*Measure #30 (NQF 0269): Perioperative Care: Timely Administration of Prophylactic Parenteral Antibiotics	

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures with the indications for prophylactic parenteral antibiotics for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

INSTRUCTIONS:
This measure is to be reported **each time** an anesthesia service in the denominator is provided for surgical patients during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians who provide anesthesia services, as specified in the denominator coding***, will submit this measure - reporting on the timeliness of parenteral antibiotic administration. The clinician providing anesthesia services does not need to be the clinician who ordered the prophylactic parenteral antibiotic.

* The anesthesia services included in the denominator are associated with some surgical procedures for which prophylactic parenteral antibiotics may not be indicated. As a result, clinicians should report **4047F-8P** for those instances in which anesthesia services are provided but not associated with surgical procedures for which prophylactic parenteral antibiotics are indicated.

If the clinician providing anesthesia services orders AND administers the prophylactic parenteral antibiotic within the appropriate timeframe, report quality-data code **CPT II 4048F**. Report **CPT II 4048F** with the **1P** modifier in circumstances where the prophylactic parenteral antibiotic was not given for medical reasons (e.g., contraindicated, patient already receiving antibiotics).

Measure Reporting via Claims:
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 CPT codes, and the appropriate CPT Category II code **OR** the appropriate 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 as the denominator codes.

Measure Reporting via Registry:
CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All surgical patients aged 18 years and older who receive an anesthetic when undergoing procedures* with the indications for prophylactic parenteral antibiotics

DENOMINATOR NOTE: *Anesthesia services included in denominator are associated with some surgical procedures for which prophylactic parenteral antibiotics may not be indicated. Clinicians should report* ***4047F-8P*** *for those instances in which anesthesia services are provided but not associated with surgical procedures for which prophylactic parenteral antibiotics are indicated*

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): Anesthesia codes for which prophylactic parenteral antibiotics are commonly indicated for associated surgical procedure(s): 00100, 00102, 00103, 00120, 00140, 00145, 00147, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00350, 00352, 00400, 00402, 00404, 00406, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00561, 00562, 00563, 00566, 00567, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00670, 00700, 00730, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00820, 00830, 00832, 00840, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00880, 00882, 00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 01120, 01140, 01150, 01170, 01173, 01180, 01190, 01202, 01210, 01212, 01214, 01215, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01360, 01382, 01392, 01400, 01402, 01404, 01430, 01432, 01440, 01442, 01444, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01500, 01502, 01520, 01522, 01610, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01710, 01712, 01714, 01716, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01924, 01925, 01926, 01951, 01952, 01953, 01961, 01962, 01963, 01965, 01966, 01968, 01969

NUMERATOR:
Surgical patients for whom administration of the prophylactic parenteral antibiotic ordered has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

Numerator Instructions: This measure seeks to identify the timely administration of prophylactic parenteral antibiotic. This administration should begin within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
The antimicrobial drugs listed below are considered prophylactic parenteral antibiotics for the purposes of this measure. ***4048F-8P*** *should be reported when antibiotics from this table were not ordered.*

• Ampicillin/sulbactam • Aztreonam • Cefazolin • Cefmetazole • Cefotetan • Cefoxitin	• Cefuroxime • Ciprofloxacin • Clindamycin • Ertapenem • Erythromycin base • Gatifloxacin	• Gentamicin • Levofloxacin • Metronidazole • Moxifloxacin • Neomycin • Vancomycin

NUMERATOR NOTE: *"Ordered" includes instances in which the prophylactic parenteral antibiotic is ordered by the clinician performing the surgical procedure OR is ordered by the clinician providing the anesthesia services.*

Documentation that Prophylactic Parenteral Antibiotic was Administered Within Specified Timeframe

CPT II 4048F: Documentation that administration of prophylactic parenteral antibiotic was initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required), as ordered.

OR

Prophylactic Parenteral Antibiotic not Administered for Medical Reasons (eg, contraindicated, patient already receiving antibiotics)

Append a modifier (**1P**) to CPT Category II code **4048F** to report documented circumstances that appropriately exclude patients from the denominator.

4048F *with* 1P: Documentation of medical reason(s) for not initiating administration of prophylactic parenteral antibiotics as specified (eg, contraindicated, patient already receiving antibiotics).

OR

If patient is not eligible for this measure because prophylactic parenteral antibiotic not ordered, report:

Prophylactic Parenteral Antibiotic not Ordered

Append a reporting modifier (**8P**) to CPT Category II code **4047F** to report circumstances when the patient is not eligible for the measure.

