

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

### DESCRIPTION:

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

### INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months.

The most recent quality code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

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

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service codes or G-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- reasons not otherwise specified.

### NUMERATOR:

Patients with most recent hemoglobin A1c level > 9.0%

Numerator Instructions: This is a poor control measure. A lower rate indicates better performance (e.g., low rates of poor control indicate better care)

#### Numerator Coding:

Most Recent Hemoglobin A1c Level > 9.0%

CPT II 3046F: Most recent hemoglobin A1c level > 9.0%

OR

If patient is not eligible for this measure because hemoglobin A1c not performed, report:

Hemoglobin A1c not Performed

Append a reporting modifier (8P) to CPT Category II code 3046F to report circumstances when the patient is not eligible for the measure.

8P: Hemoglobin A1c level was not performed during the performance period (12 months)

OR

Most Recent Hemoglobin A1c Level 7.0 to 9.0%  
CPT II 3044F: Most recent hemoglobin A1c (HbA1c) level < 7.0%  
OR CPT II 3045F: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

**DENOMINATOR:**

Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Coding:

An ICD-9 diagnosis code for diabetes and a CPT E/M service code or G-code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04

AND

CPT E/M service codes or G-codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

**RATIONALE:**

Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.

**CLINICAL RECOMMENDATION STATEMENTS:**

A glycosylated hemoglobin should be performed during an initial assessment and during follow-up assessments, which should occur at no longer than three-month intervals. (AACE/ACE) The A1c should be universally adopted as the primary method of assessment of glycemic control. On the basis of data from multiple interventional trials, the target for attainment of glycemic control should be A1c values  $\leq 6.5\%$ . (AACE/ACE)

Obtain a glycosylated hemoglobin during an initial assessment and then routinely as part of continuing care. In the absence of well-controlled studies that suggest a definite testing protocol, expert opinion recommends glycosylated hemoglobin be obtained at least twice a year in patients who are meeting treatment goals and who have stable glycemic control and more frequently (quarterly assessment) in patients whose therapy was changed or who are not meeting glycemic goals. (Level of evidence: E) (ADA)

Because different assays can give varying glycated hemoglobin values, the ADA recommends that laboratories only use assay methods that are certified as traceable to the Diabetes Control and Complications Trial A1c reference method. The ADA's goal for glycemic control is A1c  $< 7\%$ . (Level of evidence: B) (ADA)

Monitor and treat hyperglycemia, with a target A1c of 7%, but less stringent goals for therapy may be appropriate once patient preferences, diabetes severity, life expectancy and functional status have been considered. (AGS)

## **Measure #64: Asthma Assessment**

### DESCRIPTION:

Percentage of patients aged 5 through 40 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

### INSTRUCTIONS:

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

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

When reporting the measure, submit the listed ICD-9 diagnosis codes, CPT E/M service 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- reasons not otherwise specified. There are no allowable performance exclusions for this measure.

### NUMERATOR:

Patients who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms

Numerator Instructions: To be counted in calculation of this measure, symptom frequency must be numerically quantified. Measure may also be met by clinician documentation or patient completion of an asthma assessment tool/survey/questionnaire.

Assessment tool may include the Quality Metric Asthma Control Test™, National Asthma Education & Prevention Program (NAEPP) Asthma Symptoms, and Peak Flow Diary.

### Numerator Coding:

Asthma Symptom Frequency Evaluated

CPT II 1005F: Asthma symptoms evaluated (includes physician documentation of numeric frequency of symptoms or patient completion of an asthma assessment tool/survey/questionnaire)

OR

Asthma Symptom Frequency not Evaluated, Reason not Specified  
Append a reporting modifier (8P) to CPT Category II code 1005F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

8P: Asthma symptoms not evaluated, reason not otherwise specified

**DENOMINATOR:**

All patients aged 5 through 40 years with a diagnosis of asthma  
Denominator Coding:

An ICD-9 diagnosis code for asthma and a CPT E/M service code are required to identify patients for denominator inclusion.

ICD-9 diagnosis codes: 493.00, 493.01, 493.02, 493.10, 493.11, 493.12, 493.20, 493.21, 493.22, 493.81, 493.82, 493.90, 493.91, 493.92

AND

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

**RATIONALE:**

Appropriate treatment of asthma patients requires accurate classification of asthma severity. Physician assessment of the frequency of asthma symptoms is the first step in classifying asthma severity.

**CLINICAL RECOMMENDATION STATEMENTS:**

To determine whether the goals of therapy are being met, monitoring is recommended in the 6 areas listed below:

- Signs and symptoms (daytime; nocturnal awakening) of asthma
- Pulmonary function (spirometry; peak flow monitoring)
- Quality of life/functional status
- History of asthma exacerbations
- Pharmacotherapy (as-needed use of inhaled short-acting beta2-agonist, adherence to regimen of long-term-control medications)
- Patient-provider communication and patient satisfaction (NAEPP/NHLBI)

**Measure #110: Influenza Vaccination for Patients \_ 50 Years Old**

**DESCRIPTION:**

Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February)

### INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. This measure is intended to determine whether or not all patients aged 50 years and older received or had an order for influenza immunization during the flu season. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure specific denominator coding.

