2008 PQRI Measure Specifications
Release Notes

CMS is pleased to announce the release of the 2008 PQRI Measure Specifications dated 12/21/2007. Measure developers, professional organizations, and other PQRI stakeholders have provided comment, clarifications, and technical corrections. The list below details the combined list of changes made since the 2007 PQRI Measure Specifications and since previously posted versions (1.0 and 1.1) of the 2008 PQRI Measure Specifications.

Measure #1: Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus

- Added to Description, "mellitus"
- Added to Instructions, "with diabetes mellitus" in the first sentence
- In the Instructions, replaced "It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure." with "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."
- Deleted from Instructions "There are no allowable performance exclusions for this measure."
- Revised Numerator Coding:
  -Moved **OR** following 3046F to set off as numerator performance code consistent with other measures.
  -Revised Numerator Coding Statement and deleted "Performed." Now reads as "Most Recent Hemoglobin A1c Level > 9.0%".
  -Moved 3046F-8P below 3046F and above 3044F.

Measure #2: Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus

- Added to Description, "mellitus"
- Added to Instructions, "with diabetes mellitus" in the first sentence
- In the Instructions, replaced "It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure." with "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."
- Deleted from Instructions "There are no allowable performance exclusions for this measure."
- Revised Numerator Coding:
  -Moved **OR** following 3048F to set off as numerator performance code consistent with other measures.
  -Revised Numerator Coding Statement and deleted "Performed." Now reads as "Most Recent LDL-C Level <100 mg/dL"
  -Moved 3048F-8P below 3048F and above 3049F.

Measure #3: High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus

- Added to Description, "mellitus"
- Added to Instructions, "with diabetes mellitus" in the first sentence
- In the Instructions, replaced "It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure." with "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."
- Clarified Numerator Instructions, "To describe both systolic and diastolic blood pressure values, two CPT II codes must be reported – 1) One to describe the systolic value; AND 2) One to describe the diastolic value. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.
- Deleted from Instructions, "There are no allowable performance exclusions for this measure".

- Added clarification to Numerator Coding related to combinations for systolic and diastolic blood pressure values.

Measure #4: Screening for Future Fall Risk

- Added to Instructions, “There is no diagnosis associated with this measure.”
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary care for the patient will submit this measure.” with “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.”
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from Denominator Coding

Measure #5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with heart failure will submit this measure.” with “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.”
- Added to Instructions, "...which may be current or historical".
- Added Numerator Note: The correct combination of numerator codes 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.
- Added Definition for “prescribed”

Measure #6: Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease

- Added to Instructions, “with coronary artery disease” in the first sentence
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with coronary artery disease will submit this measure.” with “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.”
- Added Definition for “prescribed”

Measure #7: Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)

- Added to Instructions, “with prior myocardial infarction (MI)” in the first sentence
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with coronary artery disease with prior myocardial infarction (MI) will submit this measure.” with “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.”
- Added Definition for “prescribed”

Measure #8: Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction

- Added to Instructions, "...which may be current or historical".
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with heart failure will submit this measure.” with “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.”
- Added Definition for “prescribed”
- Removed CPT II codes 4006F, 4006F with 1P, 2P, 3P, 8P, 3021F, 3021F with 8P, and 3022F from Numerator Coding and replaced with G-codes G8395, G8396, G8450, G8451, and G8452 codes.

Measure #9: Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression

- In the Instructions, replaced "It is anticipated that clinicians who provide the primary management of patients with major depressive disorder will submit this measure" with "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."
- Added encounter codes 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 to Denominator Coding

Measure #10: Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports

- Edited Description to read, "Percentage of final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital 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 that includes documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction"
- Edited Instructions to read, "This measure is to be reported each time a CT or MRI is performed in a hospital or outpatient setting during the reporting period for patients with a diagnosis or symptom of ischemic stroke, TIA, or intracranial hemorrhage. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for patients with stroke, TIA, or intracranial hemorrhage in the hospital or outpatient setting will submit this measure. NOTE: Use of symptom codes is limited to those specified in the denominator coding.."
- Added Numerator Note: The correct combination of numerator codes 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.
- Edited Denominator statement to read, "All final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital 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".
- Added to ICD-9 codes 368.12, 368.2, 386.2, 437.7, 780.02, 781.3, 781.4, 781.94, 782.0, 784.3, 784.5 to Denominator Coding.
- Added a symptom diagnosis code to the Denominator Coding section.

