2008 Test Measures

Beginning July 1, 2008 through September 30, 2008 the Centers for Medicare & Medicaid Services (CMS) will accept data submission for a test set of eleven quality measures. The test measures have completed measures and specification development, have been adopted by the AQA Alliance, and have available CPT II codes implemented by CMS that permit claims-based data submission. The submission of quality data for the test measures will provide information for a preliminary evaluation of the test measures for data submission. There will be no financial incentive payment associated with the reporting of these test measures. Feedback reports regarding reporting and performance rates will not be provided to eligible professionals. Eligible professionals may only report the measures by submitting eligible Part B claims containing quality-data codes for dates of services from July 1, 2008 through September 30, 2008. Quality-data codes should be submitted in accordance with each individual measure's data specifications.

This document contains the complete specifications for eleven Test Measures. Each measure is assigned a unique number, T135 through T145.

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*Measure #T135: Chronic Kidney Disease (CKD): Influenza Immunization

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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for CKD patients seen during the reporting period. This measure is intended to determine whether or not CKD patients received or had an order for an influenza immunization during the flu season (September through February). It is anticipated that clinicians providing care for patients with CKD will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis code, CPT E/M service code, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reasons not otherwise specified.

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

Numerator Coding:
Influenza Immunization Ordered or Administered
CPT II 4037F: Influenza immunization ordered or administered

OR

Influenza Immunization not Ordered or Administered for Medical, Patient, or System Reasons
Append a modifier (1P, 2P, or 3P) to CPT Category II code 4037F to report documented circumstances that appropriately exclude patients from the denominator.

- 1P: Documentation of medical reason(s) for patient not receiving the influenza immunization
- 2P: Documentation of patient reason(s) for patient not receiving the influenza immunization
- 3P: Documentation of system reason(s) for patient not receiving the influenza immunization

OR

Influenza Immunization not Ordered or Administered, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4037F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Influenza immunization not ordered or administered, reason not otherwise specified

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

Denominator Coding:
An ICD-9 diagnosis code for CKD and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 585.4, 585.5
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
USRDS data shows that Medicare patients with CKD are more likely to receive a flu vaccine versus employer group health plan patients with CKD (0.43 versus 0.08 respectively). Additionally, it is estimated that fewer than 20% of all patients in high risk groups receive a flu vaccine each year. Patients with CKD need to be vaccinated yearly in order to decrease morbidity and mortality related to influenza and its complications.

CLINICAL RECOMMENDATION STATEMENTS:
Vaccination with TIV (trivalent inactivated flu vaccine) is recommended for the following persons who are at increased risk for severe complications from influenza, or at higher risk for influenza-associated clinic, emergency department, or hospital visits: adults and children who have chronic pulmonary (including asthma), cardiovascular (except hypertension), renal, hepatic, hematological, or metabolic disorders (including diabetes mellitus). (CDC, 2007)

In any given year, the optimal time to vaccinate patients cannot be determined because influenza seasons vary in their timing, and more than one outbreak might occur in a single community in a single year. (CDC, 2007)

In general, health-care providers should begin offering vaccination soon after vaccine becomes available and if possible, by October. (CDC, 2007)

Vaccine efforts should continue throughout the season, because the duration of the influenza season varies, and influenza might not occur in certain communities until February or March. The majority of adults have antibody protection against influenza within 2 weeks after vaccination. (CDC, 2007)

*Measure #T136: Melanoma: Follow-Up Aspects of Care

DESCRIPTION:
Percentage of patients, regardless of age, with a new diagnosis of melanoma or a history of melanoma who received all of the following aspects of care within 12 months: (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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma or a history of melanoma will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT E/M service codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis code, CPT E/M service code, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients who received all aspects of care at least once within 12 months

Definition: Follow-up aspects of care include all of the following: (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.

Numerator Instructions: A complete physical skin exam includes: head (including the face), neck, chest (including the axillae), abdomen, back, and extremities. The genitalia (including the groin and buttocks) may also be examined (optional).

Numerator Coding:
Follow-Up Aspects of Care Performed
CPT II 0015F: Melanoma follow-up completed

OR

Follow-Up Aspects of Care not Performed for System Reasons
Append a modifier (3P) to CPT Category II code 0015F to report documented circumstances that appropriately exclude patients from the denominator.

- 3P: Documentation of system reason(s) for not performing the follow-up service (eg, another physician performed this service)

OR

Follow-Up Aspects of Care not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 0015F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Melanoma follow-up not performed, reason not otherwise specified

DENOMINATOR:
All patients, regardless of age, with a new diagnosis of melanoma or a history of melanoma

Denominator Coding:
An ICD-9 diagnosis code for melanoma or a history of melanoma and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Early detection of an additional or secondary primary melanoma is an important goal of follow-up care. The majority of additional primary melanomas are discovered by the patient or family member. Educating patients to perform self-examinations will lead to earlier detection of secondary primary sites of melanoma. Only 60% of physicians routinely performed full-body examinations with their high-risk patients.

CLINICAL RECOMMENDATION STATEMENTS:
Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0 in situ-melanoma. Frequency of dermatologic surveillance should be determined individually, based on risk factors, including skin type, family history, presence of dysplastic nevi, and history of non-melanoma skin cancers. Clinicians should also consider educating patients about monthly self-exam of their skin and lymph nodes. (NCCN)

For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated. For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated. (NCCN) (Level of Evidence - Category 2A)

A structured follow-up program could permit the earlier detection of recurrent disease at a time when it might be more amenable to potentially curative surgical resection. This follow-up would be particularly appropriate for patients at risk for regional nodal recurrence who have not yet undergone sentinel node biopsy or elective lymph node dissection. (NCCN)

All patients should be taught self-examination because many recurrences are found by patients themselves at home rather than by clinicians in the clinic. (BAD)

*****Measure #T137: Melanoma: Continuity of Care – Recall System

DESCRIPTION:
Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma who were entered into a recall system with the date for the next complete physical skin examination specified at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma or a history of melanoma will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT E/M service codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis code, CPT E/M service code, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patients entered into a recall system with the target date for the next complete physical skin exam specified, at least once within 12 months

Numerator Instructions: To satisfy this measure, the recall system must be linked to a process for notifying patients when their next physical exam is due 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.

