PQRS More Complex for 2014
2014 Bonus Requirements Differ from Future Penalty Requirements

Correct PQRS reporting will continue to garner an annual bonus through December of 2014, disappearing in 2015, when an annual payment adjustment (penalty) will replace it. The 2015 penalty will be based on last year’s PQRS reporting. The subsequent 2016 penalty will be based on 2014 reporting. The reporting to gain the 2014 bonus differs from the 2014 reporting required to avoid the 2016 penalty.

2014 Payment Bonus: (0.5%) The new 2014 bonus rules require 9 (instead of the previous 3) PQRS measures across 3 (instead of 1) National Quality Strategy domains, for 50% of applicable Medicare patients. Earning the 2014 bonus automatically avoids the 2016 penalty.

2016 Penalty (2.0%) It is possible to avoid the 2016 penalty without earning the 2014 bonus. Reporting 3 measures on 50% of applicable patients is all that is necessary to avoid the 2016 penalty.

Dr. Quack has created 5 pages of In Office PQRS Traffic Sheets which contain 9 measures to earn the 2014 bonus. They also can be used, with much less effort, to simply avoid the 2016 penalty without gaining the 2014 bonus.

- To earn the 2014 bonus (and automatically avoid the 2016 penalty) you must report on all 9 measures included in the traffic sheets. And, unlike previous years, 2 of these PQRS measures (Medication List and Tobacco Cessation) must be reported on EVERY patient age 18 and older.
- To simply avoid the 2016 penalty, without earning the 2014 bonus, you need only report on 3 of the measures included in the traffic sheets.

The next 9 pages of this document contain comprehensive information on how to code each of the 9 measures. The subsequent 5 pages, beginning at page 11, make up the in-office traffic sheets to assist in coding PQRS. You must read, and understand, pages 2 through 10 before using the traffic sheets.

The traffic sheets are arranged as follows:
- Glaucoma (The Traffic Sheet page labeled “1a” contains two glaucoma measures.)
- AMD (The Traffic Sheet page labeled “1b” contains two AMD measures.)
- Diabetes (The Traffic Sheet pages labeled “2a” and “2b” contains three diabetes measures.)
- Medication List and Tobacco Cessation (The Traffic Sheet page labeled “3” contains the Medication List and Tobacco Cessation measures, which are coded on all patients age 18 and over.)

Traffic sheets 1a and 1b can be printed back-to-back, as can traffic sheets 2a and 2b. Traffic sheet 3 will stand alone, and will be blank on the reverse side.
Measure #12 (NQF 0086): Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with primary open-angle glaucoma (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 365.10, 365.11, 365.12, 365.15
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients who have an optic nerve head evaluation during one or more office visits within 12 months

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Optic Nerve Head Evaluation Performed
CPT II 2027F: Optic nerve head evaluation performed

OR
Optic Nerve Head Evaluation not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 2027F to report documented circumstances that appropriately exclude patients from the denominator.
2027F with 1P: Documentation of medical reason(s) for not performing an optic nerve head evaluation

OR
Optic Nerve Head Evaluation not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2027F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2027F with 8P: Optic nerve head evaluation was not performed, reason not otherwise specified

RATIONALE:
Changes in the optic nerve are one of two characteristics which currently define progression and thus worsening of glaucoma disease status (the other characteristic is visual field). There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care (Fremont, 2003), even among specialists. (Lee, 2006) Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage. Visible structural alterations of the optic nerve head or retinal nerve fiber layer and development of peripapillary choroidal atrophy frequently occur before visual field defects can be detected. Careful study of the optic disc neural rim for small hemorrhages is important, since these hemorrhages can precede visual field loss and further optic nerve damage.

CLINICAL RECOMMENDATION STATEMENTS:
Ophthalmic Evaluation
In completing the elements in the comprehensive adult medical eye evaluation, the ophthalmic evaluation specifically focuses on the following elements:
• History [A:III]
• Visual acuity measurement [A:III]
• Pupil examination [B:II]
• Anterior segment examination [A:III]
• Intraocular pressure measurement [A:II]
• Gonioscopy [A:III]
• Optic nerve head and retinal nerve fiber layer examination [A:III]
• Fundus examination [A:III]

Measure #141 (NQF 0563): Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

DESCRIPTION: Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (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.

