gt;Tobacco use cessation intervention, pharmacologic therapy</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s): None</strong> The percentage of patients who are current tobacco smokers who have been advised to quit smoking.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 1034F or 1036F or 1034F AND 4000F or 4001F for all patients in the denominator at least once during the reporting period. For patient identified as smokers who did not receive cessation intervention or counseling report 4000F with modifier 8P. There are no performance exclusions for this measure; modifiers 1P, 2P, and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


# Preventive Care & Screening (PV)

## Brief Description of Performance Measure & Source and Reporting Instructions

<table>
<thead>
<tr>
<th>Performance Measure Description</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older was screened for tobacco use AND received tobacco cessation counseling intervention if identified as a tobacco user</td>
<td>4004F</td>
<td>Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user</td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who were screened for tobacco use* AND who received tobacco cessation counseling intervention** if identified as a tobacco user</td>
<td>1036F</td>
<td>Current tobacco non-user</td>
</tr>
<tr>
<td>*Includes use of any type of tobacco</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Cessation counseling intervention includes brief counseling (3 minutes or less), and/or pharmacotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>**Percentage of patients aged 18 years and older who were screened at least once during the two-year measurement period AND who received tobacco cessation counseling intervention if identified as a tobacco user</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: For patient with appropriate exclusion criteria report 4004F with modifier 1P. If patient does not smoke or use any type of tobacco report only 1036F.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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* Last Updated June 23, 2023
<table>
<thead>
<tr>
<th>Preventive Care &amp; Screening (PV)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity Screening¹</td>
<td>3008F</td>
<td>Body Mass Index (BMI), documented</td>
</tr>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source and Reporting Instructions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older has a body mass index (BMI) documented</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients for whom body mass index (BMI) is documented</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) (eg, patient is non-ambulatory), patient reason(s) (eg, patient declined), or system reason(s) (eg, equipment not available) for not documenting body mass index (BMI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older for whom body mass index (BMI) documented at least once during the two-year measurement period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria report 3008F with modifier 1P, 2P, or 3P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3The Joint Commission, [https://www.jointcommission.org](http://www.jointcommission.org)

4National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

6The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7Optum, [www.optum.com](http://www.optum.com).


10American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

11American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

12American College of Gastroenterology (ACG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
# Preventive Care & Screening (PV)

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<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older was screened for unhealthy alcohol use using a systematic screening method</td>
<td>3016F</td>
<td>Patient screened for unhealthy alcohol use using a systematic screening method</td>
</tr>
</tbody>
</table>

**Numerator:** Patients who were screened for unhealthy alcohol use* using a systematic screening method

*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.

**Denominator:** All patients aged 18 years and older

**Exclusion(s):** Documentation of medical reason(s) for not screening for unhealthy alcohol use (eg, limited life expectancy)
Preventive Care & Screening (PV)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
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</tr>
</thead>
</table>
| **Percentage** of patients aged 18 years and older who were screened for unhealthy alcohol use at least once during the two-year measurement period using a systematic screening method  

**Reporting Instructions:** Refer to measure specifications for examples of systematic screening methods. For patient aged 18 years and older with appropriate exclusion criteria, report 3016F with modifier 1P. |  |  |

Prostate Cancer (PRCA)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Report Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
</table>
| **Initial Evaluation**

Whether or not a patient with prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR... |  |  |

Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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### Prostate Cancer (PRCA)

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>cryotherapy had documented evaluation of prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score</td>
<td>3268F</td>
<td>Prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score documented prior to initiation of treatment</td>
</tr>
</tbody>
</table>

**Numerator:** Patients with documented evaluation of prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score

**Denominator:** All patients with prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

**Exclusion(s):** Documentation of medical reason(s) for not evaluating prostate-specific antigen (PSA), OR primary tumor (T) stage, OR Gleason score

**Percentage** of patients with prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy with documented evaluation of prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score

**Reporting Instructions:**

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**Footnotes**

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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)


### Prostate Cancer (PRCA)

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Report 3268F if Prostate-specific antigen (PSA), AND primary tumor (T) stage, AND Gleason score are documented as performed prior to initiation of therapy. For patient with appropriate exclusion criteria, report 3268F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Overuse Measure – Bone Scan for Staging Low-Risk Patients

Whether or not a patient, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy did not have a bone scan performed at any time since diagnosis of prostate cancer

**Numerator:** Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer

**Denominator:** All patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

<table>
<thead>
<tr>
<th>Denominator Codes</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3269F</td>
<td>Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer</td>
</tr>
<tr>
<td>3270F</td>
<td>Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer</td>
</tr>
<tr>
<td>3271F</td>
<td>Low risk of recurrence, prostate cancer</td>
</tr>
<tr>
<td>3272F</td>
<td>Intermediate risk of recurrence, prostate cancer</td>
</tr>
</tbody>
</table>

---

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## Prostate Cancer (PRCA)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Report Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>See technical specifications for definitions of low risk, intermediate risk, and high risk for recurrence of prostate cancer</td>
<td>3273F, 3274F</td>
<td>High risk of recurrence, prostate cancer</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons)</td>
<td></td>
<td>Prostate cancer risk of recurrence not determined or neither low, intermediate nor high</td>
</tr>
<tr>
<td>Salvage therapy is defined as treatment given to a patient with clinically localized prostate cancer who has not responded to, or cannot tolerate other treatments, or any treatment given after recurrence of a tumor. Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did <strong>not</strong> have a bone scan performed at any time since diagnosis of prostate cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Prostate Cancer (PRCA)

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</tr>
</thead>
<tbody>
<tr>
<td>Report 3271F or 3272F or 3273F or 3274F for each patient with a diagnosis of prostate cancer. If the patient is classified as low risk (3271F) and did <strong>not</strong> have a bone scan performed at any time since diagnosis of prostate cancer, report 3270F. If the patient is classified as low risk (3271F) and <strong>did</strong> have a bone scan performed at any time since diagnosis of prostate cancer, report 3267F. If there is a valid medical or system reason for performing a bone scan, report 3269F with modifier 1P or 3P, do not report modifiers with 3270F. If a patient is receiving salvage therapy, report 3269F with modifier 1P.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Treatment Options for Patients with Clinically Localized Disease¹**

Whether or not patient with clinically localized prostate cancer receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy received counseling on, at a minimum, the following treatment options for clinically localized disease:

---

Footnotes

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy **</td>
<td>4163F</td>
<td>Patient counseling at a minimum on all of the following treatment options for clinically localized prostate cancer: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy, provided prior to initiation of treatment **</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who received counseling on, at a minimum, the following treatment options for clinically localized disease: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy</td>
<td></td>
<td><strong>Exclusion(s):</strong> Documentation of medical reason for not counseling patient on, at a minimum, the following treatment options for clinically localized disease: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy (ie, salvage therapy**)</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with clinically localized prostate cancer AND receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy</td>
<td></td>
<td>** Salvage therapy is defined as treatment given to a patient with clinically localized prostate cancer who has not</td>
</tr>
<tr>
<td>Brief Description of Performance Measure &amp; Source and Report Instruction</td>
<td>CPT Category II Code(s)</td>
<td>Code Descriptor(s)</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>responded to, or cannot tolerate other treatments, or any treatment given after recurrence of a tumor. <strong>Percentage</strong> of patients with clinically localized prostate cancer AND receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who received counseling on, at a minimum, the following treatment options for clinically localized disease: active surveillance, AND interstitial prostate brachytherapy, AND external beam radiotherapy, AND radical prostatectomy <strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria, report 4163F with modifier 1P.</td>
<td>4164F</td>
<td>Adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone])</td>
</tr>
</tbody>
</table>