Numerator Coding:
Recall System Utilized
CPT II 7010F: Patient information entered into a recall system with the target date for the next exam specified

OR

Recall System not Utilized for System Reasons
Append a modifier (3P) to CPT Category II code 7010F to report documented circumstances that appropriately exclude patients from the denominator.

- 3P: Documentation of system reason(s) for not entering patient's information into a recall system (eg, melanoma being monitored by another physician provider)

OR

Recall System not Utilized, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 7010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Recall system not utilized, reason not otherwise specified

DENOMINATOR:
All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma

Denominator Coding:
An ICD-9 diagnosis code for melanoma or a history of melanoma and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Lack of follow-up with providers noted in the Institute of Medicine (IOM) report on patient errors. Follow-up for skin examination and surveillance is an important aspect in the management of patients with a current diagnosis or a history of melanoma. The presence of a recall system, whether it is electronic or paper based, enables providers to ensure that patients receive follow-up appointments in accordance with their individual needs.

CLINICAL RECOMMENDATION STATEMENTS:
Skin examination and surveillance at least once a year for life is recommended for all melanoma patients, including those with stage 0 in situ-melanoma. Frequency of dermatologic surveillance should be determined individually, based on risk factors, including skin type, family history, presence of dysplastic nevi, and history of non-melanoma skin cancers. Clinicians should also consider educating patients about monthly self-exam of their skin and lymph nodes. (NCCN)

For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated. For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated. (NCCN) (Level of Evidence - Category 2A)

Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and carers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and carers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may

also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.
- Collect data for network-wide audit. (NICE)

*Measure #T138: Melanoma: Coordination of Care

DESCRIPTION:
Percentage of patient visits, regardless of patient age, with a new occurrence 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

INSTRUCTIONS:
This measure is to be reported at each visit occurring during the reporting period for melanoma patients seen during the reporting period. It is anticipated that clinicians providing care for patients with melanoma will submit this measure.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes and CPT E/M service codes are used to identify patients who are included in the measure's denominator. CPT Category II code(s) are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis code, CPT E/M service code, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifiers allowed for this measure are: 2P- patient reasons, 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Numerator Instructions: A treatment plan should include the following elements: diagnosis, tumor thickness, and plan for surgery or alternate care.

NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.

Numerator Coding:
Treatment Plan Communicated
(Two CPT II codes [5050F & 1127F] are required on the claim form to submit this category)

CPT II 5050F: Treatment plan communicated to provider(s) managing continuing care within one month of diagnosis
AND
CPT II 1127F: New episode for condition
OR

Treatment Plan not Communicated for Patient or System Reasons
(Two CPT II codes [5050F-xP & 1127F] are required on the claim form to submit this category)

Append a modifier (2P or 3P) to CPT Category II code 5050F to report documented circumstances that appropriately exclude patients from the denominator.

- 2P: Documentation of patient reason(s) for not communicating treatment plan (e.g., patients asks that treatment plan not be communicated to the physician(s) providing continuing care)
- 3P: Documentation of system reason(s) for not communicating treatment plan (e.g., patient does not have a primary care physician or referring physician)

AND
CPT II 1127F: New episode for condition

OR

If patient is not eligible for this measure because this is a subsequent episode for the condition, report:
(One CPT II code [1128F] is required on the claim form to submit this category)

CPT II 1128F: Subsequent episode for condition

OR

Treatment Plan not Communicated, Reason not Specified
(Two CPT II codes [5050F-8P & 1127F] are required on the claim form to submit this category)

Append a reporting modifier (8P) to CPT Category II code 5050F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Treatment plan not communicated, reason not otherwise specified

AND
CPT II 1127F: New episode for condition

DENOMINATOR:
All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

Denominator Coding:
An ICD-9 diagnosis code for melanoma and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:

Perceived lack of follow-up with primary care providers which is reinforced in the Institute of Medicine (IOM) report on patient errors. The intention of this measure is to enable the primary care provider to support, facilitate, and coordinate the care of the patient.

CLINICAL RECOMMENDATION STATEMENTS:

Each local skin cancer multi-disciplinary team (LSMDT) and specialist skin cancer multi-disciplinary team (SSMDT) should have at least one skin cancer clinical nurse specialist (CNS) who will play a leading role in supporting patients and carers. There should be equity of access to information and support regardless of where the care is delivered. A checklist may be used by healthcare professionals to remind them to give patients and carers the information they need in an appropriate format for pre-diagnosis, diagnosis, treatment, follow-up, and palliative care. This may also include a copy of the letter confirming the diagnosis and treatment plan sent by the consultant to the general practitioner (GP).

- Provide a rapid referral service for patients who require specialist management through the LSMDT/SSMDT.
- Be responsible for the provision of information, advice, and support for patients managed in primary care and their care givers.
- Maintain a register of all patients treated, whose care should be part of a regular audit presented to the LSMDT/SSMDT.
- Liaise and communicate with all members of the skin cancer site-specific network group.
- Ensure that referring GPs are given prompt and full information about their patients' diagnosis or treatment in line with national standards on communication to GPs of cancer diagnoses.
- Collect data for network-wide audit. (NICE)

*****Measure #T139: Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement

DESCRIPTION:
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 examination; 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

INSTRUCTIONS:
This measure is to be reported each time a cataract surgery with IOL placement is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the cataract procedure will submit this measure.