Measure Reporting via Claims: ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure. When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis code, CPT codes, and the appropriate CPT Category II code(s) with the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

- Patients aged ≥ 18 years on date of encounter
- Diagnosis for primary open-angle glaucoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 365.10, 365.11, 365.12, 365.15
- Glaucoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

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

Definitions:
- Plan of Care – May include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist.
- Plan to Recheck – in the event certain factors do not allow for the IOP to be measured (eg, patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported.
- Glaucoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

- 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 numerator option)
  - 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 numerator option)
  - CPT II 0517F: Glaucoma plan of care documented
  - 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 Otherwise Specified
  - (Two CPT II codes [0517F-8P & 3285F] are required on the claim form to submit this numerator option)
  - 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.
  - 0517F with 8P: Glaucoma plan of care not documented, reason not otherwise specified
  - 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 Otherwise Specified
  - (One CPT II code [3284F-8P] is required on the claim form to submit this numerator option)
  - Append a reporting modifier (8P) to CPT Category II code 3284F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
  - 3284F with 8P: IOP measurement not documented, reason not otherwise specified

RATIONAL: [NOTE: the rationale for this measure is lengthy, and in the interest of space, the majority has been omitted here. See source* below for the full page of rationale.]

1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate) is explained in the rationale.
2. Evidence for gap in care is explained in the rationale.

CLINICAL RECOMMENDATION STATEMENTS:

When initiating therapy, the ophthalmologist assumes that the measured pretreatment pressure range contributed to optic nerve damage and is likely to cause additional damage in the future. Lowering the pretreatment IOP by 25% or more has been shown to inhibit progression of POAG. (A.II) (AAO, 2010)

Choosing an even lower target IOP can be justified if there is more severe optic nerve damage, if the damage is progressing rapidly, or if other risk factors such as family history, age, or disc hemorrhages are present. 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. This also applies to the 2010 guidelines. 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 #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with age-related macular degeneration (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.
When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
DENOMINATOR:
All patients aged 50 years and older with a diagnosis of AMD

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for age-related macular degeneration (ICD-9-CM): 362.50, 362.51, 362.52
Diagnosis for age-related macular degeneration (ICD-10-CM): H35.30, H35.31, H35.32
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.

Definitions:
Macular Thickening – Acceptable synonyms for “macular thickening” include: intraretinal thickening, serous detachment of the retina, pigment epithelial detachment.
Severities of Macular Degeneration – Mild, moderate, or severe.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dilated Macular Examination Performed
CPT II 2019F: Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity
OR
Dilated Macular Examination not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 2019F to report documented circumstances that appropriately exclude patients from the denominator.
2019F with 1P: Documentation of medical reason(s) for not performing a dilated macular examination
2019F with 2P: Documentation of patient reason(s) for not performing a dilated macular examination
OR
Dilated Macular Examination not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2019F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2019F with 8P: Dilated macular exam was not performed, reason not otherwise specified

RATIONALE:
A documented complete macular examination is a necessary prerequisite to determine the presence and severity of AMD, so that a decision can be made as to the benefits of prescribing antioxidant vitamins. Further, periodic assessment is necessary to determine whether there is progression of the disease and to plan the on-going treatment of the disease, since several therapies exist that reduce vision loss once the advanced “wet” form of AMD occurs. While no data exist on the frequency or absence of regular examinations of the macula for patients with AMD, parallel data for key structural assessments for glaucoma, cataract and diabetic retinopathy suggest that significant gaps are likely.

CLINICAL RECOMMENDATION STATEMENTS:
According to the American Academy of Ophthalmology, a stereo biomicroscopic examination of the macula should be completed. Binocular slit-lamp biomicroscopy of the ocular fundus is often necessary to detect subtle clinical clues of CNV. These include small areas of hemorrhage, hard exudates, subretinal fluid, or pigment epithelial elevation. (A: III) (AAO, 2008)

Measure #140 (NQF 0566): Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

DESCRIPTION: Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) 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.

Measure Reporting via Claims:

ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate ICD-9-CM/ICD-10-CM diagnosis code, CPT codes, and the appropriate CPT Category II code or the CPT Category II code with the modifier. The reporting modifier allowed for this measure is: 8P—reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

DENOMINATOR:

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

Denominator Criteria (Eligible Cases):

- Patients aged ≥ 50 years on date of encounter
- AND
- Diagnosis for AMD (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.50, 362.51, 362.52
- Diagnosis for AMD (ICD-10-CM) [for use 10/01/2014-12/31/2014]: H35.30, H35.31, H35.32
- AND
- Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:

Patients with AMD 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

Definition:

Counseling – Documentation in the medical record should include a discussion of risk or benefits of the AREDS formulation. 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 NOTE: If patient is already receiving AREDS formulation, the assumption is that counseling about AREDS has already been performed.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

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, Reason not Otherwise 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.

