

2012 PULMONARY PQRS PERFORMANCE MEASURES - UPDATE FROM CMS-1524-FC

The Centers for Medicare & Medicaid Services (CMS) had proposed to retain all 2011 measures for 2012 for consistency. These include 55 registry-only measures used in the 2011 PQRS, and 144 individual quality measures for either claims-based reporting or registry-based reporting.

CMS did finalize the change to reduce the 80% reporting threshold to 50%.

PQRS redefined Group Practice to include 25 or more individual eligible professionals who have reassigned their billing rights under one tax identification number (TIN). Group practice was previously defined as two or more individual eligible professionals.

The final rule eliminated the 6-month period for claims and registry-based reporting of individual measures reported in 2012. This will align the PQRS reporting periods with the electronic health record (EHR) reporting mechanism. The move will also retain the claims-based registry and EHR-based reporting mechanisms for 2012 and beyond.

CMS states that it will not post a list of qualified registries for the 2012 program year until the summer of 2012.

PQRS: Step-by-Step Getting Started

The CMS quality initiative entitled the Physician Quality Reporting System (PQRS) is voluntary for 2012-2014, though practices not participating are foregoing available incentive payments. A penalty for not participating in PQRS will begin in 2015, with a proposed 1.5% **reduction** in all Medicare fee-for-service payments. The 2012 incentive payment will be 0.5% of all allowed Medicare charges for Medicare Part B physician fee schedule covered professional services, not just on the claims where the performance measures quality data codes are applied. Payment is in aggregate and usually paid the next year. If your practice is not already reporting PQRS, consider implementing participation as soon as possible, certainly by January 1, 2012.

STEP 1: Eligible Professionals

Determine which providers in your practice are eligible for participation. A list of professionals who are eligible and able to participate in PQRS is available at www.cms.gov/pqrs in the downloads section. Read this list carefully, as not all entities are considered eligible because they are reimbursed by Medicare under other fee schedule methods than the physician fee schedule.

STEP 2: PQRS Reporting Options

Determine which PQRS reporting option in each category best fits your practice:

- a) Select either claims-based or registry-based reporting.
- b) Select either three individual measures or a measures group.
- c) Select the PQRS reporting period, either 12 months (start date 1/1/12) or 6 months (start date 7/1/12) (if applicable, depending on the reporting option selected – see details below in Step 4).

STEP 3: PQRS Measures Selection

Eligible professionals who choose to report 2012 PQRS individual measures should select at least three applicable measures to submit, and if successful, will receive a PQRS incentive payment. If fewer than three measures are reported, CMS will apply a measure-applicability validation (MAV) process when determining incentive eligibility.

Eligible professionals who choose to report 2012 PQRS measures groups should select at least one measures group, and, if successful, will receive a PQRS incentive payment.

The applicable measure groups for ACCP members are either: the Chronic Obstructive Pulmonary Disease (COPD) and/or the Sleep Apnea measures group (sleep apnea is registry only), the Community-Acquired Pneumonia (CAP) measures group, and the Asthma measures group (patients aged 5 to 50 years of age). The COPD and Sleep Apnea measures groups are new for 2012.

If you have already been participating in PQRS, there is no requirement to select new/different measures for the 2012 PQRS. However, you might want to particularly look at the new COPD measures group. Please note that all PQRS measure specifications are updated and posted prior to the beginning

of each program year; therefore, eligible professionals will need to review them for any revisions. There are no changes to the specifications for COPD individual measures for spirometry evaluation (#51) and bronchodilator therapy (#52). There are changes (including numbers reported) to the four asthma individual measures (#53, #64), asthma individual smoking screening (#231) and intervention (#232) measure specifications had changes; however, the ages remain 5 years to 50 years of age. The four community-acquired pneumonia (#56-#59) changes had a surprising title change to add “Emergency Medicine:” to each of them. CMS contractor assures us that pulmonologists can still report the CAP measures group. Measure #110 Influenza Immunization has changes, but the #111 Pneumonia Vaccination is the same as 2011. Measure #226 Tobacco Screening and Cessation Intervention had minor revisions.