This measure is reported using CPT Category II codes:
CPT procedure codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate CPT procedure code and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patients who received a comprehensive preoperative assessment within 12 months prior to cataract surgery

Definition: Comprehensive preoperative assessment includes 1) dilated fundus examination; 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

Numerator Coding:
Comprehensive Preoperative Assessment Performed
CPT II 0014F: Comprehensive preoperative assessment performed for cataract surgery with intraocular lens (IOL) placement

OR

Comprehensive Preoperative Assessment not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 0014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Comprehensive preoperative assessment not performed for cataract surgery with intraocular lens (IOL) placement, reason not otherwise specified

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery with IOL placement

Denominator Coding:
A CPT procedure code is required to identify patients for denominator inclusion.
CPT procedure codes: 66982, 66983, 66984

RATIONALE:
1. Scientific basis for comprehensive preoperative assessment

In order to ensure that cataract surgery is APPROPRIATE and SAFE to perform, the operating surgeon is obligated to ensure that there is 1) a patient-centered problem that cataract surgery will address and improve (i.e., that there is likely to be an appropriate outcome of surgery); 2) that the safety of the procedure is maximized through appropriate IOL choice to reduce "wrong power IOL" surgery; and 3) that there are no other conditions that would impact either the appropriateness or the safety of surgery through a comprehensive eye examination, including dilation.

The purpose of the comprehensive evaluation of a patient whose chief complaint might be related to a cataract is to determine the presence of a cataract, confirm that a cataract is a significant factor related to the visual impairment and symptoms described by the patient, and exclude or identify other ocular or systemic conditions that might contribute to visual impairment or affect the cataract surgical plan or ultimate outcome.

During the preoperative evaluation, other ocular conditions could be found in the course of fundus evaluation that would lead to identification of possible contraindications for surgery:
Surgery for a visually impairing cataract should not be performed under the following circumstances:

- Eyeglasses or visual aids provide vision that meets the patient's needs.
- Surgery will not improve visual function.
- The patient cannot safely undergo surgery because of co-existing medical or ocular conditions.
- Appropriate postoperative care cannot be arranged.

The surgeon should consider the patient's individual desires and needs in selecting an appropriate postoperative refractive target. The axial length can be measured by A-scan ultrasonography using either an applanation (contact) or an immersion (non-contact) technique. Biometry measurement for both eyes is advisable, even if surgery is not planned for the other eye. Formulas for calculating IOL power rely on keratometry to determine the net refractive contribution of the cornea. These measurements can be obtained through either manual or automated keratometry, or through corneal topography. Latest generation lens calculation formulas should be used in the IOL selection process.

2. Evidence of gap in care.

Results from the Cataract Appropriateness Project from RAND and additional studies for AHCPR at RAND suggest that the gap for a comprehensive preoperative assessment range from 10 to 30+%.

CLINICAL RECOMMENDATION STATEMENTS:

The initial physical examination should include visual acuity, refraction, ocular alignment and motility, pupil reactivity and function, IOP measurement, external examination, slit-lamp biomicroscopy, evaluation of the fundus through dilated pupil, assessment of general and mental health (Level A:III Recommendation).

Achieving the targeted postoperative refraction requires measuring axial length accurately, determining corneal power, and using the most appropriate IOL power formula.

The primary indication for surgery is visual function that no longer meets the patient's needs and for which cataract surgery provides a reasonable likelihood of improved vision. Functional indications for surgery include documentation that a patient is experiencing difficulty with activities of daily living, such as reading, walking, driving, and performing other visual tasks. This may also include symptoms of anisometropia, glare, starbursts, or color vision abnormalities.

Medical indications for surgery include documentation that the presence of the cataract is contributing to disease (such as primary angle closure) or that removal is necessary for adequate visualization of the fundus. Such medical conditions for a cataract removal include the following:

- Clinically significant anisometropia in the presence of a cataract.
- The lens opacity interferes with optimal diagnosis or management of posterior segment conditions.
- The lens causes inflammation (phacolysis, phacoanaphylaxis).
- The lens induces angle closure (phacomorphic or phacotopic).

*Measure #T140: Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of AMD and/or their caregiver(s) who 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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for AMD patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with AMD will submit this measure. The system reason exclusion may be used if a clinician is asked to report on this measure but is not the clinician providing the primary management for AMD.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate ICD-9 diagnosis code, CPT code, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reasons not otherwise specified.

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

Numerator Instruction: Counseling can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, patients who are smokers (beta-carotene can increase the risk for cancer in these patients) or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given the purported risks associated with antioxidant use, patients would be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate patients about overuse as well as appropriate use.

Numerator Coding:
AREDS Counseling Performed
CPT II 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)

OR

AREDS Counseling not Performed for System Reasons
Append a modifier (3P) to CPT Category II code 4177F to report documented circumstances that appropriately exclude patients from the denominator.

- 3P: Documentation of system reason(s) for not counseling the patient and/or caregiver(s) on the benefits and/or risks of the AREDS formulation

OR

AREDS Counseling not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 4177F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: AREDS counseling not performed, reason not otherwise specified

DENOMINATOR:
All patients aged 50 years and older with a diagnosis of AMD

Denominator Coding:
An ICD-9 diagnosis code for AMD and a CPT code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 362.50, 362.51, 362.52
AND
CPT codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

RATIONALE:
1. Scientific basis for counseling regarding use of AREDS formulation for patients with AMD

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

At the same time, published meta analyses have raised an issue as to the presence of an elevated mortality risk among patients taking elements similar to parts of the AREDS formulation (and elevated risk among smokers). As such, patients need to know of their individualized risk profile for taking the AREDS formula AND the potential benefits, so that they can make their OWN individual decision as to whether or not to take the AREDS formulation.