Measure #11: Stroke and Stroke Rehabilitation: Carotid Imaging Reports

- Added to Description, "transient ischemic attack"

Measure #12: Primary Open Angle Glaucoma: Optic Nerve Evaluation

- Instructions changed to reflect "system" versus "medical" reason for exclusion when clinician reporting is not providing the primary management for primary open-angle glaucoma.
- Added modifier 3P to numerator exclusion coding.
- Added E/M codes 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 to Denominator Coding.

Measure #13: Age-Related Macular Degeneration: Age-Related Eye Disease study (AREDS) Prescribed/ Recommended

RETIRED effective January 1, 2008

Measure #14: Age-Related Macular Degeneration: Dilated Macular Examination

- Instructions changed to reflect "system" versus "medical" reason for exclusion when clinician reporting is not providing the primary management for age-related macular degeneration.
- Added modifier 3P to numerator exclusion coding.

- Added E/M codes 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 to Denominator Coding.
- Rationale clarified.

Measure #15: Cataracts: Assessment of Visual Functional Status
RETIRED effective January 1, 2008

Measure #16: Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation
RETIRED effective January 1, 2008

Measure #17: Cataracts: Pre-Surgical Dilated Fundus Evaluation
RETIRED effective January 1, 2008

Measure #18: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Instructions changed to reflect "system" versus "medical" reason for exclusion when clinician reporting is not providing the primary management for diabetic retinopathy.
- Added modifier 3P to numerator exclusion coding.
- Added E/M codes 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 to Denominator Coding.

Measure #19: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Added to Description, "mellitus"
- Added to Instructions, "with diabetic retinopathy" in the first sentence
- Instructions changed to reflect "system" versus "medical" reason for exclusion when clinician reporting is not providing the primary management for diabetic retinopathy.
- Added Numerator Note: The correct combination of numerator codes 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.
- Replaced modifier 1P with modifier 3P in the numerator exclusion coding
- Removed CPT II codes 2021F and 2021F with 8P from Numerator Coding and replaced with G-codes G8397 and G8398.
- Added E/M codes 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 to Denominator Coding.

Measure #20: Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician
- Clarified the Instructions to read as follows, "There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure."
- Clarified the Instructions by adding the following, "If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code."
- Clarified the Numerator Instructions by adding, "Note: In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied."
- Removed procedure codes 43842, 48160 from Denominator Coding.
- Removed procedure code 47719 from Denominator Coding; deleted from 2008 CPT Code Book.
- Removed duplicate procedure codes 35021, 35216, 35246, 35276, 35311 from the cardiothoracic section and left them in the general thoracic section of the Denominator Coding.

- Added procedure codes 27269 and 27769 to Denominator Coding (Trauma section).
- Added procedure code 52649 to Denominator Coding (Genitourinary section).

Measure #21: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin

- Clarified the Instructions to read as follows, "There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure."
- Clarified the Instructions by adding the following, "If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code."
- Clarified the Numerator Instructions by adding, "Note: In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied."
- Removed procedure codes 43842, 48160 from Denominator Coding.
- Removed procedure codes 47719, 49200, 49201 from Denominator Coding; deleted from 2008 CPT Code Book.
- Removed duplicate procedure codes 33300, 33310, 33320, 35021, 35216, 35246, 35276, 35311 from the cardiothoracic section and left them in the general thoracic section of the Denominator Coding.
- Added procedure codes 49203, 49204, and 49205 to Denominator Coding (Abdomen, Peritoneum & Omentum section).
- Added procedure codes 27269 and 27769 to Denominator Coding (Trauma section).

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

- Clarified the Instructions to read as follows, "There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure."
- Clarified the Instructions by adding the following, "If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code."
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed procedure codes 43842, 48160 from Denominator Coding.
- Removed procedure code 47719 from Denominator Coding; deleted from 2008 CPT Code Book.
- Added procedure codes 27269 and 27769 to Denominator Coding (Trauma section).

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

- Clarified the Instructions to read as follows, "There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure."
- Clarified the Instructions by adding the following, "If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code."
- Added a Definition, "Mechanical prophylaxis does not include TED hose."
- Removed procedure code 43842 from Denominator Coding.
- Removed procedure codes 49200, 49201 from Denominator Coding; deleted from 2008 CPT Code Book.