**Adjuvant Hormonal Therapy for High-Risk Patients**

Whether or not patient with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate was prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

---

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**Prostate Cancer (PRCA)**

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</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)</td>
<td>Denominator Codes</td>
<td>agonist or antagonist prescribed/administered</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate</td>
<td>3271F</td>
<td>Low risk of recurrence, prostate cancer</td>
</tr>
<tr>
<td>See technical specifications for definitions of low risk, intermediate risk, and high risk for recurrence of prostate cancer, and for list of medications.</td>
<td>3272F</td>
<td>Intermediate risk of recurrence, prostate cancer</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (GnRH agonist or antagonist)</td>
<td>3273F</td>
<td>High risk of recurrence, prostate cancer</td>
</tr>
<tr>
<td>Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy (GnRH agonist or antagonist)</td>
<td>3274F</td>
<td>Prostate cancer risk of recurrence not determined or neither low, intermediate nor high</td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Reporting Instructions:**

- **Denominator Codes**
  - 3271F: Low risk of recurrence, prostate cancer
  - 3272F: Intermediate risk of recurrence, prostate cancer
  - 3273F: High risk of recurrence, prostate cancer
  - 3274F: Prostate cancer risk of recurrence not determined or neither low, intermediate nor high

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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

3. **The Joint Commission**, [https://www.jointcommission.org](https://www.jointcommission.org)

4. **National Diabetes Quality Improvement Alliance (NDQIA)** - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5. Joint measure from **The Physician Consortium for Performance Improvement (PCPI)**, and **National Committee on Quality Assurance (NCQA)** - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).


10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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<table>
<thead>
<tr>
<th>Prostate Cancer (PRCA)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brief Description of Performance Measure &amp; Source and Report Instruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report 3271F or 3272F or 3273F or 3274F for each patient. If the patient is classified as high risk (3273F) and was prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist), report 4164F. For patients with appropriate exclusion criteria use 4164F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three-Dimensional Radiotherapy¹</td>
<td>4165F</td>
<td>Three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT) received</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam therapy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Footnotes

¹Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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³The Joint Commission, [https://www.jointcommission.org](https://www.jointcommission.org)

⁴National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

⁵Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

⁶The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷Optum, [www.optum.com](http://www.optum.com)

⁸American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or quality@aun.com


¹⁰American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

¹¹American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org)

¹²American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org)
<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Report Instruction</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>radiotherapy as primary therapy to the prostate with or without nodal irradiation (no metastases; no salvage therapy)</td>
<td>4200F</td>
<td>External beam radiotherapy as primary therapy to the prostate with or without nodal irradiation</td>
</tr>
<tr>
<td>Exclusion(s): None</td>
<td>4201F</td>
<td>External beam radiotherapy with or without nodal irradiation as adjuvant or salvage therapy for prostate cancer patient</td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

2. **National Committee on Quality Assurance (NCQA)**, Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3100F</td>
<td>Carotid image study report includes direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement</td>
</tr>
</tbody>
</table>

**Stenosis measurement in carotid imaging reports**

Whether or not the patient had a final report for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that included direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

**Numerator:** Final carotid imaging study reports that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

Definition: "Direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement" includes direct angiographic stenosis calculation based on the distal lumen as the denominator for stenosis measurement OR an equivalent validated method referenced to the above method (eg, for duplex ultrasound studies, velocity parameters that correlate the residual internal carotid lumen with methods based on the distal internal carotid lumen)

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**Footnotes**

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<table>
<thead>
<tr>
<th>Radiology (RAD)</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed</td>
<td>7020F</td>
<td>Mammogram assessment category [eg, Mammography Quality Standards Act (MQSA), Breast Imaging Reporting and Data System (BI-RADS®), or FDA 7020F]</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> NONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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6. **The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and **National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7. **Optum, [www.optum.com](http://www.optum.com)


10. **American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality)

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<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(BI-RADS®), or FDA approved equivalent categories] entered into an internal database to allow for analysis of abnormal interpretation (recall) rate</td>
</tr>
</tbody>
</table>

**Radiology (RAD)**

**Brief Description of Performance Measure & Source and Report Instructions**

approved equivalent categories] entered into an internal database that will, at a minimum, allow analysis of abnormal interpretation (recall) rate

**Numerator:** Patients whose assessment category [eg, Mammography Quality Standards Act (MQSA), Breast Imaging Reporting and Data System (BI-RADS®), or FDA approved equivalent categories] is entered into an internal database that will, at a minimum, allow analysis of abnormal interpretation (recall) rate

Definition of abnormal interpretation (recall): Any screening mammograms that receives an MQSA assessment category of incomplete, probably benign, suspicious or highly suggestive of malignancy; BI-RADS® category 0, 3, 4, or 5; or FDA-approved equivalent assessment categories (see technical specifications for a list of equivalent categories)

**Denominator:** All patients undergoing screening mammograms

**Exclusion(s): NONE**

**Percentage** of patients undergoing screening mammograms whose assessment category [eg, Mammography Quality

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**Footnotes**

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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## Radiology (RAD)

### Brief Description of Performance Measure & Source and Report Instructions

Standards Act (MQSA), Breast Imaging Reporting and Data System (BI-RADS®), or FDA approved equivalent categories] is entered into an internal database that will, at a minimum, allow analysis of abnormal interpretation (recall) rate. **Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.

<table>
<thead>
<tr>
<th>Inappropriate use of “probably benign” assessment category in mammography screening</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient had a final report for a screening mammogram that was classified as “probably benign”</td>
<td>3340F</td>
<td>Mammogram assessment category of “incomplete: need additional imaging evaluation”, documented</td>
</tr>
<tr>
<td>Definition of “probably benign” classification: MQSA assessment category of “probably benign”; BI-RADS® category 3; or FDA-approved equivalent assessment category (see technical specifications for a list of equivalent categories)</td>
<td>3341F</td>
<td>Mammogram assessment category of “negative”, documented</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All final reports for screening mammograms</td>
<td>3342F</td>
<td>Mammogram assessment category of “benign”, documented</td>
</tr>
<tr>
<td><strong>Exclusion(s): NONE</strong></td>
<td>3343F</td>
<td>Mammogram assessment category of “probably benign”, documented</td>
</tr>
</tbody>
</table>

### Footnotes

1. **Physician Consortium for Performance Improvement® (PCPI)** - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

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### Radiology (RAD)