This indicator thus seeks to directly enhance the provider-patient relationship to apply the results of level 1 randomized controlled trials (RCTs) in a manner that accommodates the needs of each individual patient in a patient-centered manner, rather than a paternalistic approach of either recommending or withholding treatment.

2. Evidence of gap in care.

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

CLINICAL RECOMMENDATION STATEMENTS:

Patients with intermediate AMD or advanced AMD in one eye should be counseled on the use of antioxidant vitamin and mineral supplements as recommended in the Age-related Eye Disease Study (AREDS) reports. (Level A:I Recommendation) (AAO)

TABLE 1

Antioxidant Vitamin and Mineral Supplements Used in the AREDS

Supplement	Daily Dose*
Vitamin C	500 mg
Vitamin E	400 IU
Beta-carotene	15 mg (25,000 IU)
Zinc oxide	80 mg
Cupric oxide	2 mg

* These doses are not those listed on the commercially available vitamin/mineral supplements because of a change in labeling rules by the U.S. Food and Drug Administration that specifies that the doses must reflect the amounts available at the end of the shelf life.

*****Measure #T141: Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of POAG 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

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for glaucoma patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with POAG will submit this measure. The system reason exclusion may be used if an ophthalmologist or optometrist is asked to report on this measure but is not the ophthalmologist or optometrist providing the primary management for primary open-angle glaucoma.

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate ICD-9 diagnosis code, CPT code, and the appropriate CPT Category II code(s) OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 3P- system reasons, 8P- reasons not otherwise specified.

NUMERATOR:
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 a plan of care was documented within 12 months

> Definition: 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
>
> *NUMERATOR NOTE: The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*
>
> Numerator Coding:
> Intraocular Pressure (IOP) Reduced Greater than or Equal to 15% Pre-intervention Level
> *(One CPT II code [3284F] is required on the claim form to submit this category)*
>
> CPT II 3284F: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level
> OR

Intraocular Pressure (IOP) Reduced Less than 15% Pre-intervention Level with Plan of Care
(Two CPT II codes [0517F & 3285F] are required on the claim form to submit this category)

CPT II 0517F: Glaucoma plan of care documented
AND
CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Glaucoma Plan of Care not Documented for System Reasons
(Two CPT II codes [0517F-3P & 3285F] are required on the claim form to submit this category)

Append a modifier (3P) to CPT Category II code 0517F to report documented circumstances that appropriately exclude patients from the denominator.

- 3P: Glaucoma plan of care not documented for system reason(s)

AND
CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Glaucoma Plan of Care not Documented, Reason not Specified
(Two CPT II codes [0517F-8P & 3285F] are required on the claim form to submit this category)

Append a reporting modifier (8P) to CPT Category II code 0517F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Glaucoma plan of care not documented, reason not otherwise specified

AND
CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Measurement not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 3284F to report circumstances when the IOP measurement is not documented.

- 8P: IOP measurement not documented, reason not otherwise specified

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

Denominator Coding:
An ICD-9 diagnosis code for POAG and a CPT code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 365.01, 365.10, 365.11, 365.12, 365.15
AND
CPT codes: 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

RATIONALE:
1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate)

Analyses of results of several randomized clinical trials all demonstrate that reduction of IOP of at least 18% (EMGT, CIGTS, AGIS, CNTGS) reduces the rate of worsening of visual fields by at least 40%. The various studies, however, achieved different levels of mean IOP lowering in realizing their benefit in patient outcomes, ranging from 18% in the "normal pressure" subpopulation of EMGT to 42% in the CIGTS study. (Level I studies) As such, an appropriate "failure" indicator is to NOT achieve at least a 15% IOP reduction. The rationales for a failure indicator are that 1) the results of different studies can lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) to minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary from 18 to 40+%.

In addition, "…[s]everal population based studies have demonstrated that the prevalence of POAG as well as the incidence of POAG, increases as the level of IOP increases. These studies provide strong evidence that IOP plays an important role in the neuropathy of POAG. Furthermore, studies have demonstrated that reduction in the level of IOP lessens the risk of visual field progression in open-angle glaucoma. In addition, treated eyes that have a greater IOP fluctuation are at increased risk of progression.

Intraocular pressure is the intermediate outcome of therapy used by the FDA for approval of new drugs and devices and, as noted above, has been shown to be directly related to ultimate patient outcomes of vision loss. As such, failure to achieve minimal pressure lowering, absent an appropriate plan of care to address the situation, would constitute performance whose improvement would directly benefit patients with POAG.

2. Evidence for gap in care

Based on studies in the literature reviewing documentation of IOP achieved under care, the gap could be as great as 50% or more in the community of ophthalmologists and optometrists treating patients with primary open-angle glaucoma. Based on loose criteria for control, IOP was controlled in 66% of follow-up visits for patients with mild glaucoma and 52% of visits for patients with moderate to severe glaucoma. Another study of a single comprehensive insurance plan suggested that a large proportion of individuals felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than expected from recommendations of published guidelines.

CLINICAL RECOMMENDATION STATEMENTS:

The initial target pressure selected should be at least 20% lower than the pretreatment IOP, depending upon the clinical findings. Further reduction of the target IOP is often also justified by the severity of existing optic nerve damage, the level of the measured pretreatment IOP, the rapidity with which the damage occurred, and other risk factors. In general, the more advanced the damage, the lower the initial pressure should be (Level A: III Recommendation).

Please note that the American Optometric Association's (AOA) 2002 guideline on Open-angle Glaucoma was not reviewed during the development of this measure prior to the public comment period and therefore is not presented here verbatim. Review of the AOA guideline subsequent to initial measure development indicates that the recommendations in the AOA guideline are consistent with the intent of the measure. As such, the intent of this measure is to have this indicator apply to both optometrists and ophthalmologists (and any other physician who provides glaucoma care); the use of "ophthalmologists" only in the preceding verbatim section reflects the wording in the American Academy of Ophthalmology Preferred Practice pattern.