STEP 4: Implementation

1. Physician practice ownership decides to participate in PQRS.
2. Select an employee to lead implementation.
3. Decide which performance measures (at least three) or group measures (at least one) (COPD, Sleep Apnea, CAP, and/or Asthma) to report.
4. Augment current charge capture and other practice processes to incorporate PQRS measures– eg, revise encounter form to include selected measures (include relevant CPT Category II codes or G performance measure codes), and prompt providers to document performance of the measure.
5. Select the reporting period: claims and registry-based reporting have either a January 1 or July 1 start date; EHR-based, eRx, and group practice reporting options have a January 1 start date.
6. Report \$0.00 in the payment field.
7. Audit claim forms to ensure correct reporting before submission.
8. Have practice (coding, billing, or supervisory) staff regularly and routinely monitor that the providers reporting PQRS measures are reaching appropriate thresholds – permanently changed from 80% to 50% of the applicable population of patients with the diagnoses of asthma, COPD, or pneumonia.
9. Have practice staff monitor and follow up on Medicare Summary Notices (MSNs) to verify the presence of the N365 code, which indicates process and transmission of the quality code.
10. Review each of the steps at monthly departmental meetings.

Each performance measure (both individual and group) has a Quality Data Code (QDC) (a Current Procedural Terminology [CPT] II code, or G-code) associated with it. Note that several measures allow the use of CPT II modifiers: **1P**, **2P**, **3P**, and the **8P** reporting modifier. Only allowable CPT II modifiers may be used with a CPT II code. It is advisable to not indiscriminately use the 8P modifier, attempting to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

To qualify for the incentive, the correct numerator QDC must be reported on at least 50% of the claims that are eligible for each selected measure (effective January 1, 2012). A claim is considered "eligible" in PQRS when the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis and the Current Procedural Terminology (CPT) Category I service codes on the claim match the diagnosis and encounter codes listed in the denominator criteria of the measure specification.

Each measure has a reporting frequency or timeframe requirement (called a "measure tag" in PQRS analysis) for each eligible patient seen during the reporting period for each individual eligible professional (NPI). The reporting frequency (eg, report each visit, once during the reporting period, each episode) is found in the "instructions" section of each measure specification. Ensure that all members of the team understand and capture this information in the clinical record to facilitate reporting.

MEASURES GROUPS

The ACCP recommends participation in PQRS, and, in particular, the COPD measures group in 2012.

CMS released the PQRS specifications for 2012 reporting through both claims-based and registry reporting. The most applicable groups to pulmonary of the 22 measures groups is for Chronic Obstructive Pulmonary Disease (COPD) – new for 2012, and Sleep Apnea (which requires reporting via registry only).

Continued measures groups are: Emergency Medicine: Community-Acquired Pneumonia (CAP), which bundles #56 Vital Signs, #57 Assessment of Oxygen, #58 Assessment of Mental Status, #59 Empiric

Antibiotic Prescribed. ALL four individual pneumonia measures were on the top 10 list for highest reporting for 2008. It is important to report either the 30 patient sample method or 50% patient sample method via claims between January 1 and December 31, 2012, or 80% patient sample method via Registry for either the entire year period or July 1 through Dec 31, 2012 (6 months); ie, report a minimum of 15 patients for the 12-month reporting, or if 6-month reporting July 1- Dec. 31, 2012, report a minimum of 8 patients. These need not be consecutive patients, a previous reporting criteria for measures groups. Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group.

Report 0.00 in the payment field. For claims-based submissions, the carrier/MAC remittance advice notice sent to the practice will show a denial remark code N365 for the line item on the claim containing quality codes indicating that the code is not payable and used for reporting/information purposes only. Other codes reported on the claim will not be affected by the data code reporting. The N365 code indicates that the quality code was processed and transmitted.

Additional information on specifications is available to be downloaded from www.cms.hhs.gov/pqrs under Code Measures. The two to four pages for each measure should be reviewed by every eligible professional and coding and billing staff or external biller to note any changes in the measure each year.

Unique to PQRS measures groups, an **“intent” to report a specific measures group** G-code noted below must be reported **one time on one claim**.