#### Brief Description of Performance Measure & Source and Report Instructions

**Percentage** of final reports for screening mammograms that are classified as “probably benign”

**Reporting Instructions:** Report an appropriate code from the 3340F – 3350F series for a mammogram assessment category for each patient. There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3344F</td>
<td>Mammogram assessment category of “suspicious”, documented</td>
</tr>
<tr>
<td>3345F</td>
<td>Mammogram assessment category of “highly suggestive of malignancy”, documented</td>
</tr>
<tr>
<td>3350F</td>
<td>Mammogram assessment category of “known biopsy proven malignancy”, documented</td>
</tr>
</tbody>
</table>

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**Footnotes**

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Communication of suspicious findings from the diagnostic mammogram to the practice managing ongoing care

Whether or not the patient undergoing a diagnostic mammogram classified as “suspicious” or “highly suggestive of malignancy” has documentation of direct communication of findings from the diagnostic mammogram to the practice within 3 business days of exam interpretation

**Numerator:** Patients with documentation of direct communication of findings from the diagnostic mammogram to the practice that manages the patient’s on-going care within 3 business days of exam interpretation

Direct communication is defined as communication by the diagnostic imager or a designee to the treating or referring physician or his/her representative with confirmed receipt of the findings (either by fax confirmation, verbal communication, or certified letter).

**Denominator:** All patients undergoing diagnostic mammograms that are classified as “suspicious” or “highly suggestive of malignancy”

Definition of “suspicious” or “highly suggestive of malignancy” classification: MQSA final assessment category of “suspicious” or “highly suggestive of malignancy”; BI-RADS® category 4 or 5; or FDA-approved equivalent assessment

<table>
<thead>
<tr>
<th>Denominator Codes</th>
<th>Findings from diagnostic mammogram communicated to practice managing patient’s on-going care within 3 business days of exam interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5060F</td>
<td>Mammogram assessment category of &quot;incomplete: need additional imaging evaluation&quot;, documented</td>
</tr>
<tr>
<td>3340F</td>
<td>Mammogram assessment category of &quot;negative&quot;, documented</td>
</tr>
</tbody>
</table>

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Exclusion(s): Documentation of system reason(s) for not directly communicating the findings from the diagnostic mammogram to the practice that manages the patient’s on-going care within 3 business days of exam interpretation (eg, patient is self-referred, no healthcare provider named)

Percentage of patients undergoing diagnostic mammograms that are classified as “suspicious” or “highly suggestive of malignancy” with documentation of direct communication of findings from the diagnostic mammogram to the practice that manages the patient’s on-going care within 3 business days of exam interpretation

Reporting Instructions: Report an appropriate code from the 3340F – 3350F series for a mammogram assessment category for each patient. If patient received a final mammogram assessment category of “suspicious” or “highly likely of malignancy” (3344F or 3345F), and there is documentation of direct communication of findings, also report 5060F. This measure is intended for use by the physician interpreting the mammogram.

<table>
<thead>
<tr>
<th>Mammogram assessment category of “benign”, documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>3342F</td>
</tr>
<tr>
<td>Mammogram assessment category of “probably benign”, documented</td>
</tr>
<tr>
<td>3343F</td>
</tr>
<tr>
<td>Mammogram assessment category of “suspicious”, documented</td>
</tr>
<tr>
<td>3344F</td>
</tr>
<tr>
<td>Mammogram assessment category of “highly suggestive of malignancy”, documented</td>
</tr>
<tr>
<td>3345F</td>
</tr>
<tr>
<td>Mammogram assessment category of “known biopsy proven malignancy”, documented</td>
</tr>
<tr>
<td>3350F</td>
</tr>
</tbody>
</table>

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7Optum, www.optum.com

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American Gastroenterological Association (AGA), www.gastro.org/quality.


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Communication of suspicious findings from the diagnostic mammogram to the patient

Whether or not the patient undergoing a diagnostic mammogram classified as “suspicious” or “highly suggestive of malignancy” has documentation of direct communication of findings from the diagnostic mammogram to the patient within 5 business days of exam interpretation

Numerator: Patients with documentation of direct communication of findings from the diagnostic mammogram to the patient within 5 business days of exam interpretation

Direct communication is defined as communication by the diagnostic imager or a designee to the patient with confirmed receipt of the findings (either by fax confirmation, verbal communication, or certified letter).

Denominator: All patients undergoing diagnostic mammograms that are classified as “suspicious” or “highly suggestive of malignancy”

Definition of “suspicious” or “highly suggestive of malignancy” classification: MQSA final assessment category of “suspicious” or “highly suggestive of malignancy”; BI-RADS® category 4 or 5; or FDA-approved equivalent assessment categories (see technical specifications for a list of equivalent categories)

Exclusion(s): None

Denominator codes

<table>
<thead>
<tr>
<th>Denominator codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3340F</td>
<td>Mammogram assessment category of “incomplete: need additional imaging evaluation”, documented</td>
</tr>
<tr>
<td>3341F</td>
<td>Mammogram assessment category of “negative”, documented</td>
</tr>
<tr>
<td>3342F</td>
<td>Mammogram assessment category of “benign”, documented</td>
</tr>
<tr>
<td>3343F</td>
<td>Mammogram assessment category of “probably benign”, documented</td>
</tr>
<tr>
<td>3344F</td>
<td>Mammogram assessment category of “suspicious”, documented</td>
</tr>
<tr>
<td>3345F</td>
<td>Mammogram assessment category of “highly suggestive of malignancy”, documented</td>
</tr>
<tr>
<td>3350F</td>
<td>Findings from diagnostic mammogram communicated to patient within 5 business days of exam interpretation</td>
</tr>
</tbody>
</table>

Findings from diagnostic mammogram communicated to patient within 5 business days of exam interpretation

5The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

6Optum, [www.optum.com](http://www.optum.com)

7American Academy of Neurology, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aan.com](mailto:quality@aan.com).


9American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

10American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

11American College of Gastroenterology (AGC), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).

Footnotes

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4National Diabetes Quality Improvement Alliance (NDQIA) - For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.

5Joint measure from The Physician Consortium for Performance Improvement (PCPI), and National Committee on Quality Assurance (NCQA) - For more information on measures developed as joint measures from Physician Consortium for Performance Improvement and the National Committee on Quality Assurance (NCQA), visit the NCQA website at [www.ncqa.org](http://www.ncqa.org).

6The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7Optum, [www.optum.com](http://www.optum.com)

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### Percentage of patients undergoing diagnostic mammograms that are classified as "suspicious" or "highly suggestive of malignancy" with documentation of direct communication of findings from the diagnostic mammogram to the patient within 5 business days of exam interpretation

**Reporting Instructions:** Report an appropriate code from the 3340–3350F series for a mammogram assessment category for each patient. If patient received a final mammogram assessment category of “suspicious” or “highly suggestive of malignancy” (3344F or 3345F), and there is documentation of direct communication of findings to the patient, also report 5062F. This measure is intended for use by the physician interpreting the mammogram.