4177F with 8P: AREDS counseling not performed, reason not otherwise specified

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) report. (A-I) (AO, 2008)

TABLE 1 Antioxidant Vitamin and Mineral Supplements Used in the AREDS

<table>
<thead>
<tr>
<th>Supplement</th>
<th>Daily Dose (See note below)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vitamin C</td>
<td>500 mg</td>
</tr>
<tr>
<td>Vitamin E</td>
<td>400 IU</td>
</tr>
<tr>
<td>Beta-carotene</td>
<td>15 mg (25,000 IU)</td>
</tr>
<tr>
<td>Zinc oxide</td>
<td>80 mg</td>
</tr>
<tr>
<td>Cupric oxide</td>
<td>2 mg</td>
</tr>
</tbody>
</table>

Note: 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 #18 (NQF 0088): Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

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

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
AND
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99324, 99325, 99326, 99327, 99328, 99329, 99334, 99335, 99336, 99337

NUMERATOR:
Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months

Definitions:
Documentation – The medical record must include: documentation of the level of severity of retinopathy (eg, background diabetic retinopathy, proliferative diabetic retinopathy, non-proliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent.
Macular Edema – Acceptable synonyms for macular edema include: intraretinal thickening, serous detachment of the retina, or pigment epithelial detachment.
Severity of Retinopathy – mild nonproliferative, preproliferative, very severe nonproliferative.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Macular or Fundus Exam Performed
CPT II 2021F: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy
OR
Macular or Fundus Exam not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 2021F to report documented circumstances that appropriately exclude patients from the denominator.
2021F with 1P: Documentation of medical reason(s) for not performing a dilated macular or fundus examination
2021F with 2P: Documentation of patient reason(s) for not performing a dilated macular or fundus examination
OR
Macular or Fundus Exam not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2021F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2021F with 8P: Dilated macular or fundus exam was not performed, reason not otherwise specified

RATIONALE:
Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

CLINICAL RECOMMENDATION STATEMENTS:
Because treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment:
• Presence of macular edema
• Optic nerve neovascularization and/or neovascularization elsewhere
• Signs of severe NPDR (extensive retinal hemorrhages/microaneuvesms, venous beading, and IRMA)
• Vitreous or preretinal hemorrhage

Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with diabetic retinopathy seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II and/or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR quality-data code OR the CPT Category II code with the modifier AND quality-data code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient’s diabetic care

Definitions:
Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (eg, verbally, by letter) with the clinician managing the patient’s diabetic care OR a copy of a letter in the medical record managing the patient’s diabetic care outlining the findings of the dilated macular or fundus exam.
Findings – Includes level of severity of retinopathy AND the presence or absence of macular edema.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dilated Macular or Fundus Exam Findings Communicated
(One CPT II code & one quality-data code [5010F & G8397] are required on the claim form to submit this numerator option)
CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR
Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons or Patient Reasons
(One CPT II code & one quality-data code [5010F-P & G8397] are required on the claim form to submit this numerator option)
Append a modifier (1P or 2P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.
5010F with 1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes
5010F with 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR
If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:
(One quality-data code [G8398] is required on the claim form to submit this numerator option)
G8398: Dilated macular or fundus exam not performed

OR
Dilated Macular or Fundus Exam Findings not Communicated, Reason not Otherwise Specified
(One CPT II code & one quality-data code [5010F-8P & G8397] are required on the claim form to submit this numerator option)
Append a reporting modifier (8P) to CPT Category II code 5010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
5010F with 8P: Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

RATIONALE: The physician that manages the ongoing care of the patient with diabetes should be aware of the patient’s dilated eye examination and severity of retinopathy to manage the ongoing diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS)

CLINICAL RECOMMENDATION STATEMENTS: The ophthalmologist should communicate examination results to the physician who is managing ongoing diabetes care.