*****Measure #T142: Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

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

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

This measure is reported using CPT Category II codes:
ICD-9 diagnosis codes, CPT E/M service codes, and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed ICD-9 diagnosis code, CPT E/M service code, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

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

Numerator Coding:
Assessment for Anti-inflammatory or Analgesic OTC Medications Performed
CPT II 1007F: Use of anti-inflammatory or analgesic over-the-counter (OTC) medications for symptom relief assessed

OR

Assessment for Anti-inflammatory or Analgesic OTC Medications not Performed, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 1007F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

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

DENOMINATOR:
All visits for patients aged 21 years and older with OA

Denominator Coding:
An ICD-9 diagnosis code for OA and a CPT E/M service code are required to identify patients for denominator inclusion.
ICD-9 diagnosis codes: 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98
AND
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

RATIONALE:
Management of pain in patients with osteoarthritis is an important aspect of care. Patients who are able to have their pain controlled are more likely to be able to function at their desired level, which leads to improved quality of life.

CLINICAL RECOMMENDATION STATEMENTS:
Initial treatment should include activity modification and trial of analgesic or non-steroidal anti-inflammatory medication (NSAID). (AAOS; A Recommendation)

Acetaminophen has been shown to be as effective a pain reliever as NSAIDs in patients with OA of the knee. (AAOS, A Recommendation)

Analgesic and anti-inflammatory medications are important in arthritis pain management, but should be used concurrently with nutritional, physical, educational, and cognitive-behavioral interventions. (APS; A Recommendation)

Measure #T143-A: Oncology: Medical and Radiation – Pain Intensity Quantified

This is a two-part measure which is paired with Measure #T143-B: Oncology: Medical and Radiation: Plan of Care for Pain. If pain is present (CPT II code 1125F), measure #T143-B ***must*** also be reported.

DESCRIPTION:
Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

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

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

When reporting the measure, submit the listed ICD-9 diagnosis code(s), CPT E/M service code, CPT procedure code, and the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Patient visits in which pain intensity was quantified

Numerator Instructions: Pain intensity should be quantified using a standard instrument, such as a 0-10 numeric rating scale, a categorical scale, or the pictorial scale.

Numerator Coding:
Pain Severity Quantified, Presence of Pain Documented
CPT II 1125F: Pain severity quantified; pain present
(*When CPT II code 1125F is submitted, Measure #T143-B must also be reported)*
OR
CPT II 1126F: Pain severity quantified; no pain present

OR

Pain Severity not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 1125F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Pain severity not documented, reason not otherwise specified

DENOMINATOR:
All patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

Denominator Coding:
ICD-9 diagnosis code(s) for cancer and a CPT procedure code for radiation therapy or ICD-9 diagnosis code(s) for cancer and a CPT E/M service code accompanied by a CPT procedure code for chemotherapy are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 140.0, 140.1, 140.3, 140.4, 140.5, 140.6, 140.8, 140.9, 141.0, 141.1, 141.2, 141.3, 141.4, 141.5, 141.6, 141.8, 141.9, 142.0, 142.1, 142.2, 142.8, 142.9, 143.0, 143.1, 143.8, 143.9, 144.0, 144.1, 144.8, 144.9, 145.0, 145.1, 145.2, 145.3, 145.4, 145.5, 145.6, 145.8, 145.9, 146.0, 146.1, 146.2, 146.3, 146.4, 146.5, 146.6, 146.7, 146.8, 146.9, 147.0, 147.1, 147.2, 147.3, 147.8, 147.9, 148.0, 148.1, 148.2, 148.3, 148.8, 148.9, 149.0, 149.1, 149.8, 149.9, 150.0, 150.1, 150.2, 150.3, 150.4, 150.5, 150.8, 150.9, 151.0, 151.1, 151.2, 151.3, 151.4, 151.5, 151.6, 151.8, 151.9, 152.0, 152.1, 152.2, 152.3, 152.8, 152.9, 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 155.0, 155.1, 155.2, 156.0, 156.1, 156.2, 156.8, 156.9, 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 158.0, 158.8, 158.9, 159.0, 159.1, 159.8, 159.9,160.0, 160.1, 160.2, 160.3, 160.4, 160.5, 160.8, 160.9, 161.0, 161.1, 161.2, 161.3, 161.8, 161.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9, 163.0, 163.1, 163.8, 163.9, 164.0, 164.1, 164.2, 164.3, 164.8, 164.9, 165.0, 165.8, 165.9, 170.0, 170.1, 170.2, 170.3, 170.4, 170.5, 170.6, 170.7, 170.8, 170.9, 171.0, 171.2, 171.3, 171.4, 171.5, 171.6, 171.7, 171.8, 171.9, 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, 173.0, 173.1, 173.2, 173.3, 173.4, 173.5, 173.6, 173.7, 173.8, 173.9, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9, 176.0, 176.1, 176.2, 176.3, 176.4, 176.5, 176.8, 176.9, 179, 180.0, 180.1, 180.8, 180.9, 181, 182.0, 182.1, 182.8, 183.0, 183.2, 183.3, 183.4, 183.5, 183.8, 183.9, 184.0, 184.1, 184.2, 184.3, 184.4, 184.8, 184.9, 185, 186.0, 186.9, 187.1, 187.2, 187.3, 187.4, 187.5, 187.6, 187.7, 187.8, 187.9, 188.0, 188.1, 188.2, 188.3, 188.4, 188.5, 188.6, 188.7, 188.8, 188.9, 189.0, 189.1, 189.2, 189.3, 189.4, 189.8, 189.9, 190.0, 190.1, 190.2, 190.3, 190.4, 190.5, 190.6, 190.7, 190.8, 190.9, 191.0, 191.1, 191.2, 191.3, 191.4, 191.5, 191.6, 191.7, 191.8, 191.9, 192.0, 192.1, 192.2, 192.3, 192.8, 192.9, 193, 194.0, 194.1, 194.3, 194.4, 194.5, 194.6, 194.8, 194.9, 195.0, 195.1, 195.2, 195.3, 195.4, 195.5, 195.8, 196.0, 196.1, 196.2, 196.3, 196.5, 196.6, 196.8, 196.9, 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89, 199.0, 199.1, 200.00, 200.01, 200.02, 200.03, 200.04, 200.05, 200.06, 200.07, 200.08, 200.10, 200.11, 200.12, 200.13, 200.14, 200.15, 200.16, 200.17, 200.18, 200.20, 200.21, 200.22, 200.23, 200.24, 200.25, 200.26, 200.27, 200.28, 200.30, 200.31, 200.32, 200.33, 200.34, 200.35, 200.36, 200.37, 200.38, 200.40, 200.41, 200.42, 200.43, 200.44, 200.45, 200.46, 200.47, 200.48; 200.50, 200.51, 200.52, 200.53, 200.54, 200.55, 200.56, 200.57, 200.58, 200.60, 200.61, 200.62, 200.63, 200.64, 200.65, 200.66, 200.67, 200.68, 200.70, 200.71, 200.72, 200.73, 200.74, 200.75, 200.76, 200.77, 200.78, 200.80, 200.81, 200.82, 200.83, 200.84, 200.85, 200.86, 200.87, 200.88, 201.00, 201.01, 201.02, 201.03, 201.04, 201.05, 201.06, 201.07, 201.08, 201.10, 201.11, 201.12, 201.13, 201.14, 201.15, 201.16, 201.17, 201.18, 201.20, 201.21, 201.22, 201.23, 201.24, 201.25, 201.26, 201.27, 201.28, 201.40, 201.41, 201.42, 201.43, 201.44, 201.45, 201.46, 201.47, 201.48, 201.50, 201.51, 201.52, 201.53, 201.54, 201.55, 201.56, 201.57,