### Radiology (RAD)

**Reminder system for mammograms**

Whether or not the patient aged 40 years and older undergoing a screening mammogram has information-entered into a reminder system* with a target due date for the next mammogram

**Numerator:** Patients whose information is entered into a reminder system* with a target due date for the next mammogram

*The reminder system should be linked to a process for notifying patients when their next mammogram is due and should include the following elements at a minimum: patient

<table>
<thead>
<tr>
<th>Mammogram assessment category of “known biopsy proven malignancy”, documented</th>
</tr>
</thead>
<tbody>
<tr>
<td>7025F</td>
</tr>
</tbody>
</table>

---

**Footnotes**

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| Denominator: All patients aged 40 years and older undergoing a screening mammogram | Exclusion(s): NONE | Percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system* with a target due date for the next mammogram. Reporting Instructions: There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used. | Denominator: All final reports for CT examinations performed | Exclusion(s): NONE | Patient information entered into a reminder system with a target due date for the next mammogram | 6040F | Use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure, documented |

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<table>
<thead>
<tr>
<th>Percentage of final reports for CT examinations performed with documentation of use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reporting Instructions:</strong> There are no performance exclusions for this measure; modifiers 1P, 2P, or 3P may not be used.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Exposure time reported for procedures using fluoroscopy⑥</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient has final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All final reports for procedures using fluoroscopy</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
</tr>
<tr>
<td><strong>Percentage</strong> of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time</td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Typically, fluoroscopy is not reported separately for surgical services when performed by the same physician. Visit the CPT code 6045F.</td>
</tr>
</tbody>
</table>

| Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented |

**Footnotes**

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| Disease Modifying Anti-Rheumatic Drug Therapy in Rheumatoid Arthritis<sup>2</sup>  
Whether or not patients who were diagnosed with rheumatoid arthritis were dispensed, administered or prescribed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) during the measurement year.  
**Numerator:**  
Patients with at least one prescription or dispensation for a disease modifying anti-rheumatic drug (DMARD).  
*Dispensed* encompasses administered DMARD therapy.  
**Denominator:**  
4187F Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered  

### Footnotes

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Rheumatoid Arthritis (RA)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients aged 18 years and older with a diagnosis of rheumatoid arthritis.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Documentation of medical reasons (patient diagnosed with HIV, members who have diagnosis for pregnancy during the reporting period) for not dispensing or dispersing a disease modifying anti-rheumatic drug therapy.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The percentage of patients who were diagnosed with rheumatoid arthritis and who were dispensed at least one ambulatory prescription for a disease modifying anti-rheumatic drug (DMARD) during the reporting year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Report this code for a patient at least once during the measurement year for patients identified in the eligible population. For patient with appropriate exclusion criteria report 4187F with modifier 1P</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Functional Status Assessment**

Footnotes

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### Rheumatoid Arthritis (RA)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) has a functional status assessment performed at least once within twelve months</td>
<td>1170F</td>
<td>Functional status assessed</td>
</tr>
</tbody>
</table>

**Numerator:** Patients who have functional status assessed* at least once within twelve months.

*Documentation of an assessment 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: 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, stairclimbing, reaching, gripping, shopping/running errands/house or yard work.

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### Rheumatoid Arthritis (RA)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Denominator:</strong> All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

**Reporting Instructions:**

There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.

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Glucocorticoid Management

Whether or not the patient aged 18 years and older with a diagnosis of rheumatoid arthritis has been assessed for glucocorticoid use at least once within 12 months and, for those on prolonged doses of prednisone 10 mg daily (or equivalent), has documentation of a glucocorticoid management plan.

**Numerator:** Patients who have been assessed for glucocorticoid use and for those on prolonged doses of prednisone ≥10 mg daily (or equivalent*) with worsening disease activity who have a glucocorticoid management plan** documented within 12 months

*Prednisone equivalents can be determined using the following:

- 1 mg of prednisone = 1 mg of prednisolone;
- 5 mg of cortisone;
- 4 mg of hydrocortisone;
- 0.8 mg of triamcinolone;

Patient not receiving glucocorticoid therapy

Patient receiving <10 mg daily prednisone (or equivalent), or RA activity is worsening, or glucocorticoid use is for less than 6 months

Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

Glucocorticoid management plan documented

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0.8 mg of methylprednisolone;  
0.15 mg of dexamethasone;  
0.15 mg of betamethasone  

**Glucocorticoid management plan: documentation of attempt to taper steroids OR documentation of a new prescription for a non-glucocorticoid DMARD OR increase in dose of non-glucocorticoid DMARD for persistent RA disease activity at current to reduced dose.**

**Denominator:** All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)

**Exclusion(s):** Documentation of medical reason(s) for not documenting glucocorticoid dose (ie, glucocorticoid prescription is for a medical condition other than RA)

**Percentage** of patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) who have been assessed for glucocorticoid use and, for those on prolonged doses of prednisone > 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of glucocorticoid management plan within 12 months

**Reporting instructions:** Report 4192F, 4193F or 4194F for each patient aged 18 years and older with a diagnosis of

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rheumatoid arthritis. If 4194F, and a glucocorticoid management plan is documented, also report 0540F. For patients with appropriate exclusion criteria, report 0540F with modifier 1P.

<table>
<thead>
<tr>
<th>Tuberculosis Screening</th>
<th>3455F</th>
<th>TB screening performed and results interpreted within six months prior to initiation of first-time biologic disease-modifying anti-rheumatic drug therapy for RA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator</strong>: Patients for whom a TB screening was performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic DMARD (DMARD)</td>
<td>4195F</td>
<td>Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis</td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients 18 years and older with a diagnosis of Rheumatoid Arthritis (RA) who are receiving a first course of therapy using a biologic disease-modifying anti-rheumatic drug (DMARD)</td>
<td>4196F</td>
<td>Patient not receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis</td>
</tr>
</tbody>
</table>

**Exclusion(s)**: Documentation of medical reason(s) for not performing TB screening and interpreting results (ie, patient positive for TB and documentation of past treatment; patient who has recently completed a course of anti-TB therapy)

Footnotes

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Percentage of patients 18 years and older with a diagnosis of Rheumatoid Arthritis (RA) who have documentation of a tuberculosis (TB) screening performed and results interpreted within 6 months prior to receiving a first course of therapy using a biologic disease-modifying antirheumatic drug (DMARD)

**Reporting Instructions:** Report 4195F or 4196F for each patient aged 18 years and older with a diagnosis of Rheumatoid Arthritis and who are being considered or prescribed a first course of biologic disease modifying antirheumatic drug therapy during the reporting period. If the patient is receiving a first course of therapy using a biologic disease-modifying antirheumatic drug report 4195F, and patient has TB screening performed and results interpreted within six months prior to a first prescription for a biologic DMARD, also report 3455F. For patient with appropriate exclusion criteria, report 3455F with modifier 1P.

Footnotes

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Periodic Assessment of Disease Activity

Whether or not the patient aged 18 years and older with a diagnosis of rheumatoid arthritis (RA) has an assessment and classification of disease activity at least once within 12 months

Numerator: Patients with disease activity assessed at least once within 12 months by a standardized descriptive or numeric scale or composite index* and classified into one of the following categories: low, moderate or high

* Standardized descriptive or numeric scales and/or composite indexes could include but are not limited to: DAS28, SDAI, CDAI, RADAI, RAPID

Denominator: All patients 18 years and older with a diagnosis of Rheumatoid Arthritis (RA)

Exclusion(s): None

Percentage of patients aged 18 years and older with a diagnosis of Rheumatoid Arthritis (RA) who have an assessment and classification of disease activity at least once within 12 months.