Measure #117 (NQF 0055): Diabetes: Eye Exam

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

DESCRIPTION: Percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period

INSTRUCTIONS: This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
- ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.
- When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The reporting modifier allowed for this measure is 8P - reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

DENOMINATOR:
- All patients aged 18 through 75 years of age who had a diagnosis of diabetes mellitus (ICD-9-CM) or diabetes mellitus (ICD-10-CM) in the year prior to the measurement period.

Numeric Data Coding Options for Reporting Satisfactorily:
- CPT II 2022F: Retinal or Dilated Eye Exam Performed by an Eye Care Professional
- CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
- CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

Rationale:
- Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes of either type may cause life-threatening, life-ending or life-altering complications, including glaucoma and blindness. Diabetic retinopathy is the most common diabetic eye disease and causes 21,000–24,000 new cases of blindness annually. The consensus among established clinical guidelines is that patients with both types of diabetes should have an initial dilated and comprehensive eye exam soon after diagnosis. Guidelines also recommend consultation with an ophthalmologist for treatment options if a patient has any level of macular edema or diabetic retinopathy (proliferative and nonproliferative). (American Diabetes Association 2009)
- Laser photocoagulation therapy is indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A recommendation)
- The presence of photocoagulation therapy is not indicated to reduce the risk of vision loss in patients with high-risk PDR, clinically significant macular edema, and in some cases of severe NPDR. (A recommendation)

American Geriatric Society (AGS) (Brown et al. 2003): The older adult who has new-onset DM should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopic training. (Level I, Grade B)

Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record
2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbsals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.

INSTRUCTIONS:
This measure is to be reported each visit during the 12 month reporting period. Eligible professionals meet the intent of this measure by making their best effort to document a current, complete and accurate medication list during each encounter. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits that are included in the measure’s denominator. Quality-data codes are used to report the numerator of the measure. When reporting the measure via claims, submit the CPT or HCPCS codes, and the appropriate numerator quality-data code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

DENOMINATOR:
All visits for patients aged 18 years and older

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90957, 90958, 90959, 90960, 90962, 90965, 90966, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92541, 92542, 92543, 92544, 92545, 92547, 92557, 92567, 92568, 92570, 92585, 92588, 92596, 96116, 96150, 96159, 97001, 97002, 97003, 97004, 97110, 97140, 97532, 97802, 97804, 98660, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:
Eligible professional attests to documenting, updating or reviewing a patient’s current medications using all immediate resources available on the date of encounter. This list must include ALL prescriptions, over-the-counters, herbsals, and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.

Definitions:
Current Medications - Medications the patient is presently taking including all prescriptions, over-the-counters, herbsals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.
Route - Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)

Not Eligible - A patient is not eligible if the following reason is documented:
• Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status

NUMERATOR NOTE: The eligible professional must document in the medical record they obtained, updated, or reviewed a medication list on the date of the encounter. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources. G8427 should be reported if the eligible professional documented that the patient is not currently taking any medications.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Current Medications Documented
G8427: Eligible professional attests to documenting in the medical record they obtained, updated, or reviewed the patient’s current medications

OR

Current Medications not Documented, Patient not Eligible
G8430: Eligible professional attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated, or reviewed by the eligible professional

OR

Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason not Given
G8428: Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given

RATIONALE: [NOTE: the rationale for this measure is lengthy, and in the interest of space, the majority has been omitted here. See source* below for the full page of rationale.] In the American Medical Association’s (AMA) Physician’s Role in Medication Reconciliation (2007), critical patient information, including medical and medication histories, current medications the patient is receiving and taking, and sources of medications, is essential to the delivery of safe medical care. However, interruptions in the continuity of care and information gaps in patient health records are common and significantly affect patient outcomes. Consequently, clinical judgments may be based on incomplete, inaccurate, poorly documented or unavailable information about the patient and his or her medication.

CLINICAL RECOMMENDATION STATEMENTS:
The Joint Commission’s 2011 National Patient Safety Goals guides providers to maintain and communicate accurate patient medication information guiding elements of performance to obtain and/ or update information on the medications the patient is currently taking. The National Quality Forum’s 2010 update of the Safe Practices for Better Healthcare, states healthcare organizations must develop, reconcile, and communicate an accurate patient medication list throughout the continuum of care. Improving the safety of healthcare delivery saves lives, helps avoid unnecessary complications, and increases the confidence that receiving medical care actually makes patients better, not worse. Every healthcare stakeholder group should insist that provider organizations demonstrate their commitment to reducing healthcare error and improving safety by putting into place evidence-based safe practices.