201.58, 201.60, 201.61, 201.62, 201.63, 201.64, 201.65, 201.66, 201.67, 201.68, 201.70, 201.71, 201.72, 201.73, 201.74, 201.75, 201.76, 201.77, 201.78, 201.90, 201.91, 201.92, 201.93, 201.94, 201.95, 201.96, 201.97, 201.98, 202.00, 202.01, 202.02, 202.03, 202.04, 202.05, 202.06, 202.07, 202.08, 202.10, 202.11, 202.12, 202.13, 202.14, 202.15, 202.16, 202.17, 202.18, 202.20, 202.21, 202.22, 202.23, 202.24, 202.25, 202.26, 202.27, 202.28, 202.30, 202.31, 202.32, 202.33, 202.34, 202.35, 202.36, 202.37, 202.38, 202.40, 202.41, 202.42, 202.43, 202.44, 202.45, 202.46, 202.47, 202.48, 202.50, 202.51, 202.52, 202.53, 202.54, 202.55, 202.56, 202.57, 202.58, 202.60, 202.61, 202.62, 202.63, 202.64, 202.65, 202.66, 202.67, 202.68, 202.70, 202.71, 202.72, 202.73, 202.74, 202.75, 202.76, 202.77, 202.78, 202.80, 202.81, 202.82, 202.83, 202.84, 202.85, 202.86, 202.87, 202.88, 202.90, 202.91, 202.92, 202.93, 202.94, 202.95, 202.96, 202.97, 202.98, 203.00, 203.01, 203.10, 203.11, 203.80, 203.81, 204.00, 204.01, 204.10, 204.11, 204.20, 204.21, 204.80, 204.81, 204.90, 204.91, 205.00, 205.01, 205.10, 205.11, 205.20, 205.21, 205.30, 205.31, 205.80, 205.81, 205.90, 205.91, 206.00, 206.01, 206.10, 206.11, 206.20, 206.21, 206.80, 206.81, 206.90, 206.91, 207.00, 207.01, 207.10, 207.11, 207.20, 207.21, 207.80, 207.81, 208.00, 208.01, 208.10, 208.11, 208.20, 208.21, 208.80, 208.81, 208.90, 208.91 235.0, 235.1, 235.2, 235.3, 235.4, 235.5, 235.6, 235.7, 235.8, 235.9, 236.0, 236.1, 236.2, 236.3, 236.4, 236.5, 236.6, 236.7, 236.90, 236.91, 236.99, 237.0, 237.1, 237.2, 237.3, 237.4, 237.5, 237.6, 237.70, 237.71, 237.72, 237.9, 238.0, 238.1, 238.2, 238.3, 238.4, 238.5, 238.6, 238.71, 238.72, 238.73, 238.74, 238.75, 238.76, 238.79, 238.8, 238.9, 239.0, 239.1, 239.2, 239.3, 239.4, 239.5, 239.6, 239.7, 239.8, 239.9

AND Either:

Coding Option 1
CPT procedure codes: 77427, 77431, 77432, 77435, 77470

OR

Coding Option 2
CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215
AND
CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549

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

CLINICAL RECOMMENDATION STATEMENTS:
All patients with cancer should be screened during the initial evaluation, at regular intervals, and whenever new therapy is initiated. The standard means for determining how much pain a patient is experiencing relies on a patient's self-report. Severity should be quantified using a 0-10 numerical rating scale, a categorical scale, or the pictorial scale (Wong-Baker Faces Pain Rating Scale). Faces can be used with patients who have difficulty with the above scales, eg, children, the elderly,

and patients with language or cultural differences or other communication barriers (Category 2A). (NCCN)