Reporting Instructions: There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.

Footnotes
1Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.
2National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), www.ncqa.org
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7Optum, www.optum.com

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### Assessment and Classification of Disease Prognosis

Whether or not the patient aged 18 years and older with a diagnosis of Rheumatoid Arthritis (RA) has an assessment and classification of disease prognosis at least once within 12 months

**Numerator:** Patients with at least one documented assessment and classification (good/poor) of disease prognosis utilizing clinical markers* within 12 months

*Prognostic classification should be based upon at minimum the following markers of poor prognosis: functional limitation (eg, HAQ Disability Index), extraarticular disease (eg, vasculitis, Sjögren’s syndrome, RA lung disease, rheumatoid nodules), RF positivity, positive anti-CCP antibodies (both characterized dichotomously, per CEP recommendation), and/or bony erosions by radiography

**Denominator:** All patients 18 years and older with a diagnosis of Rheumatoid Arthritis (RA)

**Exclusion(s):** None

**Percentage** of patients aged 18 years and older with a diagnosis of Rheumatoid Arthritis (RA) who have an assessment and classification of disease prognosis at least once within 12 months

**Reporting Instructions:** There are no performance exclusions for this measure; modifiers 1P, 2P or 3P may not be used.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3475F</td>
<td>Disease prognosis for rheumatoid arthritis assessed, poor prognosis documented</td>
</tr>
<tr>
<td>3476F</td>
<td>Disease prognosis for rheumatoid arthritis assessed, good prognosis documented</td>
</tr>
</tbody>
</table>

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**Footnotes**

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<table>
<thead>
<tr>
<th>Screening Colonoscopy Adenoma Detection Rate (SCADR)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brief Description of Performance Measure &amp; Source</strong></td>
</tr>
<tr>
<td>For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.</td>
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<tr>
<td>For more information on measures developed by the National Diabetes Quality Improvement Alliance (NDQIA), see the appropriate Payor website.</td>
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7**Optum**, [www.optum.com](http://www.optum.com)


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12**American College of Gastroenterology (ACG)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)
### Screening Colonoscopy Adenoma Rate Detection

Whether or not patient age 50 years or older had at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy

**Numerator:** Patients age 50 years or older who had at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy

**Denominator:** All patients age 50 years or older undergoing a screening colonoscopy

**Exclusion(s):** Patients with medical reasons for not having at least one adenoma or other colorectal cancer precursor or colorectal cancer detected during screening colonoscopy (e.g., colonoscopy incomplete or inadequate preparation for colonoscopy)

**Reporting Instructions:**

This measure is to be reported each time a screening colonoscopy for colorectal cancer is performed 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.

For patients with appropriate exclusion criteria, report code 3776F with modifier 1P.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3775F</td>
<td>Adenoma(s) or other neoplasm detected during screening colonoscopy</td>
</tr>
<tr>
<td>3776F</td>
<td>Adenoma(s) or other neoplasm not detected during screening colonoscopy</td>
</tr>
</tbody>
</table>

---

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Stroke and Stroke Rehabilitation (STR)

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</table>
| Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage<sup>5</sup>  
Whether or not the patient aged 18 years and older with the diagnosis of ischemic stroke OR intracranial hemorrhage received DVT prophylaxis by end of hospital day 2  
**Numerator:** Patients who received Deep Vein Thrombosis (DVT) prophylaxis by end of hospital day 2  
Definition: For purposes of this measure, DVT prophylaxis can include Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), intravenous heparin, low-dose subcutaneous heparin, or intermittent pneumatic compression devices  
**Denominator:** All patients aged 18 years and older with the diagnosis of ischemic stroke OR intracranial hemorrhage  
**Exclusion(s):** Documentation of medical reason(s) (including physician documentation that patient is ambulatory) for not receiving DVT prophylaxis by end of hospital day 2; documentation of patient reason(s) for not receiving DVT prophylaxis by end of hospital day 2 | 4070F | Deep Vein Thrombosis (DVT) prophylaxis received by end of hospital day 2 |

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8. **American Academy of Neurology**, [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com/practice/neuromuscular-quality-measures) or [quality@aan.com](mailto:quality@aan.com)
10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)
11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)
12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org) and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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# Stroke and Stroke Rehabilitation (STR)

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</table>
| **Percentage** of patients aged 18 years and older with the diagnosis of ischemic stroke OR intracranial hemorrhage who received DVT prophylaxis by end of hospital day 2  
**Reporting Instructions:** For patient with appropriate exclusion criteria report 4070F with modifier 1P or 2P. |  |  |
| **Discharged on Antiplatelet Therapy**️  
Whether or not the patient aged 18 years and older with the diagnosis of ischemic stroke or TIA was prescribed antiplatelet therapy at discharge  
**Numerator:** Patients who were prescribed antiplatelet therapy at discharge  
**Definition:** Antiplatelet therapy: aspirin, combination of aspirin and extended-release dipyridamole, clopidogrel, ticlopidine  
**Denominator:** All patients aged 18 years and older with a diagnosis of ischemic stroke or TIA  
**Exclusion(s):** Documention of medical reason(s) (including documentation that patient is on anticoagulation therapy) for not prescribing antiplatelet therapy at discharge; | 4073F | Oral antiplatelet therapy prescribed at discharge |

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**Stroke and Stroke Rehabilitation (STR)**

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<tbody>
<tr>
<td>documentation of patient reason(s) for not prescribing antiplatelet therapy at discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA who were prescribed antiplatelet therapy at discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For patient with appropriate exclusion criteria report 4073F with modifier 1P or 2P.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Whether or not the patient aged 18 years and older with the diagnosis of ischemic stroke or TIA with documented permanent, persistent, or paroxysmal atrial fibrillation was prescribed an anticoagulant at discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were prescribed an anticoagulant at discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 18 years and older with the diagnosis of ischemic stroke or TIA with documented permanent, persistent, or paroxysmal atrial fibrillation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>4075F</td>
<td>Anticoagulant therapy prescribed at discharge</td>
</tr>
<tr>
<td>1060F</td>
<td>Denominator codes</td>
</tr>
<tr>
<td>1061F</td>
<td>Documentation of permanent OR persistent OR paroxysmal atrial fibrillation</td>
</tr>
</tbody>
</table>

**Exclusion(s):** Documentation of medical reason(s) for not prescribing an anticoagulant at discharge; documentation of patient reason(s) for not prescribing an anticoagulant at discharge

**Percentage** of patients aged 18 years and older with the diagnosis of ischemic stroke or TIA with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge

**Reporting Instructions:** Report 1060F or 1061F for each patient. If anticoagulant therapy prescribed at discharge, also report 4075F. For patient with appropriate exclusion criteria report 4075F with modifier 1P or 2P.