4047F *with* 8P: No documentation of order for prophylactic parenteral antibiotics to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision (or start of procedure when no incision is required)

OR

Prophylactic Parenteral Antibiotic Ordered but not Initiated Within One Hour, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **4048F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4048F *with* 8P: Administration of prophylactic parenteral antibiotic was **not** initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required), reason not otherwise specified.

RATIONALE:

The appropriate timing of administration of prophylactic parenteral antibiotics has been demonstrated to reduce the incidence of surgical wound infections. Available evidence suggests that although most surgical patients receive a prophylactic antibiotic, many do not receive the drug within one hour before incision as recommended.

CLINICAL RECOMMENDATION STATEMENTS:

The anti-infective drug should ideally be given within 30 minutes to 1 hour before the initial incision to ensure its presence in an adequate concentration in the targeted tissues. For most procedures, scheduling administration at the time of induction of anesthesia ensures adequate concentrations during the period of potential contamination. Exceptions: cesarean procedures (after cross clamping of the umbilical cord); colonic procedures (starting 19 hours before the scheduled time of surgery). (ASHP)

Infusion of the first antimicrobial dose should begin within 60 minutes before incision. However, when a fluoroquinolone or vancomycin is indicated, the infusion should begin within 120 minutes before incision to prevent antibiotic-associated reactions. Although research has demonstrated that administration of the antimicrobial at the time of anesthesia induction is safe and results in adequate serum and tissue drug levels at the time of incision, there was no consensus that the infusion must be completed before incision. (SIPGWW)

▲Measure #76 (NQF 0464): Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, who undergo 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 for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed

INSTRUCTIONS:
This measure is to be reported **each time** a CVC insertion is performed during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians who perform CVC insertion** will submit this measure.

Measure Reporting via Claims:
CPT procedure codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed 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, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, who undergo CVC insertion

> **Denominator Criteria (Eligible Cases):**
> **Patient encounter during the reporting period (CPT):** 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 93503

NUMERATOR:
Patients for whom central venous catheter (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 for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)] followed

Definition:
Maximal Sterile Barrier Technique during CVC Insertion – Includes use of **all** of the following: Cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
All Elements of Maximal Sterile Barrier Technique Followed
CPT II 6030F: All elements of maximal sterile barrier technique followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline)

OR

All Elements of Maximal Sterile Barrier Technique not Followed for Medical Reasons
Append a modifier (**1P**) to CPT Category II code **6030F** to report documented circumstances that appropriately exclude patients from the denominator.
6030F *with* 1P: Documentation of medical reason(s) for not following all elements of maximal sterile barrier technique during CVC insertion (including CVC insertion performed on emergency basis)

OR

All Elements of Maximal Sterile Barrier Technique not Followed, Reason not Otherwise Specified
Append a reporting modifier (**8P**) to CPT Category II code **6030F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
6030F *with* 8P: All elements of maximal sterile barrier technique **not** followed including: cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics, per current guideline), reason not otherwise specified

RATIONALE:
Catheter-related bloodstream infection is a costly complication of central venous catheter insertion, but may be avoided with routine use of aseptic technique during catheter insertion. This measure is constructed to require that *all* of the listed elements of aseptic technique are followed and documented.

Existing hospital-level measures for this topic were consulted and, to the extent feasible, harmonization between physician- and hospital- level measurement was achieved.

CLINICAL RECOMMENDATION STATEMENTS:
Maximal sterile barrier precautions during catheter insertion: Use aseptic technique including the use of a cap, mask, sterile gown, sterile gloves, and a large sterile sheet, for the insertion of CVCs (including PICCS) or guidewire exchange. (CDC/MMWR) (Category IA)

Hand hygiene: Observe proper hand-hygiene procedures either by washing hands with conventional antiseptic-containing soap and water or with waterless alcohol-based gels or foams. Observe hand hygiene before and after palpating catheter insertion sites, as well as before and after inserting, replacing, accessing, repairing, or dressing an intravascular catheter. Palpation of the insertion site should not be performed after the application of antiseptic, unless aseptic technique is maintained. Use of gloves does not obviate the need for hand hygiene. (CDC/MMWR) (Category IA)

Cutaneous antisepsis: Disinfect clean skin with an appropriate antiseptic before catheter insertion and during dressing changes. Although a 2% chlorhexidine-based preparation is preferred, tincture of iodine, an iodophor, or 70% alcohol can be used. (CDC/MMWR) (Category IA)

♠ Measure #128 (NQF 0421): Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is **outside of normal parameters**, a follow-up plan is documented within the past six months or during the current visit

Normal Parameters: Age 65 years and older BMI ≥ 23 and < 30
Age 18 – 64 years BMI ≥ 18.5 and < 25

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. *The most recent quality code submitted will be used for performance calculation.* 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 at the time of the qualifying visit and the measure-specific denominator coding. Calculated BMI or follow-up plan for BMI outside of normal parameters that is documented in the medical record may be reported if done in the provider's office/facility, or if obtained by the provider, from outside medical records within the past six months. The documented follow-up interventions must be related to the BMI outside of normal parameters, example: "Patient referred to nutrition counseling for BMI above normal parameters".