The AMA’s published report, The Physician’s Role in Medication Reconciliation, identified the best practice medication reconciliation team as one that is multidisciplinary and—in all settings of care—will include physicians, pharmacists, nurses, ancillary health care professionals and clerical staff. The team’s variable requisite knowledge, skills, experiences, and perspectives are needed to make medication reconciliation work as safely and smoothly as possible. Team members may have access to vital information or data needed to optimize medication safety. Because physicians are ultimately responsible for the medication reconciliation process and subsequently accountable for medication management, physician leadership and involvement in all phases of developing and initiating a medication reconciliation process or model is important to its success.

Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

2014 PQRS OPTIONS FOR INDIVIDUAL MEASURES:

DESCRIPTION: Percentage of patients aged 18 years and 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

INSTRUCTIONS: This measure is to be reported once per reporting period for patients seen during the reporting period. This measure is intended to reflect the quality of services provided for preventive screening for tobacco use.

Measure Reporting via Claims:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the appropriate CPT or HCPCS codes, and the appropriate CPT Category II code OR the CPT Category II code with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

DENOMINATOR:
All patients aged 18 years and older

Denominator Criteria (Eligible Cases):
- Patients aged ≥ 18 years on date of encounter
- AND
- Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

NUMERATOR:
Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user

Definitions:
- Tobacco Use – Includes use of any type of tobacco.
- Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

NUMERATOR NOTE: In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation counseling report 4004F with 8P.

Numerators Quality-Data Coding Options for Reporting Satisfactorily:
- Patient Screened for Tobacco Use
- CPT II 4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user OR
- Patient Screened for Tobacco Use and Identified as a Non-User of Tobacco
- CPT II 1036F: Current tobacco non-user

OR

Tobacco Screening not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 4004F to report documented circumstances that appropriately exclude patients from the denominator

4004F with 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)

OR

Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason Not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4004F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4004F with 8P: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified

RATIONALITY: This measure is intended to promote adult tobacco screening and tobacco cessation interventions for those who use tobacco products. There is good evidence that tobacco screening and brief cessation intervention (including counseling and/or pharmacotherapy) is successful in helping tobacco users quit. Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke.

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

All patients should be asked if they use tobacco and should have their tobacco use status documented on a regular basis. Evidence has shown that clinic screening systems, such as expanding the vital signs to include tobacco use status or the use of other reminder systems such as chart stickers or computer prompts, significantly increase rates of clinician intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

All physicians should strongly advise every patient who smokes to quit because evidence shows that physician advice to quit smoking increases abstinence rates. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Minimal interventions lasting less than 3 minutes increase overall tobacco abstinence rates. Every tobacco user should be offered at least a minimal intervention, whether or not he or she is referred to an intensive intervention. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The combination of counseling and medication is more effective for smoking cessation than either medication or counseling alone. Therefore, whenever feasible and appropriate, both counseling and medication should be provided to patients trying to quit smoking. (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

Clinicians should encourage all patients attempting to quit to use effective medications for tobacco dependence treatment, except where contraindicated or for specific populations for which there is insufficient evidence of effectiveness (i.e., pregnant women, smokeless tobacco users, light smokers, and adolescents). (Strength of Evidence = A) (U.S. Department of Health and Human Services. Public Health Service, 2008)

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (U.S. Preventive Services Task Force, 2009)

Measure #12 (NQF 0086): Primary Open-Angle Glaucoma: Optic Nerve Evaluation

**DESCRIPTION:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months

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

**Denominator Criteria (Eligible Cases):**
- Patients aged ≥ 18 years on date of encounter
- AND
- Diagnosis for primary open-angle glaucoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 365.10, 365.11, 365.12, 365.15
- OR

**AND**
- Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

**NUMERATOR:** Patients who have an optic nerve head evaluation during one or more office visits within 12 months

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
- **Optic Nerve Head Evaluation Performed**
  - CPT II 2027F: Optic nerve head evaluation performed

**OR**
- **Optic Nerve Head Evaluation not Performed for Medical Reasons**
  - Append a modifier (1P) to CPT Category II code 2027F to report documented circumstances that appropriately exclude patients from the denominator.