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</thead>
<tbody>
<tr>
<td><strong>Tissue Plasminogen Activator (t-PA) Considered</strong>: Whether or not the patient aged 18 years and older with the diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours was considered for t-PA administration</td>
<td>4077F</td>
<td>Documentation of absence of permanent AND persistent AND paroxysmal atrial fibrillation</td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who were considered for t-PA administration (given t-PA or documented reasons for patient not being a candidate for therapy)</td>
<td>1065F</td>
<td>Documentation that tissue plasminogen activator (t-PA) administration was considered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ischemic stroke symptom onset of less than 3 hours prior to arrival</td>
</tr>
</tbody>
</table>

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# Stroke and Stroke Rehabilitation (STR)

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<th>Code(s)</th>
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</thead>
<tbody>
<tr>
<td>1066F</td>
<td>Ischemic stroke symptom onset greater than or equal to 3 hours prior to arrival</td>
</tr>
</tbody>
</table>

### Denominator:
All patients aged 18 years and older with the diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours.

### Exclusion(s):
None

### Percentage:
Of patients aged 18 years and older with the diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration.

### Reporting Instructions:
Report either 1065F or 1066F for each patient. If time from symptom onset to arrival is less than 3 hours, and t-PA was considered, also report 4077F.

## Screening for Dysphagia

Whether or not the patient aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage underwent a dysphagia screening process before taking any foods, fluids or medication by mouth.

### Numerator:
Patients who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth.

<table>
<thead>
<tr>
<th>Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6010F</td>
<td>Dysphagia screening conducted prior to order for or receipt of any foods, fluids or medication by mouth</td>
</tr>
</tbody>
</table>

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## Stroke and Stroke Rehabilitation (STR)

### Brief Description of Performance Measure & Source and Reporting Instructions

**Denominator:** All patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage who receive any food, fluids or medication by mouth

**Exclusion(s):** Documentation of medical reason(s) for not screening for dysphagia before taking any foods, fluids or medication by mouth

**Percentage** of patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage who underwent a dysphagia screening process before taking any foods, fluids or medication by mouth

**Reporting Instructions:**
- Report 6015F or 6020F for each patient.
- If dysphagia screening was conducted prior to receiving food, fluid or medication by mouth or prior to ordering food, fluid, or medication by mouth, also report 6010F.
- If patient is NPO, only report 6020F.
- For patient with appropriate exclusion criteria, report 6010F with modifier 1P.

<table>
<thead>
<tr>
<th>Denominator Codes</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>6015F</td>
<td>Patient receiving or eligible to receive food, fluids or medication by mouth</td>
</tr>
<tr>
<td>6020F</td>
<td>NPO (nothing by mouth) ordered</td>
</tr>
</tbody>
</table>

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</tr>
</thead>
</table>
| **Consideration of Rehabilitation Services**<sup>5</sup>  
Whether or not consideration of rehabilitation services is documented for patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage  
**Numerator:** Patients for whom consideration of rehabilitation services (ordered rehabilitation or documented that rehabilitation was not indicated) is documented  
**Denominator:** All patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage  
**Exclusion(s):** None  
**Percentage** of patients aged 18 years and older with the diagnosis of ischemic stroke or intracranial hemorrhage for whom consideration of rehabilitation services is documented  
**Reporting Instructions:**  
Report 4079F if rehabilitation services considered (ordered or not indicated with documented reasons).  
There are no exclusions; modifiers may not be used with this measure.  
| 4079F | Documentation that rehabilitation services were considered |

---

**Footnotes**

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### Stroke and Stroke Rehabilitation (STR)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When 4079F is not reported it indicates rehabilitation services were not considered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports</strong>&lt;sup&gt;5&lt;/sup&gt;</td>
<td>3110F</td>
<td>Documentation in final CT or MRI report of presence or absence of hemorrhage and mass lesion and acute infarction</td>
</tr>
<tr>
<td>Whether or not the final report of a CT or MRI study of the brain performed in the hospital within 24 hours of arrival (or performed in an outpatient imaging center to confirm initial diagnosis of stroke, TIA or hemorrhage) for a patient aged 18 years and older with a diagnosis of ischemic stroke or TIA or intracranial hemorrhage includes documentation of the presence of absence of the following: hemorrhage and mass lesion and acute infarction</td>
<td>3111F</td>
<td>CT or MRI of the brain performed in the hospital</td>
</tr>
<tr>
<td><strong>Numerator:</strong> Final reports of the initial CT or MRI that include documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All final reports for CT or MRI studies of the brain performed either:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In the hospital within 24 hours of arrival, OR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In an outpatient imaging center to confirm initial diagnosis of stroke, TIA or hemorrhage,</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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<sup>6</sup>**The Society of Thoracic Surgeons** at [www.sts.org](http://www.sts.org) and [National Quality Forum](http://www.qualityforum.org)

<sup>7</sup>**Optum**, [www.optum.com](http://www.optum.com)


<sup>10</sup>**American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality).

<sup>11</sup>**American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org).

<sup>12</sup>**American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); [American Gastroenterological Association (AGA)](http://www.gastro.org); and [American Society for Gastrointestinal Endoscopy (ASGE)](http://www.asge.org).
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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>For patients aged 18 years and older with either a diagnosis of ischemic stroke or TIA or intracranial hemorrhage OR at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage</td>
<td>3112F</td>
<td>within 24 hours of arrival OR performed in an outpatient imaging center, to confirm initial diagnosis of stroke, TIA or hemorrhage</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td></td>
<td>CT or MRI of the brain performed greater than 24 hours after arrival OR performed in an outpatient imaging center for purpose other than confirmation of initial diagnosis of stroke, TIA, or hemorrhage</td>
</tr>
<tr>
<td><strong>Percentage</strong> of final reports for CT or MRI studies of the brain performed either:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In the hospital within 24 hours of arrival</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• In an outpatient imaging center to confirm initial diagnosis of stroke, TIA or hemorrhage,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For patients aged 18 years and older with either a diagnosis of ischemic stroke or transient ischemic attack (TIA) or intracranial hemorrhage or at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage that includes documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> Report 3111F or 3112F for each final report for CT or MRI studies of the brain for patients aged 18 years and older with a diagnosis of ischemic stroke or TIA or intracranial hemorrhage or at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If CT or MRI of brain was performed in the hospital within 24 hours of arrival or performed in an outpatient imaging center to confirm initial diagnosis of stroke, TIA or hemorrhage (3111F) and final CT or MRI report included documentation of presence of hemorrhage and mass lesion and acute infarction, also report 3110F. There are no performance exclusions; modifiers 1P, 2P and 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Substance Use Disorders (SUD)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorders (SUD) Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence</td>
<td>4320F</td>
<td>Patient counseled regarding psychosocial AND pharmacologic</td>
</tr>
</tbody>
</table>

---

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### Substance Use Disorders (SUD)

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</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of current alcohol dependence was counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period.</td>
<td></td>
<td>treatment options for alcohol dependence</td>
</tr>
<tr>
<td><strong>Numerator</strong>: Patients who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator</strong>: All patients aged 18 years and older with a diagnosis of current alcohol dependence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s)</strong>: NONE</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial AND pharmacologic treatment options for alcohol dependence within the 12-month reporting period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reporting Instructions: There are no performance exclusions for code 4320F. Do not report modifiers 1P, 2P, or 3P with this code.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Opioid Addiction**

---

Footnotes

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Substance Use Disorders (SUD)

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<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of current opioid addiction was counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction</td>
<td>4306F</td>
<td>Patient counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction</td>
</tr>
</tbody>
</table>

**Numerator:** Patients who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12-month reporting period

Note: The term “opioid addiction” in this context corresponds to the DSM-IV classification of opioid dependence that is characterized by a maladaptive pattern of substance use causing clinically significant impairment or distress, and manifesting by 3 (or more) of the 7 designated criteria. This classification is distinct from and not to be confused with physical dependence (ie, tolerance and withdrawal) that is commonly experienced by patients with chronic pain who are treated with opioid analgesics. Please refer to the section below for additional information regarding this distinction.