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

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447

NUMERATOR:
Patients with BMI calculated within the past six months or during the current visit, and a follow-up plan documented within the past six months or during the current visit if the BMI is outside of normal parameters

Definitions:
BMI – Body mass index (BMI), is expressed as weight/height (kg/m^2) and is commonly used to classify weight categories.
Calculated BMI – Requires an eligible professional or their staff to measure both the height and weight. Self-reported values cannot be used. BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared.
Follow-Up Plan – Proposed outline of treatment to be conducted as a result of a BMI out of normal parameters. Such follow-up may include but is not limited to: documentation of a future appointment, education, referral (such as, a registered dietician, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon), pharmacological interventions, dietary supplements, exercise counseling, or nutrition counseling.
Not Eligible/Not Appropriate for BMI Measurement or Follow-Up Plan – A patient is **not** eligible if one or more of the following reasons exists:

- Patient is receiving palliative care
- Patient is pregnant
- Patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement or follow-up plan was not appropriate
- 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 Quality-Data Coding Options for Reporting Satisfactorily:
BMI Calculated as Normal, No Follow-Up Plan Required
*(One G-code [*G84xx*] is required on the claim form to submit this numerator option)*
G8420: Calculated BMI within normal parameters and documented
OR
BMI Calculated Above Normal Parameters, Follow-Up Documented
G8417: Calculated BMI above normal parameters and a follow-up plan was documented
OR
BMI Calculated Below Normal Parameters, Follow-Up Documented
G8418: Calculated BMI below normal parameters and a follow-up plan was documented

OR

BMI not Calculated, Patient not Eligible/not Appropriate
*(One G-code [*G8422 or G8938*] is required on the claim form to submit this numerator option)*
G8422: Patient not eligible for BMI calculation
OR
BMI Calculated, Patient not Eligible/not Appropriate for Follow-up Plan
G8938: BMI is calculated, but patient not eligible for follow-up plan

OR

BMI not Calculated, Reason not Given
*(One G-code [*G84xx*] is required on the claim form to submit this numerator option)*
G8421: BMI **not** calculated
OR
BMI Calculated Outside Normal Parameters, Follow-Up Plan not Documented, Reason not Given
G8419: Calculated BMI outside normal parameters, **no** follow-up plan documented

RATIONALE:

BMI Above Upper Parameters

"In 2009, no state met the healthy people 2012 obesity target of 15 percent, and the self reported overall prevalence of obesity among U.S. adults had increased 1.1 percentage points from 2007. Overall self-reported obesity prevalence in the U.S. was 26.7 percent" (CDC, 2010).

Obesity continues to be a public health concern in the United States and throughout the world. In the United States, obesity prevalence doubled among adults between 1980 and 2004 (Flegal et al., 2002; Ogden et al., 2006). Obesity is associated with increased risk of a number of conditions, including diabetes mellitus, cardiovascular disease, hypertension, and certain cancers, as well as with increased risk of disability and a modestly elevated risk of all-cause mortality. "Obesity is associated with an increased risk of death, particularly in adults younger than age 65 years. Obesity has been shown to reduce life expectancy by 6 to 20 years depending on age and race. Ischemic heart disease, diabetes, cancer (especially liver, kidney, breast, endometrial, prostate and colon), and respiratory diseases are the leading causes of death in persons who are obese" (AHRQ, 2011).

Results from the 2009-2010 National Health and Nutrition Examination Survey (NHANES) indicate that an estimated 35.7 percent of adults are obese (NCHS, CDC, 2012). Although the prevalence of adults in the U.S. who are obese is still high with about one-third of adults obese in 2007-2008, data suggest that the rate of increase for obesity in the U.S. in recent decades may be slowing (Flegal et al., 2010).

Finkelstein et al. (2009) found that across all payers, per capita medical spending for the obese is $1,429 higher per year, or roughly 42 percent higher than for someone of normal weight. In aggregate, the annual medical burden of obesity has increased from 6.5 percent to 9.1 percent of annual medical spending and could be as high as $147 billion per year (in 2008 dollars). A study by Tsai et al. (2010) estimated cost for obesity to be even higher. A recent study by Cawley et al. (2012) reported findings that indicate that the effect of obesity of medical care cost is much greater than previously appreciated.