- Added procedure codes 49203, 49204, and 49205 to Denominator Coding (General Surgery section).
- Added procedure code 27269 to Denominator Coding (Hip Fracture section).

Measure #24: Osteoporosis: Communication with the Physician Managing Ongoing Care Post-Fracture
- Added to Instructions, "Claims data will be analyzed to determine unique occurrences." and "If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted"

Measure #25: Melanoma: Patient Medical History
RETIRED effective January 1, 2008

Measure #26: Melanoma: Complete Physical Skin Examination
RETIRED effective January 1, 2008

Measure #27: Melanoma: Counseling on Self-Examination
RETIRED effective January 1, 2008

Measure #28: Aspirin at Arrival for Acute Myocardial Infarction (AMI)
- Added "regardless of age" to Description and Denominator statements
- Added to Instructions, "The Part B claim form place-of-service field must indicate that the encounter has taken place in the emergency department."
- Added place-of-service indicator = 23 to Denominator Coding

Measure #29: Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)
RETIRED effective January 1, 2008

Measure #30: Perioperative Care: Timing of Prophylactic Antibiotics – Administering Physician
- Clarified the Instructions to read as follows, "It is anticipated that clinicians who provide anesthesia care for surgical procedures with an order for prophylactic antibiotics will submit this measure." and added "Only" CPT II codes are to be used.
- Added Numerator Instructions, "This measure seeks to identify the timely administration of prophylactic antibiotic. This administration should begin within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision."

Measure #31: Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage
- Added to Instructions, "Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted."

Measure #32: Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy
- Added to Description, "transient ischemic attack"
- Added to Instructions, "Part B claims data will be analyzed to determine a hospital discharge. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted."

Measure #33: Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge
- Added to Description, "transient ischemic attack"
- Added to Instructions, "Part B claims data will be analyzed to determine a hospital discharge. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted."

Measure #34: Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered

- Added to Instructions, "Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted."
- Added Numerator Note: The correct combination of numerator codes 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.

Measure #35: Stroke and Stroke Rehabilitation: Screening for Dysphagia

- Added to Instructions, "Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted."
- Added Numerator Note: The correct combination of numerator codes 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.

Measure #36: Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services

- Added to Instructions, "Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted."

Measure #37: Dialysis Dose in End Stage Renal Disease (ESRD) Patients

RETIRED effective January 1, 2008

Measure #38: Hematocrit Level in End Stage Renal Disease (ESRD) Patients

RETIRED effective January 1, 2008

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

- Added to Instructions, "There is no diagnosis associated with this measure."
- In the Instructions, replaced "It is anticipated that clinicians who provide the primary care or care for treatment of fracture or osteoporosis will submit this measure." with "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."
- Added Definition for "prescribed"
- Removed CPT II codes 3096F, 3095F, 4005F (including 1P, 2P, 3P, 8P) and replaced with G-codes G8399, G8400, and G8401.
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from Denominator Coding.

Measure #40: Osteoporosis: Management Following Fracture

- Added to Instructions, "Claims data will be analyzed to determine unique occurrences." and "If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted."
- In the Instructions, replaced "It is anticipated that clinicians who manage the primary or ongoing care for osteoporosis or osteoporosis related fracture(s) will submit this measure." with "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."
- Added to Numerator Instructions, "Modifiers may be appended to any of the CPT Category II codes for medical reasons, patient reasons, system reasons, or reasons not otherwise specified."
- Added Definition for "prescribed"

Measure #41: Osteoporosis: Pharmacologic Therapy

- Added Definition for "prescribed"
- Removed encounter codes 99386, 99387, 99396, 99397, 99401, 99402, 99403, 99404 from Denominator Coding.

Measure #42: Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise

RETIRED effective January 1, 2008

Measure #43: Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery

- Added "aged 18 years and older" to Measure Description.
- Included "isolated" in Description, Instructions, Denominator and coding statement.
- Added to Instructions for clarification, a Definition of "isolated" CABG to read, "CABG using arterial and/or venous grafts only." and "Part B claims data will be analyzed to determine "isolated" CABG."

Measure #44: Preoperative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery

- Added "aged 18 years and older" to Measure Description.
- Included "isolated" in Description, Instructions, Denominator and coding statement.
- Added to Instructions for clarification, a Definition of "isolated" CABG to read, "CABG using arterial and/or venous grafts only." and "Part B claims data will be analyzed to determine "isolated" CABG."