**Denominator:** All patients aged 18 years and older with a diagnosis of current opioid addiction

**Exclusion(s):** None

---

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### Substance Use Disorders (SUD)

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<th>CPT category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of current opioid addiction who were counseled regarding psychosocial AND pharmacologic treatment options for opioid addiction within the 12-month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions</strong>: There are no performance exclusions for this measure; modifiers 1P or 2P or 3P may not be used.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Substance Use Disorders (SUD) Screening for Depression Among Patients with Substance Abuse or Dependence

Whether or not the patient aged 18 years and older with a diagnosis of current substance abuse or dependence was screened for depression within the 12-month reporting period

**Numerator**: Patients who were screened for depression within the 12-month reporting period

**Denominator**: All patients aged 18 years and older with a diagnosis of current substance abuse or dependence

| Code Descriptor(s) | 1220F | Patient screened for depression |

---

Footnotes

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**Substance Use Disorders (SUD)**

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<th>CPT category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of medical reason(s) for not screening for depression</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12-month reporting period</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong> For the patient with appropriate exclusion criteria, report 1220F with modifier 1P.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

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Last Updated June 23, 2023
Upper Respiratory Infection in Children (URI)

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure &amp; Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Appropriate Treatment for Children with Upper Respiratory Infection</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td>4120F 4124F</td>
<td>Antibiotic prescribed or dispensed Antibiotic neither prescribed nor dispensed</td>
</tr>
<tr>
<td>Whether or not children 3 months to 18 years of age (inclusive) who were seen for a visit with a diagnosis of only upper respiratory infection (URI) were appropriately NOT prescribed or dispensed an antibiotic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Numerator:</strong> Patients who were not prescribed or dispensed an antibiotic on the visit.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients aged 3 months to 18 years (inclusive) with only a diagnosis of upper respiratory infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> Documentation of Medical Reason(s) for prescribing antibiotic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percentage</strong> of children 3 months to 18 years of age (inclusive) who were seen for a visit with a diagnosis of only upper respiratory infection (URI) and were appropriately not prescribed or dispensed an antibiotic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Reporting Instructions:</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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## Upper Respiratory Infection in Children (URI)

**Brief Description of Performance Measure & Source and Reporting Instructions**

- **Measure note:** **This measure is being specified for physician reporting. Antibiotic dispensing from claims data is not the denominator criteria (see NCQA HEDIS®2007 health plan measure)**
- For URI patients with documented medical reasons for prescribing or dispensing an antibiotic, report modifier 1P with code 4124F.
- There are no performance measure exclusions for 4120F. Do not report modifiers 1P, 2P, or 3P with this code.

<table>
<thead>
<tr>
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</table>

## Non-Measure Claims Based Reporting:

The following codes are included for reporting of certain aspects of care. These factors are not represented by measures developed by existing measures organizations or recognized measures-development processes at the time they are placed in CPT, but may ultimately be associated with measures approved by an appropriate quality improvement organization.

### Non-Measure Claims Based Reporting: Abdominal Aortic Aneurysm Repair

Patient undergoing open or endovascular repair of infrarenal, non-ruptured abdominal aortic aneurysm

---

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<th>Code Descriptor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> None</td>
<td>9001F</td>
<td>Aortic aneurysm less than 5.0 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT</td>
</tr>
<tr>
<td><strong>Denominator:</strong> All patients undergoing non-ruptured infrarenal open or endovascular Abdominal Aortic Aneurysm (AAA) repair</td>
<td>9002F</td>
<td>Aortic aneurysm 5.0 - 5.4 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td>9003F</td>
<td>Aortic aneurysm 5.5 - 5.9 cm maximum diameter on centerline formatted CT or minor diameter on axial formatted CT</td>
</tr>
<tr>
<td><strong>Reporting Instruction(s):</strong></td>
<td>9004F</td>
<td>Aortic aneurysm 6.0 cm or greater maximum diameter on centerline formatted CT or minor diameter on axial formatted CT</td>
</tr>
<tr>
<td>Report 9001F, 9002F, 9003F, or 9004F for each patient in the denominator population.</td>
<td></td>
<td></td>
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10. **American Gastroenterological Association (AGA)**, [www.gastro.org/quality](http://www.gastro.org/quality)

11. **American Society of Anesthesiologists (ASA)**, [www.asahq.org](http://www.asahq.org)

12. **American College of Gastroenterology (AGC)**, [www.gi.org](http://www.gi.org); **American Gastroenterological Association (AGA)**, [www.gastro.org](http://www.gastro.org); and **American Society for Gastrointestinal Endoscopy (ASGE)**, [www.asge.org](http://www.asge.org)

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### Non-Measure Claims Based Reporting: Carotid Intervention

Patient undergoing carotid endarterectomy or carotid artery stenting

<table>
<thead>
<tr>
<th>Description of Non-Measure Information</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Numerator:</strong> None</td>
<td>9005F</td>
<td>Asymptomatic carotid stenosis: No history of any transient ischemic attack or stroke in any carotid or vertebrobasilar territory</td>
</tr>
<tr>
<td><strong>Denominator:</strong></td>
<td>9006F</td>
<td>Symptomatic carotid stenosis: Ipsilateral carotid territory TIA or stroke less than 120 days prior to procedure</td>
</tr>
<tr>
<td><strong>Exclusion(s):</strong> None</td>
<td>9007F</td>
<td>Other carotid stenosis: Ipsilateral TIA or stroke 120 days or greater prior to procedure or any prior contralateral carotid territory or vertebrobasilar TIA or stroke</td>
</tr>
<tr>
<td><strong>Reporting Instruction(s):</strong></td>
<td></td>
<td>Report 9005F, 9006F, or 9007F for each patient in the denominator population.</td>
</tr>
</tbody>
</table>

---

**Footnotes**

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List of Category II and Alphabetical Clinical Topics Listing Revisions for CPT 2020 Code Set

February 2019 Panel Meeting Revisions

Category II
Diagnostic/Screening Processes or Results

<table>
<thead>
<tr>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3044F</td>
<td>Most recent hemoglobin A1c (HbA1c) level less than 7.0% (DM)²⁴</td>
</tr>
<tr>
<td>3045F</td>
<td>Most recent hemoglobin A1c (HbA1c) level 7.0%–9.0% (DM)²⁴</td>
</tr>
</tbody>
</table>

(3045F has been deleted. To report control of HbA1c, see 3051F, 3052F)

| #●3051F                | Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0% (DM)²  |
| #●3052F                | Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0% (DM)²  |

| 3046F                   | Most recent hemoglobin A1c level greater than 9.0% (DM)⁴ |

Footnotes

¹ Physician Consortium for Performance Improvement® (PCPI) - For more information on measures developed by the Physician Consortium for Performance Improvement® (PCPI), see the appropriate Payor website.