G8546 I intend to report the Community- Acquired Pneumonia measures group

G8645 I intend to report the Asthma measures group

G8898 I intend to report the Chronic Obstructive Pulmonary Disease (COPD) measures group

G8900 I intend to report the Sleep Apnea measures group (Registry Only)

There are three participation strategies for satisfactorily reporting measures groups:

- 30 patient sample method for claims-based and registry-based submissions
 - 12 month reporting only, starting January 1, 2012; or
- 50% patient sample method via claims; or
- 80% patient sample method via registry.

It is important to review the *2012 PQRS Getting Started with Measures Groups* available in the downloads section of the CMS Web site.

COPD Measures Group (New for 2012)

Applicable G-Codes for the COPD Measures Group

- **G8898:** Report this code only once to notify CMS of your intention to participate in the COPD measures group.
 - **ONLY report this code on the first claim submitted.**
 - The claim can only be for a patient >18 years of age, with ICD-9-CM COPD diagnosis codes **491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496.**
 - The applicable CPT codes for the COPD measures group are: New Patient **99201-99205**, Established Patient **99212-99215** (**note this does not include 99211**).
 - Relevant diagnosis and CPT codes must be on the same claim as the applicable quality codes. Claims cannot be submitted to report missing quality codes.

PQRS Measures in COPD Measures Group includes:

#51 COPD: Spirometry Evaluation

#52 COPD: Bronchodilator Therapy

#110 Preventive Care and Screening: Influenza Immunization

#111 Preventive Care and Screening: Pneumonia Vaccination (for patients 65 and older)

#226 Preventive Care and Screening: Tobacco Use: Screening and

Cessation Intervention

How to Report 2012 COPD Measures Group

For patients 18 years and older, report **G8898** (I intend to report the COPD measures group on **ONLY the first claim** form) for both the 30 patient sample and the 50% patient sample methods (not for registry reporting). All claims must include the denominator codes, ie, an ICD-9-CM pneumonia diagnosis code **491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496**, where the following office or other outpatient procedure was performed on a New Patient **99201-99205** and an Established Patient **99212-99215**.

If all of the quality actions for the patient have been performed for all measures within the group (#51, #52, #110, #111, #226), the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. The COPD measures group Composite G code needs to be reported for every claim during each occurrence of CAP: **G8757: ALL quality actions for the applicable measures in the COPD measures group have been performed for this patient**. This COPD measures code is reported once during the reporting period.

Sleep Apnea Measures Group – REGISTRY ONLY (New for 2012)

- **G8900**: Report this code only once to notify CMS of your intention to participate in the Sleep Apnea measures group.
 - **ONLY report this code on the first claim submitted via REGISTRY reporting only.**
 - The claim can only be for a patient >18 years of age, with ICD-9-CM sleep apnea diagnosis codes **327.23, 780.51, 780.53, 780.57**.
 - The applicable CPT codes for the Sleep Apnea measures group are: New Patient **99201-99205**, Established Patient **99212-99215 (note this does not include 99211)**.

- Relevant diagnosis and CPT codes must be on the same claim as the applicable quality codes. Claims cannot be submitted to report missing quality codes.

PQRS Measures in Sleep Apnea measures group includes:

#276 Sleep Apnea: Assessment of Sleep Symptoms

#277 Sleep Apnea: Severity Assessment at Initial Diagnosis

#278 Sleep Apnea: Positive Airway Pressure Therapy Prescribed

#279 Sleep Apnea: Assessment of Adherence to Positive Airway Pressure Therapy

Community-Acquired Pneumonia (CAP) Measures Group

Applicable G-Codes for the CAP measures group

- **G8546:** Report this code only once to notify CMS of your intention to participate in the CAP measures group.
 - **ONLY report this code on the first claim submitted.**
 - The claim can only be for a patient >18 years of age, with ICD-9-CM pneumonia diagnosis codes **481-483.8, 485, 486, 487.0.**
 - The applicable CPT codes for the CAP Measures group are: New Patient **99201-99205**, Established Patient **99212-99215**, Emergency Department **99281-99285**, Critical Care **99291** (must report ED place of service 23 on Part B claim form **ONLY** for **99291**), Domiciliary, Rest Home, Custodial Care **99324-99337**, Home Services **99341-99350.**
- **G8550:** All quality actions for the applicable measures in the CAP measures group (#56-#59) have been performed for this patient.
 - Reported in lieu of the individual quality-data codes for each of

the measures within the group

- This CAP group measures code is reported once during each occurrence (ie, 45-day period from onset of CAP).