Measure #45: Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)

- Clarified the Instructions to read as follows, "There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure."
- Clarified the Instructions section by adding the following, "If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary to submit the CPT Category II code with each procedure."
- Added Numerator Note: The correct combination of numerator codes 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.
- Minor clarification made to the note under CPT II code 4043F
- Removed procedure codes 33300, 33310, 33320, 35021, 35216, 35246, 35276, and 35311 from Denominator Coding.

Measure #46: Medication Reconciliation

- In the Instructions, replaced "It is anticipated that clinicians who provide primary on-going care will submit this measure when a patient is seen in the office within 60 days following discharge from an inpatient facility." with "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."
- Added to Instructions, "There is no diagnosis associated with this measure." "If multiple claims are submitted within 60 days of inpatient discharge, only one instance of reporting will be counted", "Part B claims data will be analyzed to determine inpatient discharge date", and "This measure is not to be reported unless a patient has been discharged from an inpatient facility within 60 days prior to the outpatient visit."
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from Denominator Coding.

Measure #47: Advance Care Plan

- Updated Description and Numerator statement to add, "or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan in the medical record"
- Added to Instructions, "There is no diagnosis associated with this measure."
- In the Instructions, replaced "It is anticipated that clinicians who provide the primary care for the patient will submit this measure." with "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."
- Updated Instructions to add "(eg, inpatient, nursing home, ambulatory) except the emergency department. For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.", "There are no allowable performance exclusions for this measure." and removed "2P- patient reasons."
- Added a 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"
- Added a Numerator Instruction, "If patient's cultural and/or spiritual beliefs preclude a discussion of advance care planning, report 1124F."
- Revised Numerator Coding:
  -Removed CPT II 1080F, 1080F-2P and 1080F-8P including all descriptions for the coding.
  -Added CPT II 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record and CPT II 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan for numerator inclusion
  -Added CPT II 1123F-8P
- Updated Rationale
- Removed encounter codes 99281, 99282, 99283, 99284, 99285, 99387, 99397, 99401, 99402, 99403, 99404 from Denominator Coding.
- Added an asterisk (*) next to denominator code 99291 along with a note which states "*Clinicians indicating the place of service as the emergency department will not be included in this measure."

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

- Added to Instructions, "and is considered a general screening measure" and "There is no diagnosis associated with this measure."
- In the Instructions, replaced "It is anticipated that clinicians who provide primary care for the patient will submit this measure." with "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."
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from Denominator Coding.

Measure #49: Characterization of Urinary Incontinence in Women Aged 65 Years and Older

- Removed diagnosis code 788.32 from Denominator Coding
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from Denominator Coding.

Measure #50: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

- Removed diagnosis code 788.32 from Denominator Coding.
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from Denominator Coding.

Measure #51: Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation

- Added to the Instructions, "Do not limit the search for spirometry results to the reporting period."
- In the Instructions, replaced "It is anticipated that clinicians who provide the primary care services for the patient will submit this measure." with "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."
- Removed encounter codes 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403 and 99404 from Denominator Coding

Measure #52: Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

- In the Instructions, replaced "It is anticipated that clinicians who provide the primary care services for the patient will submit this measure." with "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."
- Added Definition for "prescribed"
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed encounter codes 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403 and 99404 from Denominator Coding

Measure #53: Asthma: Pharmacologic Therapy

- In the Instructions, replaced "It is anticipated that clinicians who provide the primary care services for the patient will submit this measure." with "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."
- Added Definition for "prescribed"
- Added Numerator Note: The correct combination of numerator codes 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.
- Added diagnosis code 493.91 to Denominator Coding.
- Removed encounter codes 99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396, 99401, 99402, 99403, 99404 from Denominator coding.