Pain intensity must be quantified, as the algorithm bases therapeutic decisions on a numerical value assigned to the severity of pain. Opioid naïve patients experiencing severe or increasing pain should receive rapid escalating doses of short-acting opioids, a bowel regimen, and Nonopioid analgesics as indicated. Psychosocial support is needed to ensure that patients encountering common barriers to appropriate pain control (eg, fear of addiction or side effects, inability to purchase opioids) or needing additional assistance (eg, depression, rapidly declining functional status) receive appropriate aid. Although pain intensity ratings will be obtained frequently to judge opioid dose increases, a formal reassessment is mandated in 24 hours for severe pain (Category 2A). (NCCN)

Regular, on-going assessment of pain, non-pain symptoms (including but not limited to shortness of breath, nausea, fatigue and weakness, anorexia, insomnia, anxiety, depression, confusion, and constipation), treatment side effects, and functional capacities are documented. Validated instruments, where available, should be used. (NCP)

All patients should be routinely screened for pain, and when it is present, pain intensity should be recorded in highly visible ways that facilitate regular review by health care providers. A standard for pain assessment and documentation should be established in each setting to ensure that pain is recognized, documented, and treated promptly. (APS)

Measure #T143-B: Oncology: Medical and Radiation – Plan of Care for Pain

This is a two-part measure which is paired with Measure #T143-A: Oncology: Medical and Radiation: Pain Intensity Quantified. This measure ***must*** be reported if CPT II code 1125F- "Pain severity quantified-pain present" is submitted through Measure #T143-A.

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

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

This measure is reported using CPT Category II codes:
All eligible instances when CPT II code 1125F (Pain severity quantified; pain present) is reported in the numerator for Measure #T143-A make up the denominator for this measure. CPT Category II code(s) are used to report the numerator of the measure.

When CPT II code 1125F is reported with Measure #T143-A, add the appropriate CPT Category II code(s) OR the CPT Category II code(s) with the modifier for this measure. The modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

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

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

Numerator Coding:
Plan of Care for Pain Documented
CPT II 0521F: Plan of care to address pain documented

OR

Plan of Care for Pain not Documented, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 0521F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

- 8P: Plan of care for pain not documented, reason not otherwise specified

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

Denominator Coding:
All eligible instances when CPT II code 1125F (Pain severity quantified; pain present) is reported in the numerator for Measure #T143-A.

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

CLINICAL RECOMMENDATION STATEMENTS:
All patients with cancer should be screened during the initial evaluation, at regular intervals, and whenever new therapy is initiated. The standard means for determining how much pain a patient is experiencing relies on a patient's self-report. Severity should be quantified using a 0-10 numerical rating scale, a categorical scale, or the pictorial scale (Wong-Baker Faces Pain Rating Scale). Faces can be used with patients who have difficulty with the above scales, eg, children, the elderly, and patients with language or cultural differences or other communication barriers (Category 2A). (NCCN)

Pain intensity must be quantified, as the algorithm bases therapeutic decisions on a numerical value assigned to the severity of pain. Opioid naïve patients experiencing severe or increasing pain should receive rapid escalating doses of short-acting opioids, a bowel regimen, and Nonopioid analgesics as indicated. Psychosocial support is needed to ensure that patients encountering common barriers to appropriate pain control (eg, fear of addiction or side effects, inability to purchase opioids) or needing additional assistance (eg, depression, rapidly declining functional status) receive appropriate aid. Although pain intensity ratings will be obtained frequently to judge opioid dose increases, a formal reassessment is mandated in 24 hours for severe pain (Category 2A). (NCCN)

For patients whose pain is less than 7 at presentation, the pathways are similar. The main differences include the option to perform the formal pain intensity reassessment less frequently (24-48 hours) and to consider beginning with slower titration of short-acting opioids for patients with moderate pain intensity rating 4-6 or with NSAID or acetaminophen if the patient has mild pain intensity rating from 1 to 0 and is opioid and NSAID-naïve (Category 2A). (NCCN)

Regular, on-going assessment of pain, non-pain symptoms (including but not limited to shortness of breath, nausea, fatigue and weakness, anorexia, insomnia, anxiety, depression, confusion, and constipation), treatment side effects, and functional capacities are documented. Validated instruments, where available, should be used. (NCP)

All patients should be routinely screened for pain, and when it is present, pain intensity should be recorded in highly visible ways that facilitate regular review by health care providers. A standard for pain assessment and documentation should be established in each setting to ensure that pain is recognized, documented, and treated promptly. (APS)

Measure #T144: Radiology: Computed Tomography (CT) Radiation Dose Reduction

DESCRIPTION:
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

INSTRUCTIONS:
This measure is to be reported each time a CT is performed in a hospital or outpatient setting during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for CT examinations will submit this measure.

This measure can be reported using CPT Category II codes:
CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed CPT procedure code and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

NUMERATOR:
Final reports for CT examinations that include documentation of use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure

Numerator Instruction: Physician will need to document that radiation dose reduction device (i.e., automated exposure control) was turned on for each scan or that the ALARA protocol was followed for manual techniques (ie, patient-size-specific scan parameters), while maintaining the necessary diagnostic image quality.