Ma et al. (2009) performed a retrospective, cross-sectional analysis of ambulatory visits in the National Ambulatory Medical Care Survey from 2005 and 2006. The study findings on obesity and office-based quality of care concluded the evidence is compelling and that obesity is underappreciated in office-based physician practices across the United States. Many opportunities are missed for obesity screening and diagnosis, as well as for the prevention and treatment of obesity and related health risks, regardless of patient and provider characteristics.

BMI Below Normal Parameters

Poor nutrition or underlying health conditions can result in underweight. Results from the 2007-2008 National Health and Nutrition Examination Survey (CDC, 2010), using measured heights and weights, indicate an estimated 1.6% of U.S. adults are underweight with women more likely to be underweight than men.

Huffman (2002) states elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In an observational study, Ranhoff et al. (2005) recommended using BMI < 23 for the elderly to identify positive results with malnutrition screens and poor nutritional status.

CLINICAL RECOMMENDATION STATEMENTS:

Although multiple clinical recommendations addressing obesity have been developed by professional organizations, societies and associations, two recommendations have been identified which exemplify the intent of the measure and address the numerator and denominator.

The US Preventive Health Services Task Force (USPSTF) *The Guide to Clinical Preventive Services*, 2010-2011 recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (Level Evidence B).

Institute for Clinical Systems Improvement (ICSI, 2011) Prevention and Management of Obesity (Mature Adolescents and Adults) provides the following guidance:

- Calculate the body mass index; classify the individual based on the body mass index categories. Educate patients about their body mass index and their associated risks.
- Weight management requires a team approach. Be aware of clinical and community resources. The patient needs to have an ongoing therapeutic relationship and follow-up with a health care team.
- Weight control is a lifelong commitment, and the health care team can assist with setting specific goals with the patient.

♠ Measure #130 (NQF 0419): Documentation of Current Medications in the Medical Record

2013PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of specified visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list ***must*** include ALL prescriptions, over-the-counters, herbals, 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 at **each visit** during the 12 month reporting period. Eligible professionals meet the intent of this measure by making a 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. G-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 G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes, and patient demographics are used to identify visits that are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All visits occurring during the 12 month reporting period for patients aged 18 years and older on the date of the encounter where one or more CPT or HCPCS codes listed below are reported on the claims submission for that encounter.

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, 92548, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96152, 97001, 97002, 97003, 97004, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0270, G0402, G0438, G0439

NUMERATOR:
Eligible professional attests to documenting a list of current medications to the best of his/her knowledge and ability. This list ***must*** include ALL prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND ***must*** contain the medications' name, dosages, frequency and route of administration

Definitions:
Current Medications – Medications the patient is presently taking including all prescriptions, over-the-counters, herbals and vitamin/mineral/dietary (nutritional) supplements with each medication's name, dosage, frequency and administered route.
Not Eligible – A patient is **not** eligible if the following reason exist:

- 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: *By reporting **G8427**, the eligible professional is attesting the documented medication information is current, accurate and complete to the best of his/her knowledge and ability at the time of the patient encounter. This code should also be reported if the eligible professional documented that the patient is not currently taking any medications. Eligible professionals reporting this measure may document medication information received from the patient, authorized representative(s), caregiver(s) or other available healthcare resources.*

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Current Medications Documented
G8427: Eligible professional attests to documenting the patient's current medications to the best of his/her knowledge and ability

OR

Current Medications not Documented, Patient not Eligible
G8430: Eligible professional attests the patient is not eligible for medication documentation

OR

Current Medications with Name, Dosage, Frequency, Route not Documented, Reason not Given
G8428: Current medications **not** documented by the eligible professional, reason not given

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.

Medication safety efforts have primarily focused on hospitals; however, the majority of health care services are provided in the outpatient setting where two-thirds of physician visits result in writing at least one prescription (Stock et al., 2009). Chronically ill patients are increasingly being treated as outpatients, many of whom take multiple medications requiring close monitoring (Nassaralla et al., 2007).

Adverse drug events (ADEs) prove to be more fatal in outpatient settings (1 of 131 outpatient deaths) than in hospitals (1 of 854 inpatient deaths) (Nassaralla et al., 2007). According to The Commonwealth Fund report (2010) about 11 to 15 of every 1,000 Americans visit a health care provider because of ADEs in a given year, representing about three to four of every 1,000 patient visits during 1995 to 2001. The total number of visits to treat ADEs increased from 2.9 million in 1995 to 4.3 million visits in 2001.

ADEs in the ambulatory setting substantially increased the healthcare costs of elderly persons and estimated costs of $1,983 per case. Further findings of The Commonwealth Fund studies additionally identified 11% to 28% of the 4.3 million VADEs in 2001 might have been prevented with improved systems of care and better patient education, yielding an estimate of 473,000 to 1.2 million potentially preventable VADEs annually and potential cost-savings of $946 million to $2.4 billion.