Measure #54: Electrocardiogram Performed for Non-Traumatic Chest Pain

- Added to Description, Instructions and Numerator Statement to clarify as "a 12-Lead" electrocardiogram/ECG. The statement(s) now read "a 12-Lead electrocardiogram (ECG)" or "a 12-Lead ECG"
- Added to Instructions, "Claims data will be analyzed to determine the emergency department discharge."
- Added to Instructions, "The Part B claim form place-of-service field must indicate that the encounter has taken place in the emergency department."
- Added place-of-service indicator = 23 to Denominator Coding

Measure #55: Electrocardiogram Performed for Syncope

- Added to Description, Instructions and Numerator Statement to clarify as "a 12-Lead" electrocardiogram/ECG. The statement(s) now read "a 12-Lead electrocardiogram (ECG)" or "a 12-Lead ECG"
- Added to Instructions, "Claims data will be analyzed to determine the emergency department discharge."
- Added to Instructions, "The Part B claim form place-of-service field must indicate that the encounter has taken place in the emergency department."
- Added place-of-service indicator = 23 to Denominator Coding

Measure #56: Vital Signs for Community-Acquired Bacterial Pneumonia

- Added to Instructions, "Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.", "Claims data will be analyzed to determine unique occurrences.", and "Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator."
- Clarified Denominator Coding by adding, "* *Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure."*

Measure #57: Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia

- Added to Instructions, "Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.", "Claims data will be analyzed to determine unique occurrences.", and "Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator."
- Clarified Denominator Coding by adding, "* *Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure."*

Measure #58: Assessment of Mental Status for Community-Acquired Bacterial Pneumonia

- Added to Instructions, "Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.", "Claims data will be analyzed to determine unique occurrences.", and "Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator."
- Clarified Denominator Coding by adding, "* *Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure."*

Measure #59: Empiric Antibiotic for Community-Acquired Bacterial Pneumonia

- Added to Instructions, "Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.", "Claims data will be analyzed to determine unique occurrences.", and "Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure's denominator."
- Added Definition for "prescribed"
- Clarified Denominator Coding by adding, "* *Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure."*

Measure #60: Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms

RETIRED effective January 1, 2008

Measure #61: Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms

RETIRED effective January 1, 2008

Measure #62: Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus

RETIRED effective January 1, 2008

Measure #63: Gastroesophageal Reflux Disease (GERD): Barium Swallow- Inappropriate Use

RETIRED effective January 1, 2008

Measure #64: Asthma Assessment

- Added to Instructions, "with asthma" in the first sentence
- In the Instructions, replaced "It is anticipated that clinicians who provide the primary care services with a diagnosis of asthma will submit this measure." with "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."
- Added diagnosis code 493.91 to Denominator Coding.
- Removed encounter codes 99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396, 99401, 99402, 99403, 99404 from Denominator Coding.

Measure #65: Appropriate Treatment for Children with Upper Respiratory Infection (URI)
- Updated the Description and Numerator Statement to be consistent with other avoidance of inappropriate use measure. Added to the Description "prescribed" and "on or within 3 days of the initial date of service". Added to the Numerator Statement "not" dispensed and "on or within 3 days of the initial date of service".
- Added to Instructions, "Claims data will be analyzed to determine unique occurrences."
- In the Instructions, "It is anticipated that clinicians who provide the care to all patients 3 months-18 years of age with a diagnosis of upper respiratory infection would have documentation of having appropriate treatment will submit this measure." with "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."
- Updated Numerator Instructions to be consistent with other avoidance of inappropriate use measures.
- Rearranged the Numerator Coding to be consistent with other avoidance of inappropriate use measure structures.
- Changed CPT II code to append the modifier 1P to from 4124F to 4120F in the Numerator Coding.
- Removed encounter codes 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99499 from Denominator Coding.

Measure #66: Appropriate Testing for Children with Pharyngitis
- Added to Instructions, "Claims data will be analyzed to determine unique occurrences."
- In the Instructions, "It is anticipated that clinicians who provide the care to all patients 2 through 18 years of age with a diagnosis of pharyngitis will submit this measure." with "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."
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed encounter codes 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99499 from Denominator Coding.

Measure #67: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
NO CHANGES

Measure #68: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
- Added to Instructions, "all MDS" in the first sentence
- Added Numerator Note: The correct combination of numerator codes 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.

Measure #69: Multiple Myeloma: Treatment with Bisphosphonates
- Clarified the Description and Numerator Statement to read "…within the 12 month reporting period" instead of "within 12 months"
- Added to Instructions, "not in remission"

Measure #70: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
NO CHANGES

Measure #71: Hormonal Therapy for Stage IC - III ER/PR Positive Breast Cancer
- Multiple specification updates with revised coding
- Added Numerator Note: The correct combination of numerator codes 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.
- Deleted CPT II codes 3304F, 3308F, 3313F and 3314F from Numerator Coding.
- Added clarifications to Numerator Coding, "Report 3305F for the Stage T1c Breast Cancer – Tumor more than 1 cm but not more than 2 cm in greatest dimension." and "Report 3303F for the following Stage I Breast Cancers: T1a – Tumor more than 0.1 cm but not more than 0.5 cm in greatest dimension; T1b – Tumor more than 0.5 cm but not more than 1 cm in greatest dimension."
- Added Notes to clarify the numerator exclusion coding section.
- Added numerator code 3316F *with* 8P: No documentation of estrogen receptor (ER) and progesterone receptor (PR) status.