Individual Pneumonia Measures included in the CAP Measures Group

- **#56: Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs**
 - Percentage of patients, 18 years and older, with diagnosis for CAP with vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed.
- **#57: Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation**
 - Percentage of patients, 18 years and older, with diagnosis for CAP with oxygen saturation assessed through pulse oximetry or arterial blood gas measurement, documented and reviewed.
 - Documentation may include one of the following: clinical documentation that oxygen saturation was reviewed, dictation by the clinician including oxygen saturation, clinician initials in the chart that oxygen saturation was reviewed, or other indication that oxygen saturation has been acknowledged by the clinician.
- **#58: Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status**
 - Percentage of patients, 18 years and older, with diagnosis for CAP with documentation of mental status assessed, eg, patient is oriented or disoriented.
- **#59: Emergency Medicine: Community-Acquired Pneumonia (CAP): Empiric Antibiotic**

- Percentage of patients, 18 years and older, with diagnosis for CAP with appropriate empiric antibiotic prescribed, even if the prescription for the medication was ordered prior to the encounter.
- Medications should include one of the following four classes: fluoroquinolones, macrolides, doxycycline, beta-lactam with macrolide or doxycycline (as defined by current ATS/IDSA guidelines).

How to Report 2012 Emergency Department: CAP Measures Group

- For patients 18 years and older, report **G8546** (I intend to report the CAP measures group on **ONLY the first claim** form) for both the 30 patient sample and the 50% patient sample methods (not for registry reporting). All claims must include the denominator codes, ie, an ICD-9-CM pneumonia diagnosis code **481-483.8, 486, 487.0**, where the following office or other outpatient procedure was performed: New Patient **99201-99205**, Established Patient **99212-99215**, Emergency Department **99281-99285**, Critical Care **99291** (must report ED place of service 23 on Part B claim form **ONLY** for **99291**), Domiciliary, Rest Home, Custodial Care **99324-99337**, Home Services **99341-99350**, on the same claim form.
- If all of the quality actions for the patient have been performed for all measures within the group (#56-#59), the following composite G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. The CAP measures group Composite G code needs to be reported for every claim during each occurrence of CAP: **G8550: ALL quality actions for the applicable measures in the CAP measures group have been performed for this patient.** This CAP measures code is reported once during each occurrence (ie, 45-day period from onset of CAP).

Additional information on specifications for these and all other performance measures is available for download from www.cms.gov/pqrs under Code Measures.

P M#	Descriptor	CPT II Code	Appropriate Modifiers	ICD-9-CM	CPT E/M codes
	COPD				
51	COPD: Spirometry Evaluation Aged 18 and older	3023F	1P, 2P, 3P, 8P	491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496	99201-99205, 99212-99215
52	COPD: Bronchodilator Rx Aged 18 and older	4025F + 3025F or 3027F	1P, 2P, 3P, 8P to 4025F + 3025F or 3025F-8P + 3027F	491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496	99201-99205, 99212-99215
	PNEUMONIA				
56	Emergency Medicine: Community- Acquired Pneumonia (CAP): Vital Signs Aged 18 and older	2010F	8P	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0	99201-99205, 99212-99215, 99281-99285, 99291 (99291 requires ED POS 23), 99324-99350
57	Emergency Medicine: Community- Acquired Pneumonia (CAP): Assessment of Oxygen Saturation Aged 18 and older	3028F	1P, 2P, 3P, 8P	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0	99201-99205, 99212-99215, 99281-99285, 99291 (99291 requires ED POS 23), 99324-99350
58	Emergency Medicine: Community-	2014F	8P	481, 482.0, 482.1, 482.2, 482.30, 482.31,	99201-99205, 99212-99215, 99281-99285,