  **2027F with 1P:** Documentation of medical reason(s) for not performing an optic nerve head evaluation

**OR**
- **Optic Nerve Head Evaluation not Performed, Reason not Otherwise Specified**
  - Append a reporting modifier (8P) to CPT Category II code 2027F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

  **2027F with 8P:** Optic nerve head evaluation was not performed, reason not otherwise specified

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Measure #141 (NQF 0563): Primary Open-Angle Glaucoma: Reduction of IOP by 15% OR Documentation of a Plan of Care

**DESCRIPTION:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (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

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

**Denominator Criteria (Eligible Cases):**
- Patients aged ≥ 18 years on date of encounter
- AND
- Diagnosis for primary open-angle glaucoma (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 365.10, 365.11, 365.12, 365.15
- OR

**AND**
- Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

**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

**Definitions:**
- **Plan of Care – May include:** recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist.
- **Plan to Recheck – In the event certain factors do not allow for the IOP to be measured (eg, patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported.**
- **Gluacoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.**

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

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
- **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 numerator option)
  - 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 numerator option)

  **CPT II 0517F:** Glaucoma plan of care documented

  **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 Otherwise Specified**
  - (Two CPT II codes [0517F-8P & 3285F] are required on the claim form to submit this numerator option)

  Append a reporting modifier (8P) to CPT Category II code 3285F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

  **0517F with 8P:** Glaucoma plan of care not documented, reason not otherwise specified

  **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 Otherwise Specified**
  - (One CPT II code [3284F-8P] is required on the claim form to submit this numerator option)

    Append a reporting modifier (8P) to CPT Category II code 3284F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

    **3284F with 8P:** IOP measurement not documented, reason not otherwise specified
Measure #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Exam

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure’s denominator. CPT Category II codes are used to report the numerator of the measure.

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

Numerator:
Patients who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months.

Definitions:
- Macular Thickening – Acceptable synonyms for “macular thickening” include: intraretinal thickening, serous detachment of the retina, pigment epithelial detachment.
- Severity of Macular Degeneration – Mild, moderate, or severe.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dilated Macular Examination Performed
CPT II 2019F: Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity

OR

Dilated Macular Examination not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 2019F to report documented circumstances that appropriately exclude patients from the denominator.
2019F with 1P: Documentation of medical reason(s) for not performing a dilated macular examination
2019F with 2P: Documentation of patient reason(s) for not performing a dilated macular examination

OR

Dilated Macular Examination not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2019F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2019F with 8P: Dilated macular exam was not performed, reason not otherwise specified

Measure #140 (NQF 0566): Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration (AMD) that were counseled about the benefits and/or risks of the AREDS formulation for preventing progression of AMD.

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

Numerator:
Patients with AMD 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.

Definition:
Counseling – Documentation in the medical record should include a discussion of risk or benefits of the AREDS formulation. 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 NOTE: If patient is already receiving AREDS formulation, the assumption is that counseling about AREDS has already been performed.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
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, Reason not Otherwise 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.
4177F with 8P: AREDS counseling not performed, reason not otherwise specified
Measure #18 (NQF 0088): Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

**DESCRIPTION:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

**DENOMINATOR:** All patients aged 18 years and older with a diagnosis of diabetic retinopathy

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

**NUMERATOR:** Patients who had a dilated macular or fundus exam performed which included documentation of the presence or absence of macular edema during one or more office visits within 12 months

**Definitions:**
- **Documentation** – The medical record must include: documentation of the level of severity of retinopathy (e.g. background diabetic retinopathy, proliferative diabetic retinopathy) and documentation of whether macular edema was present or absent.
- **Severity of Retinopathy** – mild nonproliferative, preproliferative, very severe nonproliferative.

**Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

**DESCRIPTION:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

**DENOMINATOR:** All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
- **Diabetic Retinopathy:**
  - Diagnosis for diabetic retinopathy (ICD-9-CM) [for use 1/1/2014-9/30/2014]: 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

**NUMERATOR:** Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient’s diabetes care

**Definitions:**
- **Communication** – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g. verbally, by letter) with the clinician managing the ongoing care of the patient with diabetes.

**Measure #18 (NQF 0088): Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy**

**Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care**
Measure #117 (NQF 0055): Diabetes: Eye Exam

DESCRIPTION: Percentage of patients 18 through 75 years of age with a diagnosis of diabetes (type 1 and type 2) who had a retinal or dilated eye exam in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) in the year prior to the measurement period.

DENOMINATOR: All patients aged 18 through 75 years of age who had a diagnosis of diabetes with a visit during the measurement period.