In the Institute for Safe Medication Practices *The White Paper on Medication Safety in the U.S. and the Roles of Community Pharmacists* (2007), the American Pharmaceutical Association identified that Americans spend more than $75 billion per year on prescription and nonprescription drugs. Unnecessary costs include: improper use of prescription medicines due to lack of knowledge costs the economy an estimated $20-100 billion per year; American businesses lose an estimated 20 million workdays per year due to incorrect use of medicines prescribed for heart and circulatory diseases alone; failure to have prescriptions dispensed and/or renewed has resulted in an estimated cost of $8.5 billion for increased hospital admissions and physician visits, nearly one percent of the country's total health care expenditures.

In 2005, the rate of medication errors during hospitalization was estimated to be 52 per 100 admissions, or 70 per 1,000 patient days. Emerging research suggests the scope of medication-related errors in ambulatory settings is as extensive as or more extensive than during hospitalization. Ambulatory visits result in a prescription for medication 50 to 70% of the time. One study estimated the rate of ADEs in the ambulatory setting to be 27 per 100 patients. It is estimated that between 2004 and 2005 in the United States, 701,547 patients were treated for ADEs in emergency departments, and 117,318 patients were hospitalized for injuries caused by an ADE. Individuals aged 65 years and older are more likely than any other population group to require treatment in the emergency department for ADEs (AMA, 2007).

The Agency for Healthcare Quality's (AHRQ) The National Healthcare Disparities Report (2008) identified the rate of adverse drug events (ADE) among Medicare beneficiaries in ambulatory settings as 50 per 1,000 person-years. In 2005, AHRQ reported data on adults age 65 and over who received potentially inappropriate prescription medicines in the calendar year, by race, ethnicity, income, education, insurance status, and gender. The disparities were identified as follows: older Asians were more likely than older whites to have inappropriate drug use (20.3% compared with 17.3%); older Hispanics were less likely than older non-Hispanic Whites to have inappropriate drug use (13.5% compared with 17.6%); older women were more likely than older men to have inappropriate drug use (20.2% compared with 14.3%); there were no statistically significant differences by income or education.

Weeks et al. (2010) noted that fragmented medication records across the health care continuum, inaccurate reporting of medication regimens by patients, and provider failure to acquire all of the all the necessary elements of medication information from the patient or record, present significant obstacles to obtaining an accurate medication list in the ambulatory care setting. Because these obstacles require solutions demonstrating improvements in access to information and communication, the Institute of Medicine and others have encouraged the incorporation of IT solutions in the medication reconciliation process. In a survey administered to office-based physicians with high rates of EMR use, Weeks, et al found there is an opportunity for universal medication lists utilizing health IT.

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 #131 (NQF 0420): Pain Assessment and Follow-Up

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present

INSTRUCTIONS:
This measure is to be reported for **each visit** occurring during the reporting period for patients seen during the reporting period. 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. The documented follow up plan must be related to the presence of pain, example: "Patient referred to pain management specialist for back pain".

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate numerator G-code. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify visits included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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, 92507, 92508, 92526, 96116, 96150, 97001, 97003, 97532, 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439

NUMERATOR:
Patient's pain assessment is documented through discussion with the patient including the use of a standardized tool(s) AND a follow-up plan is documented when pain is present

Definitions:
Pain Assessment - A clinical assessment of pain using a standardized tool for the presence and characteristics of pain; characteristics may include location, intensity, quality, and onset/duration.

Standardized Tool – An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment, include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).
Follow-Up Plan – Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up ***must*** include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other care providers as applicable.
Not Eligible – A patient is **not** eligible if one or more of the following reasons exist:

- Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools.
- Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Pain Assessment Documented as Positive AND Follow-Up Plan Documented
*(One G-code [*G873x*] is required on the claim form to submit this numerator option)*
G8730: Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented
OR
Pain Assessment Documented as Negative, No Follow-Up Plan Required
G8731: Pain assessment documented as negative, no follow-up plan required

OR

Patient not Eligible for Pain Assessment for Documented Reasons
*(One G-code [*G8442 or G8939*] is required on the claim form to submit this numerator option)*
G8442: Documentation that patient is not eligible for a pain assessment
OR
Pain Assessment Documented, Follow-Up Plan not Documented, Patient not Eligible/Appropriate
G8939: Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate

OR

Pain Assessment not Documented, Reason not Given
*(One G-code [*G87xx*] is required on the claim form to submit this numerator option)*
G8732: **No** documentation of pain assessment, reason not given
OR
Pain Assessment Documented as Positive, Follow-Up Plan not Documented, Reason not Given
G8509: Documentation of positive pain assessment; **no** documentation of a follow-up plan, reason not given

RATIONALE:
Several provisions from the National Pain Care Policy Act (H.R. 756/S. 660) have been included in the Affordable Care Act (ACA) of 2010 to improve pain care. The legislation includes:

- Mandating an Institute of Medicine (IOM) conference on pain to address key medical and policy issues affecting the delivery of quality pain care
- Establishing a training program to improve the skills of health care professionals to assess and treat pain
- Enhancing the pain research agenda for the National Institute of Health (NIH)

The American Pain Foundation (2009) identified pertinent facts related to the impact of pain as follows:

- 76.5 million Americans suffering from pain.

- Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.
- Uncontrolled pain is a leading cause of disability and diminishes quality of life for patients, survivors, and their loved ones. It interferes with all aspects of daily activity, including sleep, work, social and sexual relations.
- Under-treated pain drives up costs – estimated at $100 billion annually in healthcare expenses, lost income, and lost productivity – extending length of hospital stays, as well as increasing emergency room trips and unplanned clinic visits.
- Medically underserved populations endure a disproportionate pain burden in all health care settings. Disparities exist among racial and ethnic minorities in pain perception, assessment, and treatment for all types of pain, whether chronic or acute.

The Institute Of Medicine's (IOM) *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) report suggests that chronic pain rates will continue to increase as a result of:

- More Americans will experience a disease in which chronic pain is associated (diabetes, cardiovascular disease, etc)
- Increase in obesity which is associated with chronic conditions that have painful symptoms
- Progress in lifesaving techniques for catastrophic injuries for people who would have previously died leads to a group of young people at risk for lifelong chronic pain
- Surgical patients are at risk for acute and chronic pain
- The public has a better understanding of chronic pain syndromes and new treatments and therefore may seek help when they may not have sought help in the past.

The prevalence of pain has a tremendous impact on business, with an estimated annual cost of $61.2 billion in lost productive time. Studies show that most of the pain-related lost productive time occurs while employees are at work, and is in the form of reduced performance. The cost of pain is an enormous burden on today's society, particularly to employers (American Academy of Pain Medicine, 2010). Stewart et al. (2003) identified almost thirteen percent of the total workforce experienced a loss in productive time during a two-week period due to a common pain condition: 5.4% for headache; 3.2% for back pain; 2.0% for arthritis pain; 2.0% for other musculoskeletal pain.

There are no current estimates of the total cost of poorly controlled pain in today's dollars. Viewed from the perspective of health care inflation at levels of more than 40% during the past decade (President's Council of Economic Advisors, 2009), the cost of health care due to pain is estimated to be between $261 to $300 billion. The value of lost productivity based on estimates of days of work missed is $11.6 to 12.7 billion, hours of work lost is $95.2 to $96.5 billion and lower wages is $190.6 to $226.3 billion. Total financial cost of pain to society, combining healthcare cost estimates and productivity estimates, ranges from $560 to $635 billion in 2010 dollars (Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research, Appendix C, 2011).

Chronic pain—commonly defined as pain persisting longer than six months—affects an estimated 70 million Americans and is a tragically overlooked public health problem (USDHHS, 2006). It is clear the enormous pain-related costs represent both a great challenge and an opportunity in terms of improving the quality and cost-effectiveness of care (The Mayday Fund, 2009).

Research also shows gender differences in the experience and treatment of pain. Most chronic pain conditions are more prevalent among women; however, women's pain complaints tend to be poorly assessed and undertreated (Green, 2003 , Chronic Pain Research Alliance 2011).

A growing body of research reveals even more extensive gaps in pain assessment and treatment among racial and ethnic populations, with minorities receiving less care for pain than non-Hispanic whites (Green, 2003; Green, 2007; Green et al., 2011; Todd et al., 2004; Todd et al., 2007). Differences in pain care occur across all types of pain (e.g.,

acute, chronic, cancer-related) and medical settings (e.g., emergency departments and primary care) (Green, 2003; Green, 2007; Todd et al., 2007). Even when income, insurance status and access to health care are accounted for, minorities are still less likely than whites to receive necessary pain treatments (Green, 2003; Green, 2007; Paulson et al., 2007).

CLINICAL RECOMMENDATION STATEMENTS:

Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.

A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors, spiritual and cultural issues are also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.

The Institute for Clinical Systems Improvement (ICSI, 2009) *Assessment and Management of Chronic Pain Guideline, Fourth Edition* was chosen because it addresses the key factors of the plan of care, pain assessment, and outcomes. In addition, it is based on a very broad foundation of evidence, and addresses a wide range of clinical conditions.