	Acquired Pneumonia (CAP): Assessment of Mental Status Aged 18 and older			482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0	99291 (99291 requires ED POS 23), 99324-99350
59	Emergency Medicine: Community-Acquired Pneumonia (CAP): Empiric Antibiotic Aged 18 and older	4045F	1P, 2P, 3P, 8P	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0	99201-99205, 99212-99215, 99281-99285, 99291 (99291 requires ED POS 23), 99324-99350
	ASTHMA - NOTE AGE REQUIREMENT				
53	Asthma: Pharmacologic Therapy for Persistent Asthma Aged 5-50	4140F or 4144F + 1038F or 1039F	4140F-2P or -8P+ 1038F or 1039F	493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.81, 493.82, 493.90, 493.92	99201-99205, 99212-99215, 99341-99350
64	Asthma: Assessment of Asthma Control Aged 5-50	2015F + 2016F	8P	493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.81, 493.82, 493.90, 493.92	99201-99205, 99212-99215, 99341-99350
	CVS Protocol				
76	Prevention of Catheter-Related	6030F	1P, 8P	Any diagnosis with a CVC inserted	36555-36571, 36578- 36585, 93503 SWAN

76	Prevention of Catheter-Related Bloodstream Infections (CRBSI) - Central Venous Catheter (CVC) Insertion Protocol	6030F	1P, 8P	Any diagnosis with a CVC inserted	36555-36571, 36578- 36585, 93503 SWAN GANZ
	TOBACCO USE				
226	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention Aged 18 years and older	4004F or 1036F	1P, 8P	Any diagnosis	99201-99205, 99212-99215 G0438, G0439
	THORACIC SURGERY				
157	Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection	3323F	1P, 8P	150.3, 150.4, 150.5, 151.0, 162.2, 162.3, 162.4, 162.5, 162.9	32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32503, 32504, 32505, 32663, 32666, 32669, 32670, 32671, 43107, 43108, 43112, 43113, 43116, 43117, 43118,

If just starting to review performance measures, it is important to have the practice leadership support this initiative. Plan and implement processes to ensure satisfactory reporting of measures. A sample template follows at the end.

INDIVIDUAL PERFORMANCE MEASURES – ONLY reported for January 1 to December 31, 2012

Pay for performance initiatives are developed in nearly all sites of service to focus on the performance of quality medicine. In December 2011, the CMS PQRS finalized the list of performance measure specifications for their 2012 initiative which began January 1, 2012. All 144 measures have been reviewed, and the eight specific measures (two for COPD, four for Pneumonia, and two for Asthma) are the same since inception of the PQRI program on July 1, 2007, with the addition of the Chronic Obstructive Pulmonary Disease (COPD) and Sleep Apnea (registry only) measures groups added in 2012 and Community-Acquired Pneumonia and Asthma added in 2010 described above.

For 2012, there are three reporting options: claims-based, registry, and measures groups. Most chest medicine practices will be reporting the COPD measures group, and the COPD, Pneumonia, Asthma, and other individual measures. The patient age is specified as 18 years of age and older for COPD and Pneumonia. For the Central Venous Catheter Insertion Protocol Measure #76, reporting is for any age, and the Asthma Measures #53 and #64 require patients aged 5 through 50 years. COPD and Asthma measures are reported once per reporting period, Pneumonia measures are reported each occurrence. Some of the individual measures as part of the measures group(s) include other requirements.

Specifications of these measures are detailed on the CMS Web site and are available through the link: www.cms.gov/pqrs under Measures Codes. Denominator codes are the universe of eligible cases and are listed below as the ICD-9-CM diagnoses and the CPT Evaluation and Management codes, or CMS G-codes. The numerator quality-data codes (QDC) are the CPT Category-II codes listed in the table. QDC descriptors are listed below the table. Review closely the appropriate PQRS (**1P**, **2P**, **3P**, **8P**) modifiers below. In 2010, there was a new Group Practice Reporting Option for practices with >200 eligible providers, which has been modified

to >2 for 2011, and further modified >25 eligible providers for 2012, identified by individual NPIs, who have reassigned billing rights to the TIN. Large group practices need to send a self-nomination letter to CMS by January 31, 2012.