Numerator Coding:
Radiation Dose Reduction Documented in CT Report
CPT II 6040F: Use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure, documented

OR

Radiation Dose Reduction not Documented in CT Report, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 6040F 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: Final reports for CT examinations does not include documentation of use of appropriate radiation dose reduction devices OR manual techniques for appropriate moderation of exposure, reason not otherwise specified

DENOMINATOR:
All final reports for CT examinations performed

Denominator Coding:
A CPT procedure code is required to identify patients for denominator inclusion.
CPT procedure codes: 0042T, 0066T, 0067T, 0144T, 0145T, 0146T, 0147T, 0148T, 0149T, 0150T, 0151T, 20982, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 71250, 71260, 71270, 71275, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72191, 72192, 72193, 72194, 72292, 73200, 73201, 73202, 73206, 73700, 73701, 73702, 73706, 74150, 74160, 74170, 74175, 75635, 76380, 76497, 77011, 77012, 77013, 77078, 77079, 78814, 78815, 78816

RATIONALE:
While the use of CT in adults and children has increased nearly 7-fold in the past 10 years, data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation. (NCI, 2002) The BEIR (Biological Effects of Ionizing Radiation) report concluded that "the linear no-threshold model (LNT) provided the most reasonable description of the relation between low-dose exposure to ionizing radiation and the incidence of solid cancers that are induced by ionizing radiation." (NRC, 2006) Although dose-reduction techniques, such as automated exposure controls, have been shown to reduce radiation dose by 20-40%, broad use of procedures or protocols is not in place to tailor CT examinations to the patient for dose reduction. (Frush, 2004) As children are more sensitive to radiation and have a longer anticipated lifespan over which time cancerous changes may occur, the ALARA concept is of particular concern in this population. The National Cancer Institute has noted "adjustments are not frequently made in the exposure parameters that determine the amount of radiation children receive from CT, resulting in a greater radiation dose than necessary." (NCI, 2002)

CLINICAL RECOMMENDATION STATEMENTS:
Radiologists, radiologic technologists, and all supervising physicians have a responsibility to minimize radiation dose to individual patients, to staff, and to society as a whole, while maintaining the necessary diagnostic image quality. This is the concept "As Low As Reasonably Achievable (ALARA)." (ACR, 2006)

Facilities, in consultation with the medical physicist, should have in place and should adhere to policies and procedures, in accordance with ALARA, to vary examination protocols to take into account patient body habitus, such as height and/or weight, body mass index, or lateral width. (ACR, 2006)

The dose reduction devices that are available on imaging equipment should be active or manual techniques should be used to moderate the exposure while maintaining the necessary diagnostic image quality. (ACR, 2006)

❑Measure #T145: Radiology: Exposure Time Reported for Procedures Using Fluoroscopy

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

INSTRUCTIONS:
This measure is to be reported each time fluoroscopy is performed in a hospital or outpatient setting during the reporting period. There is no diagnosis associated with this measure. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for fluoroscopy examinations will submit this measure.

This measure can be reported using CPT Category II codes:
CPT procedure codes or G-codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure, submit the listed CPT procedure code(s) or G-code and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

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

Numerator Coding:
Radiation Exposure or Exposure Time Documented in Fluoroscopy Report
CPT II 6045F: Radiation exposure or exposure time in final report for procedure using fluoroscopy, documented

OR

Radiation Exposure or Exposure Time not Documented in Fluoroscopy Report, Reason not Specified
Append a reporting modifier (8P) to CPT Category II code 6045F 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: Final fluoroscopy report does not include documentation of radiation exposure or exposure time, reason not otherwise specified

DENOMINATOR:
All final reports for procedures using fluoroscopy

Denominator Coding:
A CPT procedure code(s) or G-code is required to identify patients for denominator inclusion.

CPT procedure codes or G-codes: 0062T, 0075T, 0080T, 24516, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27235, 27244, 27245, 27506, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 36597, 36598, 37182, 37183, 37184, 37187, 37188, 37210, 43752, 44500, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465,50382, 50384, 50385, 50386, 50387, 50389, 50590, 61623, 62263, 62264, 62280, 62281, 62282, 62318, 62319, 63610, 64510, 64520, 64530, 64561, 64605, 64610, 64620, 64622, 64626, 64680, 64681, 70010, 70015, 70170, 70332, 70370, 70371, 70373, 70390, 71023, 71034, 71040, 71060, 71090, 72240, 72255, 72265, 72270, 72275, 72285, 72291, 72295, 73040, 73085, 73115, 73525, 73542, 73580, 73615, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74291, 74300, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74400, 74410, 74415, 74420, 74425, 74430, 74440, 74445, 74450, 74455,74470, 74475, 74480, 74485, 74740, 74742, 75600, 75605, 75625, 75630, 75650, 75658, 75660, 75662, 75665, 75671, 75676, 75680, 75685, 75705, 75710, 75716, 75722, 75724, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75790, 75801, 75803, 75805, 75807, 75809, 75810, 75820, 75822, 75825, 75827, 75831, 75833, 75840, 75842, 75860, 75870, 75872, 75880, 75885, 75887, 75889, 75891, 75893, 75894, 75896, 75898, 75900, 75901, 75902, 75940, 75952, 75953, 75954, 75956, 75957, 75958, 75959, 75960, 75961, 75962, 75966, 75970, 75978, 75980, 75982, 75984, 75992, 75994, 75995, 76000, 76001, 76080, 76100, 76101, 76102, 76120, 76150, 76496, 77001, 77002, 77003, 77031, 77053, 77054, 77071, 92611, 93555, 93556, G0106, G0120, G0122, G0259, G0260, G0275, G0278, G0365

RATIONALE:

Data suggests that the lifetime risk for cancer can be increased, albeit by a small amount, with frequent or repeated exposure to ionizing radiation, including procedures using fluoroscopy. (NCI, 2002) The BEIR report concluded that "the linear no-threshold model (LNT) provided the most reasonable description of the relation between low-dose exposure to ionizing radiation and the incidence of solid cancers that are induced by ionizing radiation." (NRC, 2006) In order to monitor these long-term effects, the exposure time or radiation dose that a patient receives as a result of the procedure should be measured and recorded in the patient's record.

CLINICAL RECOMMENDATION STATEMENTS:

Radiation dose related information provided by automated dosimetry systems should be recorded in the patient's permanent record for procedures involving more than 10 minutes of fluoroscopic exposure. If automated dosimetry data is not available, fluoroscopic exposure times should be recorded in the patient's medical record for such procedures. (ACR, 2003)

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

Measure & record patient radiation dose:

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

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