▲Measure #193 (NQF 0454): Perioperative Temperature Management

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass, for whom *either* active warming was used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

INSTRUCTIONS:
This measure is to be reported **each time** a surgical or therapeutic procedure not involving cardiopulmonary bypass is performed under general or neuraxial anesthesia during the reporting period. There is no diagnosis associated with this measure. It is anticipated that **clinicians who provide the listed anesthesia services** as specified in the denominator coding will submit this measure.

Measure Reporting via Claims:
CPT codes are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:
CPT codes are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients, regardless of age, undergoing surgical or therapeutic procedures under general or neuraxial anesthesia of 60 minutes duration or longer, except patients undergoing cardiopulmonary bypass

Denominator Criteria (Eligible Cases):
Patient encounter during the reporting period (CPT): Anesthesia codes for surgical or therapeutic procedures under general or neuraxial anesthesia: 00100, 00102, 00103, 00104, 00120, 00124, 00126, 00140, 00142, 00144, 00145, 00147, 00148, 00160, 00162, 00164, 00170, 00172, 00174, 00176, 00190, 00192, 00210, 00211, 00212, 00214, 00215, 00216, 00218, 00220, 00222, 00300, 00320, 00322, 00326, 00350, 00352, 00400, 00402, 00404, 00406, 00410, 00450, 00452, 00454, 00470, 00472, 00474, 00500, 00520, 00522, 00524, 00528, 00529, 00530, 00532, 00534, 00537, 00539, 00540, 00541, 00542, 00546, 00548, 00550, 00560, 00566, 00580, 00600, 00604, 00620, 00622, 00625, 00626, 00630, 00632, 00634, 00635, 00640, 00670, 00700, 00702, 00730, 00740, 00750, 00752, 00754, 00756, 00770, 00790, 00792, 00794, 00796, 00797, 00800, 00802, 00810, 00820, 00830, 00832, 00834, 00836, 00840, 00842, 00844, 00846, 00848, 00851, 00860, 00862, 00864, 00865, 00866, 00868, 00870, 00872, 00873, 00880, 00882,

00902, 00904, 00906, 00908, 00910, 00912, 00914, 00916, 00918, 00920, 00921, 00922, 00924, 00926, 00928, 00930, 00932, 00934, 00936, 00938, 00940, 00942, 00944, 00948, 00950, 00952, 01112, 01120, 01130, 01140, 01150, 01160, 01170, 01173, 01180, 01190, 01200, 01202, 01210, 01212, 01214, 01215, 01220, 01230, 01232, 01234, 01250, 01260, 01270, 01272, 01274, 01320, 01340, 01360, 01380, 01382, 01390, 01392, 01400, 01402, 01404, 01420, 01430, 01432, 01440, 01442, 01444, 01462, 01464, 01470, 01472, 01474, 01480, 01482, 01484, 01486, 01490, 01500, 01502, 01520, 01522, 01610, 01620, 01622, 01630, 01634, 01636, 01638, 01650, 01652, 01654, 01656, 01670, 01680, 01682, 01710, 01712, 01714, 01716, 01730, 01732, 01740, 01742, 01744, 01756, 01758, 01760, 01770, 01772, 01780, 01782, 01810, 01820, 01829, 01830, 01832, 01840, 01842, 01844, 01850, 01852, 01860, 01924, 01925, 01926, 01930, 01931, 01932, 01933, 01935, 01936, 01951, 01952, 01961, 01962, 01963, 01965, 01966, 01968, 01969

NUMERATOR:

Patients for whom *either*

- Active warming was used intraoperatively for the purpose of maintaining normothermia
  OR
- At least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) was recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

Numerator Instructions: The anesthesia time used for this measure should be the time recorded in the anesthesia record.

Definition:
For purposes of this measure, **"active warming"** – is limited to over-the-body active warming (e.g., forced air, warm-water garments, and resistive heating blankets).

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Active Warming Used Intraoperatively OR At Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Recorded Within Designated Timeframe

*(Two CPT II codes [*4250F & 4255F*] are required on the claim form to submit this numerator option)*

CPT II 4250F: Active warming used intraoperatively for the purpose of maintaining normothermia, OR at least one body temperature equal to or greater than 36 degrees Centigrade (or 96.8 degrees Fahrenheit) recorded within the 30 minutes immediately before or the 15 minutes immediately after anesthesia end time

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade not Achieved Within Designated Timeframe for one of the following Medical Reasons:

*(Two CPT II codes [*4250F-1P & 4255F*] are required on the claim form to submit this numerator option)*

Append a modifier (**1P**) to CPT Category II code **4250F** to report one of the following documented circumstances that appropriately exclude patients from the denominator.