The ACCP encourages practices to participate in PQRS. If you have any PQRS questions, do not hesitate to contact the ACCP coding and reimbursement consultant staff, Diane Krier-Morrow, at (847) 677-9464 or dkriermorr@aol.com.

Note that **99211** is NOT included as any of the denominator codes above. For 2012 reporting, all 144 performance **individual** measure specifications and 22 group measures specifications are available at the CMS Web site.

Both 2012 PQRI Quality Measure Specifications Manual and Release Notes and 2012 PQRI **Measures Groups** Specifications Manual, are found at: www.cms.gov/pqrs under Measures Codes.

The above performance measures are of interest to pulmonologists; five general performance measures listed below are clinical performance measures, and the last one is a structural performance measure. Details on the modifiers follow.

PULMONARY PERFORMANCE MEASURES DESCRIPTION

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

#51 COPD: Spirometry Evaluation:

Percentage of patients **aged 18 years and older** with a diagnosis of COPD who had spirometry evaluation results documented. Report a minimum of **once per reporting period** using the most recent spirometry results in the patient record for patients seen during the reporting period. Do not limit the search for spirometry results to the reporting period.

CPT II **3023F** Spirometry results documented and reviewed

#52 COPD: Bronchodilator Therapy:

Percentage of patients **aged 18 years and older** with a diagnosis of COPD and who have an FEV₁/FVC < 70% and have symptoms who were prescribed an inhaled bronchodilator. Report a minimum of **once per reporting period** for all COPD patients seen during the reporting period.

CPT II **4025F** Inhaled bronchodilator prescribed **AND**

CPT II **3025F** Spirometry test results demonstrate $FEV_1/FVC < 70\%$ with COPD symptoms (eg, dyspnea, cough/sputum, wheezing)

OR

CPT II **3027F** Spirometry test results demonstrate $FEV_1/FVC \geq 70\%$ or patient does not have COPD symptoms

PNEUMONIA

#56 Emergency Medicine: Community-Acquired Pneumonia (CAP): Vital Signs

Percentage of patients **aged 18 years and older** with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed. Report once for **each occurrence** of CAP during the reporting period.

CPT II **2010F** Vital signs (temperature, pulse, respiratory rate, and blood pressure) documented and reviewed

#57 Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation

Percentage of patients **aged 18 years and older** with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed. Report once for **each occurrence** of CAP during the reporting period.

CPT II **3028F** Oxygen saturation results documented and reviewed (includes assessment through pulse oximetry or arterial blood gas measurement)

#58 Emergency Medicine: Community-Acquired Pneumonia (CAP): Assessment of Mental Status

Percentage of patients **aged 18 years and older** with a diagnosis of community-acquired bacterial pneumonia with mental status assessed. Report once for **each occurrence** of CAP during the reporting period.

CPT II **2014F** Mental status assessed

#59 Emergency Medicine: Community-Acquired Pneumonia (CAP): Empiric Antibiotic

Percentage of patients **aged 18 years and older** with a diagnosis of community-acquired bacterial pneumonia with appropriate empiric antibiotic prescribed. Report once for **each occurrence** of CAP during the reporting period.

CPT II **4045F** Appropriate empiric antibiotic prescribed

ASTHMA MEASURES GROUP (#53, #64, #231, #232)

#53 Asthma: Pharmacologic Therapy for Persistent Asthma:

Percentage of patients **aged 5 through 50 years** with a diagnosis of persistent asthma and at least one medical encounter for asthma during the measurement year who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment (inhaled steroid combinations, anti-asthmatic combinations, antibody inhibitor, leukotriene modifiers, mast cell stabilizers, methylxanthines, long-acting or short-acting inhaled beta₂-agonists). This measure is to be reported **once per reporting period** for all patients with a diagnosis of persistent asthma seen during the reporting period.