² National Committee on Quality Assurance (NCQA), Health Employer Data Information Set (HEDIS®), [www.ncqa.org](http://www.ncqa.org)

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⁶ The Society of Thoracic Surgeons at [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

⁷ Optum, [www.optum.com](http://www.optum.com).


¹⁰ American Gastroenterological Association (AGA), [www.gastro.org/quality](http://www.gastro.org/quality).

¹¹ American Society of Anesthesiologists (ASA), [www.asahq.org](http://www.asahq.org).

¹² American College of Gastroenterology (AG), [www.gi.org](http://www.gi.org); American Gastroenterological Association (AGA), [www.gastro.org](http://www.gastro.org); and American Society for Gastrointestinal Endoscopy (ASGE), [www.asge.org](http://www.asge.org).
Percentage of patients with diagnosed diabetes aged 18-75 years with one or more A1c test(s).

**Exclusion(s):** NONE

**Reporting Instructions:** In order to meet this measure, the date of test, when it was performed, and the corresponding result are required. For this reason, report one of the three Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. The measure may also be met by reporting the Category I code, 83036 Hemoglobin; glycosylated (A1C), when performed.

To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3045F, 3051F, 3052F.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3051F</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%</td>
</tr>
<tr>
<td>3052F</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%</td>
</tr>
<tr>
<td>3046F</td>
<td>Most recent hemoglobin A1c (HbA1c) level &gt; 9.0%</td>
</tr>
</tbody>
</table>

### A1c Management

**Whether or not patient’s most recent A1c level > 9.0% (poor control)**

**Numerator:** Patients with most recent A1c level > 9.0% (poor control)

**Denominator:** Patients diagnosed with diabetes 18-75 years of age

**Percentage of patients with most recent A1c level > 9.0% (poor control)

**Exclusion(s):** NONE

**Reporting Instructions:** In order to meet this measure, the date of test when it was performed and the corresponding result are required. For this reason, report one of the four Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code.

To report most recent hemoglobin A1c level ≤9.0%, see codes 3044F, 3045F, 3051F, 3052F.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3044F</td>
<td>Most recent hemoglobin A1c (HbA1c) level less than 7.0%</td>
</tr>
<tr>
<td>3045F</td>
<td>Most recent hemoglobin A1c (HbA1c) level 7.0% to 9.0%</td>
</tr>
<tr>
<td>3051F</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than or equal to 7.0% and less than 8.0%</td>
</tr>
<tr>
<td>3052F</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%</td>
</tr>
<tr>
<td>3046F</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than 9.0%</td>
</tr>
</tbody>
</table>

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6. **The Society of Thoracic Surgeons at** [www.sts.org](http://www.sts.org) and National Quality Forum, [www.qualityforum.org](http://www.qualityforum.org)

7. **Optum,** [www.optum.com](http://www.optum.com)

8. **American Academy of Neurology,** [https://www.aan.com/practice/neuromuscular-quality-measures](https://www.aan.com) or quality@aan.com


10. **American Gastroenterological Association (AGA),** [www.gastro.org/quality](http://www.gastro.org/quality)

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### A1c Management

Whether or not patient’s most recent A1c level \( \leq 7.0\% \) (tight control) is controlled

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
<th>Exclusion(s)</th>
<th>Reporting Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with most recent A1c level ( &lt; 7.0% ) (tight control) OR Patients with most recent A1c level ( &lt; 8.0% ) OR Patients with most recent A1c level ( &gt; 9.0% )</td>
<td>Patients diagnosed with diabetes 18-75 years of age</td>
<td>Documentation of medical reasons for not pursuing tight control of A1c level (eg, steroid-induced or gestational diabetes, frailty and/or advanced illness)</td>
<td>In order to meet this measure, the date of test when it was performed and the corresponding result are required. For this reason, report one of the three four Category II codes listed and use the date of service as the date of the test, not the date of the reporting of the Category II code. Reference the HEDIS Value Sets cited in the Comprehensive Diabetes Care Exclusions section for information on reporting for patients with appropriate exclusion criteria.</td>
</tr>
<tr>
<td>3044F</td>
<td>Most recent hemoglobin A1c level less than 7.0%</td>
<td>Most recent hemoglobin A1c level 7.0% to 9.0%</td>
<td></td>
</tr>
<tr>
<td>3045F</td>
<td>Most recent hemoglobin A1c level greater than or equal to 7.0% and less than 8.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3051F</td>
<td>Most recent hemoglobin A1c (HbA1c) level greater than or equal to 8.0% and less than or equal to 9.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3052F</td>
<td>Most recent hemoglobin A1c level greater than 9.0%</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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6. [The Society of Thoracic Surgeons](https://www.sts.org) at [www.sts.org](http://www.sts.org) and [National Quality Forum](https://www.qualityforum.org).

7. [Optum](https://www.optum.com).

8. [American Academy of Neurology](https://www.aan.com/practice/neuromuscular-quality-measures), or [quality@aun.com](mailto:quality@aun.com).


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### Chronic Lymphocytic Leukemia (CLL)-Baseline Flow Cytometry

<table>
<thead>
<tr>
<th>Brief Description of Performance Measure and Source and Reporting Instructions</th>
<th>CPT Category II Code(s)</th>
<th>Code Descriptor(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whether or not the patient aged 18 years and older with a diagnosis of CLL had baseline flow cytometry studies performed</td>
<td>▲3170F</td>
<td>Baseline flow cytometry studies performed at time of diagnosis or prior to initiating treatment</td>
</tr>
</tbody>
</table>

#### Exclusion(s) / Exception(s):
- Documentation of medical, patient, or system reason(s) for not performing baseline flow cytometry studies

---

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10. [American Gastroenterological Association (AGA),](https://www.gastro.org) [www.gastro.org](http://www.gastro.org) / [quality@aan.com](mailto:quality@aan.com).


Percentage of patients aged 18 years and older, seen within a 12-month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period who had baseline flow cytometry studies performed and documented in the chart.

Reporting Instructions: Treatment may include antineoplastic therapy.

For patients with a medical reason for not performing baseline flow cytometry studies, report 3170F with modifier 1P.

For patients with a patient reason for not performing cytogenetic testing (e.g., receiving palliative care or not receiving treatment as defined above), report 3170F with modifier 2P.

For patients with a system reason for not performing cytogenetic testing (e.g., patient previously treated by another physician at the time baseline flow cytometry studies were performed), report 3170F with modifier 3P.

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