4250F *with* 1P: Intentional hypothermia OR active warming not indicated due to anesthetic technique: peripheral nerve block without general anesthesia, OR monitored anesthesia care

AND

CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

OR

If patient does not meet denominator inclusion because anesthesia time as indicated on the anesthesia record is less than 60 minutes duration (including anesthesia services provided using monitored anesthesia care [MAC] or peripheral nerve block [PNB] less than 60 minutes duration):
(One CPT II code [4256F] is required on the claim form to submit this numerator option)
CPT II 4256F: Duration of general or neuraxial anesthesia less than 60 minutes, as documented in the anesthesia record

OR

Active Warming Not Performed OR at Least One Body Temperature Equal to or Greater than 36 Degrees Centigrade Not Achieved Within Designated Timeframe, Reason Not Otherwise Specified
(Two CPT II codes [4250F-8P & 4255F] are required on the claim form to submit this numerator option)
Append a reporting modifier (**8P**) to CPT Category II code **4250F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4250F *with* 8P: Active warming **not performed** OR at least one body temperature equal to or greater than 36 degrees Centigrade **not achieved** within designated timeframe, reason not otherwise specified

AND
CPT II 4255F: Duration of general or neuraxial anesthesia 60 minutes or longer, as documented in the anesthesia record

RATIONALE:
Anesthetic-induced impairment of thermoregulatory control is the primary cause of perioperative hypothermia. Even mild hypothermia (1-2°C below normal) has been associated in randomized trials with a number of adverse consequences, including: increased susceptibility to infection, impaired coagulation and increased transfusion requirements, cardiovascular stress and cardiac complications, post-anesthetic shivering and thermal discomfort. Whether the benefits of avoiding hypothermia in patients undergoing cardiopulmonary bypass (CPB) outweigh potential harm is uncertain, because known complications of CPB include cerebral injury, which may be mitigated by mild hypothermia. Therefore, patients undergoing CPB are excluded from the denominator population for this measure. Several methods to maintain normothermia are available to the anesthesiologist in the perioperative period; various studies have demonstrated the superior efficacy of over-the-body active warming (e.g., forced air, warm-water garments, and resistive heating blankets). Data elements required for the measure can be captured and the measure is actionable by the physician.

Existing hospital-level measures for this topic were consulted and, to the extent feasible, harmonization between physician- and hospital-level measurement was achieved.

CLINICAL RECOMMENDATION STATEMENTS:
Preoperative patient management
Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Measure patient temperature on admission. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities).
Interventions: Institute preventive warming measures for patients who are normothermic (normothermia is defined as a core temperature range from 36°C-38°C [96.8°F-100.4°F]). A variety of measures may be used, unless contraindicated. Passive insulation may include warmed cotton blankets, socks, head covering, limited skin exposure, circulating water mattresses, and increase in ambient room temperature (minimum 68ºF- 75ºF). Institute active warming measures for patients who are hypothermic (defined as a core temperature less than 36°C). Active warming is the application of a forced air convection warming system. Apply appropriate passive insulation and increase the ambient room temperature (minimum 68ºF-75ºF). Consider warmed intravenous (IV) fluids. (ASPAN)

Intraoperative patient management

Assessment: Identify patient's risk factors for unplanned perioperative hypothermia. Determine patient's thermal comfort level (ask the patients if they are cold). Assess for other signs and symptoms of hypothermia (shivering, piloerection, and/or cold extremities). Monitor patient's temperature intraoperatively.
Intervention: Implement warming methods. (ASPAN)
Maintenance of body temperature in a normothermic range is recommended for most procedures other than during periods in which mild hypothermia is intended to provide organ protection (e.g., during high aortic cross-clamping). (Class I Recommendation, Level of Evidence B) (ACC/AHA)

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

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

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.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

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****.*

Numerator 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 reason)

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

RATIONALE:
There is good evidence that tobacco screening and brief cessation intervention (including counseling and pharmacotherapy) in the primary care setting is successful in helping tobacco users quit. (USPSTF, 2003) Tobacco users who are able to stop smoking lower their risk for heart disease, lung disease, and stroke. (USPSTF, 2003)

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

The USPSTF strongly recommends that clinicians screen all adults for tobacco use and provide tobacco cessation interventions for those who use tobacco products. (A Recommendation) (USPSTF, 2003)

During new patient encounters and at least annually, patients in general and mental healthcare settings should be screened for at-risk drinking, alcohol use problems and illnesses, and any tobacco use. (NQF, 2007)

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 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 & 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 & 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 & Human Services-Public Health Service, 2008)