CPT II **1038F** Persistent asthma (mild, moderate, or severe) **AND**

CPT II **4140F** Inhaled corticosteroids prescribed or CPT II 4144F Alternative long-term control medication prescribed

OR CPT **4140F-2P** **AND** CPT II **1039F** Intermittent asthma

OR

4140F-8P Inhaled corticosteroids not prescribed, reason not otherwise specified **AND** CPT II **1038F** Persistent asthma (mild, moderate or severe)

#64 Asthma: Assessment of Asthma Control:

Percentage of patients **aged 5 through 50 years** with a diagnosis of asthma who were evaluated at least once for asthma control (comprising asthma impairment, ie, daytime symptoms **AND** nighttime awakenings **AND** interference with normal activity **AND** short-acting beta₂-agonist user for symptom control, and asthma risk, ie, the number of asthma exacerbations requiring oral systemic corticosteroids in the prior 12 months).

CPT II **2015F** Asthma impairment assessed (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/ questionnaire, include but not limited to Asthma Therapy Assessment Questionnaire [ATAQ], the Asthma Control Questionnaire [ACQ], or the Asthma Control Test [ACT]) **AND**

CPT II **2016F** Asthma Risk Assessed **OR**

2015F-8P Asthma Control not evaluated, reason not otherwise specified **OR**

2016F-8P Asthma risk not assessed, reason not otherwise specified

#231 Asthma: Tobacco Use: Screening - Ambulatory Care Setting:

Percentage of patients (or their primary caregiver) **aged 5 through 50 years** with a diagnosis of asthma who were queried about tobacco use and exposure to secondhand smoke within their home environment at least once during the 1-year measurement period.

Numerator: Patients (or their primary caregiver) who were queried about tobacco use and exposure to secondhand smoke in their home environment at least once. Document that the patient was queried about both smoking status AND exposure to environmental smoke in the home environment. Tobacco user refers to tobacco smoker and a nonuser includes smokeless tobacco users, eg, chew, snuff.

CPT II **1031F** Smoking status and exposure to secondhand smoke in the home assessed

OR

1031F-8P Smoking status and exposure to secondhand smoke In the home not assessed, reason not otherwise specified

#232 Asthma: Tobacco Use: Intervention - Ambulatory Care Setting:

Percentage of patients (or their primary caregiver) **aged 5 through 50 years** with a diagnosis of asthma who were identified as tobacco users (patients who currently use tobacco AND patients who do not currently use tobacco but are exposed to secondhand smoke in their home environment) who received tobacco cessation intervention at least once during the 1-year measurement period.

Tobacco Use Cessation Intervention - May include brief counseling (3 minutes or less) and/or pharmacotherapy.

CPT II **4000F** Tobacco Use Cessation Intervention, Counseling

CPT II **4001F** Tobacco Use Cessation Intervention, Pharmacologic Therapy
AND

CPT II **1032F** Current Tobacco Smoker OR Currently Exposed to Secondhand Smoke **OR**

CPT II **1033F** Current Tobacco Non-Smoker AND Not Currently Exposed to Secondhand Smoke **OR**

G8751 Smoking Status and exposure to secondhand smoke in the home NOT assessed, reason not specified **OR**

4000F-8P OR 4001F-8P AND 1032F

CATHETER-RELATED BLOODSTREAM INFECTIONS (CRBSI)

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

Percentage of patients, **regardless of age**, who undergo central venous catheter (CVC) insertion for whom CVC was inserted with all elements of maximal sterile barrier technique (cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine or cutaneous antiseptics, or acceptable alternative antiseptics, per current guideline) followed). Report **each time** a CVC insertion is performed during the reporting period.

CPT II **6030F** All elements of maximal sterile barrier technique including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antiseptics, or acceptable alternative antiseptics, per current guideline) followed. (only use modifiers 1P or 8P)

SMOKING CESSATION

#226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention:

Percentage of patients **aged 18 years or older** who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user. Report a minimum of **once per reporting period** for all patients seen during the reporting period. Tobacco use includes any type of tobacco. Cessation Counseling Intervention includes counseling or pharmacotherapy.

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

CPT II **1036F** Current tobacco nonuser

THORACIC SURGERY - LUNG CANCER STAGING

#157: Thoracic Surgery: Recording of Clinical Stage Prior to Lung Cancer or Esophageal Cancer Resection:

Percentage of surgical patients **aged 18 years and older** undergoing resection

for lung or esophageal cancer who had clinical staging provided prior to surgery. Report **each time** a major cancer resection of the lung or esophagus is performed.