Denominator Criteria (Eligible Cases):

NUMERATOR: Patients who had a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) in the measurement period or a negative retinal or dilated eye exam (negative for retinopathy) by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement period. For retinal or dilated eye exams performed 12 months prior to the measurement period, an automated result must be available.

Definition: Automated Result – Electronic system-based data that includes results generated from test or procedures. For administrative data collection automated/electronic results are necessary in order to show that the exam during the 12 months prior was negative for retinopathy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Retinal or Dilated Eye Exam Performed by an Eye Care Professional
CPT II 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed
OR
CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed
OR
CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed
OR
CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year) *Note: This code can only be used if the claim/encounter was during the measurement period because it indicates that the patient had “no evidence of retinopathy in the prior year”. This code definition indicates results were negative; therefore an automated result is not required.
OR
Retinal or Dilated Eye Exam not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2022F or 2024F or 2026F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
CPT II 2022F or 2024F or 2026F with 8P: Dilated eye exam was not performed, reason not otherwise specified.
Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record

**DESCRIPTION:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counter, herbs, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.

**DENOMINATOR:** All visits for patients aged 18 years and older

**NUMERATOR:** Eligible professional attests to documenting, updating or reviewing a patient’s current medications using all immediate resources available on the date of encounter. This list must include ALL prescriptions, over-the-counter, herbs, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications’ name, dosage, frequency and route of administration.

**Definitions:**
- Current Medications: Medications the patient is presently taking including all prescriptions, over-the-counter, herbs, and vitamin/mineral/dietary (nutritional) supplements with each medication’s name, dosage, frequency and route administered.
- Route: Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous, intramuscular, intravenous).

**NUMERATOR NOTE:** The eligible professional must document in the medical record the patient is currently taking all medications with the patient’s name, dosage, frequency and route administered.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
- Current Medications Documented
  - G8427: Eligible professional attests to documenting in the medical record the patient is currently taking all medications with the patient’s name, dosage, frequency and route administered.
- Current Medications not Documented, Patient not Eligible
  - G8438: Eligible professional attests to documenting in the medical record the patient is not currently taking any medications.
- Current Medications with Name, Dosage, Frequency, or Route not Documented, Reason Not Given
  - G8428: Current list of medications not documented as obtained, updated, or reviewed by the eligible professional, reason not given.

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Measure #226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

**DESCRIPTION:** Percentage of patients aged 18 years and 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.

**DENOMINATOR:** All patients aged 18 years and older

**NUMERATOR:** Patients who were screened for tobacco use at least once within 24 months AND who received tobacco cessation counseling intervention if identified as a tobacco user.

**Definitions:**
- Tobacco Use – Includes use of any type of tobacco.
- Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

**Numerator Quality-Data Coding Options for Reporting Satisfactorily:**
- Tobacco Use
  - CPT II 4004F: Patient screened for tobacco use CPT II 1036F: Current tobacco non-user
- Tobacco Cessation Intervention
  - G8438: Eligible professional attests to documenting in the medical record the patient is currently taking all medications with the patient’s name, dosage, frequency and route administered.
- Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason with 1P
  - G8439: Current tobacco non-user
- Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason Not Otherwise Specified
  - G8439: Current tobacco non-user

**NOTE:** TO OBTAIN THE PQRS BONUS, BOTH OF THESE MEASURES MUST BE REPORTED ON EVERY PATIENT 18 & OLDER

**Directions:** For each patient 18 years old and older, check the box next to the appropriate CPT II codes (the “numerator”), which your staff will then file on that same Medicare claim. File for BOTH measures (#130 and #226) to obtain the PQRS bonus.

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**Screening: Tobacco Use: Screening and Cessation Intervention**

**Definitions:**
- Tobacco Use OR Tobacco Cessation Intervention
  - Current tobacco non-user
- Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason with 1P
  - G8438: Current tobacco non-user
- Tobacco Screening OR Tobacco Cessation Intervention not Performed Reason Not Otherwise Specified
  - G8439: Current tobacco non-user

For each patient 18 years old and older, check the box next to the appropriate CPT II codes (the “numerator”), which your staff will then file on that same Medicare claim. File for BOTH measures (#130 and #226) to obtain the PQRS bonus.

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**Directions:** For each patient 18 years old and older, check the box next to the appropriate CPT II codes (the “numerator”), which your staff will then file on that same Medicare claim. File for BOTH measures (#130 and #226) to obtain the PQRS bonus.