Measure #72: Chemotherapy for Stage III Colon Cancer Patients
- Multiple specification updates with revised coding
- Added Numerator Note: The correct combination of numerator codes 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.
- Deleted CPT II codes 3303F, 3305F, 3308F, 3313F and 3314F from Numerator Coding.
- Added clarification to Numerator Coding, "Report 3304F for all Stage I colon cancers."

Measure #73: Plan for Chemotherapy Documented Before Chemotherapy Administered
- Multiple specification updates with revised coding

Measure #74: Radiation Therapy Recommended for Invasive Breast Cancer Patients who have Undergone Breast Conserving Surgery
NO CHANGES

Measure #78: Vascular Access for Patients Undergoing Hemodialysis
- Deleted the example from CPT II code 4051F-1P "(e.g., documentation of a functioning AV graft)".

Measure #80: Plan of Care for ESRD Patients with Anemia
- Clarified Instructions on how to report calendar months.

Measure #81: Plan of Care for Inadequate Hemodialysis in ESRD Patients
- Clarified Instructions on how to report calendar months.

Measure #83: Testing of Patients with Chronic Hepatitis C (HCV) for Hepatitis C Viremia
- Modified first sentence of Instructions to read, "This measure should be reported on the first visit occurring during the reporting period for all patients with a diagnosis of hepatitis C seen during the reporting period."

Measure #95: Otitis Media with Effusion (OME): Hearing Testing
- Deleted CPT E/M service codes 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, and 99245 from Denominator Coding.

Measure #101: Appropriate Initial Evaluation of Patients with Prostate Cancer

- Added to Description and Numerator Statement, "prior to initiation of treatment".
- Added to Instructions and Denominator Coding, "to the prostate" after external beam radiotherapy.
- Added procedure code 77427 to Denominator Coding.

Measure #102: Inappropriate Use of Bone Scan for Staging Low-Risk Prostate Cancer Patients

- Added to Instructions, "to the prostate" after external beam radiotherapy.
- Added procedure code 77427 to Denominator Coding.

Measure #103: Review of Treatment Options in Patients with Clinically Localized Prostate Cancer

- Added to Description and Numerator Statement, "prior to initiation of treatment".
- Added to Denominator Coding, "to the prostate" after external beam radiotherapy.

Measure #104: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients

- Added to Instructions and Denominator Coding, "to the prostate" after external beam radiotherapy.
- Added procedure code 77427 to Denominator Coding.

Measure #105: Three-dimensional Radiotherapy for Patients with Prostate Cancer

- Added to Instructions and Denominator Coding, "to the prostate" after external beam radiotherapy.
- Added procedure code 77427 to Denominator Coding.

Measure #106: Patients who have Major Depression Disorder who meet DSM IV Criteria

- Clarified Instructions.
- Replaced CPT II code 3093F with G-code G8467 throughout measure.
- Replaced CPT II code 3092F with G-code G8466 throughout measure.
- Added Definition, "Patient is considered to be in remission if he/she no longer meets DSM-IV™ criteria."
- Added CPT codes 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90845, and 90862 to Denominator Coding.
- Added additional Clinical Recommendations.

Measure #107: Patients who have Major Depression Disorder who are Assessed for Suicide Risks

- Clarified Instructions.
- Replaced G-code G8467 with CPT II code 3093F throughout measure.
- Replaced G-code G8466 with CPT II code 3092F throughout measure.
- Deleted CPT E/M service codes 90847, 90849, 90853, and 90857 from Denominator Coding.

Measure #111: Pneumonia Vaccination for Patients 65 years and Older

- Added encounter codes 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 to Denominator Coding.

Measure #123: Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)

- Clarified Instructions on how to report calendar months.

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

- Added CPT codes 97001 and 97002 to Denominator Coding.

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

- Added CPT codes 97001 and 97002 to Denominator Coding.