CPT II **3323F** Clinical tumor, node, and metastases (TNM) staging documented and reviewed prior to surgery

GENERAL CLINICAL PERFORMANCE MEASURES

#46 Medication Reconciliation: Reconciliation After Discharge From an Inpatient Facility:

Percentage of patients **aged 65 years and older** discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physicians providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented

CPT II **1111F** Discharge medications reconciled with the current medication list in outpatient medical record (only modifier 8P allowed) AND

CPT II **1110F** Patient discharged from an inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility, such as LTACH) within the last 60 days

#47 Advance Care Plan:

Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed, but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. Report **once per reporting period**. There is no diagnosis associated with this measure. This measure is appropriate in all health-care settings except the emergency department.

CPT II **1123F** Advance Care Planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record (only modifier 8P allowed) OR

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

#110: Preventive Care and Screening: Influenza Vaccination for Patients 6 Months of Age and Older:

Percentage of patients **6 months of age and older** who received an influenza immunization during the flu season (October 1 through March 31). Report **once per reporting period**. There is no diagnosis associated with this measure.

CPT II **G8482** Influenza immunization was ordered or administered OR

CPT II **G8483** Influenza immunization was not ordered or administered for reasons documented by clinician

CPT II **G8484** Influenza immunization was not ordered or administered, reason not specified

#111 Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older:

Percentage of patients **aged 65 years and older** who have ever received a pneumococcal vaccine. Report **once per reporting period**. There is no diagnosis associated with this measure.

CPT II **4040F** Pneumococcal vaccine administered or previously received (only 1P, 8P modifiers)

#130 Documentation of Current Medications in the Medical Record:

Percentage of patients **aged 18 years and older** with a list of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) and documented by the provider, including drug name, dosage, frequency and route. Report at **each visit** during the reporting period.

CPT II **G8427** List of current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) documented by the provider, including drug name, dosage, frequency or route

CPT II **G8428** Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route not documented by the provider

CPT II **G8430** Provider documentation that patient is not eligible for medication assessment

Cross-references and origins of Category II performance measures are listed in Index of Clinical Alphabetical Topics for CPT 2012, available online at www.ama-assn.org/ama1/pub/upload/mm/362/cptcat2-alpha-measures-index.pdf

STRUCTURAL MEASURE

#124: Health Information Technology (HIT) - Adoption/Use of Electronic Health Records (EHR):

This measure is to be reported at each visit. There is no diagnosis associated with this measure. There are no allowable performance measure exclusions for this measure.

CPT II **G8447** Patient encounter was documented using an EHR system that has been certified by an Authorized Testing and Certification Body (ATCB)
OR

CPT II **G8448** Patient encounter was documented using a Physician Quality Reporting System qualified EHR or other acceptable systems

PERFORMANCE MEASURE EXCLUSION MODIFIERS FOR CATEGORY II CODES ARE:

1P Performance Measure Exclusion Modifier due to Medical Reasons (eg, not indicated (absence of organ/limb, already received/performed); contraindicated (patient allergic history, potential adverse drug reaction))

2P Performance Measure Exclusion Modifier due to Patient Reasons (eg, patient declined; economic, social, or religious reasons)

3P Performance Measure Exclusion Modifier due to System Reasons (eg, resources to perform the services not available; insurance or coverage/payer-related limitations)

Reporting Modifier

8P Report appended to CPT Category II code to report circumstances when the action described in the performance measure is not performed and the reason is not otherwise specified

ELECTRONIC PRESCRIBING INCENTIVE PROGRAM

SEPARATE CMS WEB PAGE available at
www.cms.gov/ERXincentive/01_overview.asp

ELECTRONIC PRESCRIBING

CPT II **G8553** At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.

(reporting G codes were different for 2010)

Need Assistance

QualityNet Help Desk

Phone: 1 (866) 288-8912

Email: qnetsupport@sdps.org

Quality measures for 2012 PQRS are listed. A sample pulmonary PQRS encounter form including three PQRS measures is provided . You can copy the form, and insert whatever measures you choose to report.