This measure is reported using G-codes:

CPT E/M service codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

### NUMERATOR:

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

Numerator Coding:

Influenza Immunization Administered

G8482: Influenza immunization was ordered or administered

OR

Influenza Immunization not Administered for Documented Reasons

G8483: Influenza immunization was not ordered or administered for reasons documented by clinician

OR

Influenza Immunization not Administered, Reason not Specified

G8484: Influenza immunization was not ordered or administered, reason not specified

### DENOMINATOR:

All patients aged 50 years and older

Denominator Coding:

A CPT E/M service code is required to identify patients for denominator inclusion.

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

### RATIONALE:

Influenza vaccination has shown to decrease hospitalizations for influenza, especially with risk factors, however annual influenza vaccination rates remain low.

## CLINICAL RECOMMENDATION STATEMENTS:

Annual influenza immunization is recommended for all groups who are at increased risk complications from influenza including persons aged > 50 years. (CDC, USPSTF)

## Measure #112: Screening Mammography

### DESCRIPTION:

Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months

### INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for female patients seen during the reporting period. There is no diagnosis associated with this measure. Breast cancer screening is to be performed at least once within 24 months prior to the date of service. Performance for this measure is not limited to 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.

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

When reporting the measure, submit the listed CPT E/M service 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- reasons not otherwise specified.

### NUMERATOR:

Patients who had a mammogram at least once within 24 months

#### Numerator Coding:

Mammogram Performed

CPT II 3014F: Screening mammography results documented and reviewed

OR

Mammogram not Performed for Medical Reasons

Append a modifier (1P) to the above CPT Category II code 3014F to report documented circumstances that appropriately exclude patients from the denominator

1P: Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies).

OR

Mammogram not Performed, Reason not Specified

Append a reporting modifier (8P) to CPT Category II code 3014F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

8P: Screening mammography results were not documented and reviewed, reason not otherwise specified

## **Measure #115: Advising Smokers to Quit**

### DESCRIPTION:

Percentage of patients aged 18 years and older and are smokers who received advice to quit smoking

### INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for all patients (whether or not they use tobacco) seen during the reporting period. There is no diagnosis associated with this measure. This measure is appropriate for use in all healthcare settings. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This measure is reported using G-codes:

CPT E/M service codes and patient demographics (age, gender, etc.) are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

When reporting the measure, submit the appropriate denominator code(s) and the appropriate numerator G-code.

### NUMERATOR:

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

Numerator Coding:

Identify Tobacco Smokers Receiving Cessation Intervention

(Two G-codes [G8455 & G8402] are required on the claim form to submit this category)

G8455: Current tobacco smoker

AND

G8402: Tobacco (smoke) use cessation intervention, counseling

OR

If patient is not eligible for this measure because patient is a smokeless tobacco

user or a non tobacco user, report:

(One G-code [G84\_\_F] is required on the claim form to submit this category)

Smokeless Tobacco User

G8456: Current smokeless tobacco user

OR

Tobacco Non-User

G8457: Tobacco non-user

OR

Tobacco Smokers not Advised to Quit, Reason not Specified

(Two G-codes [G8455 & G8403] are required on the claim form to submit this category)

G8455: Current tobacco smoker

AND

G8403: Tobacco (smoke) use cessation intervention not counseled

#### DENOMINATOR:

All patients aged 18 years and older

Denominator Coding:

A CPT E/M service code is required to identify patients for denominator inclusion.

CPT E/M service codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99241, 99242, 99243, 99244, 99245

#### RATIONALE:

Interventions to control smoking are strategically important because smoking is the leading preventable cause of death in the United States, clinical interventions are known to be effective in increasing cessation rates, and quitting smoking has been shown to improve health outcomes (Fiore, 2000)

#### CLINICAL RECOMMENDATION STATEMENTS:

The Clinical Practice Guidelines: Treating tobacco use and dependence published by USDHHS Public Health Service (Fiore, 2002) provide convincing empirical support for providing advice to and assistance with quitting smoking for patients who smoke.

Specifically, these guidelines recommend:

1) repeated advice and support at all or most visits, and

2) delivery of cessation assistance and follow-up at all or most visits.

There have been more than 12 million premature deaths attributable to smoking since the first published Surgeon General's report on smoking and health in 1964. Smoking remains the leading preventable cause of premature death in the United States. Nearly every organ in the body is affected by smoking (USDHHS, 2004). Smoking causes many diseases and reduces the health of smokers in general. The list of diseases caused by smoking has been expanded to include abdominal aortic aneurysm, acute myeloid leukemia, cataract, cervical cancer, kidney cancer, pancreatic cancer, pneumonia, periodontitis, and stomach cancer



(USDHHS, 2004).

In the US in 2003, 45.4 million adults (21.6 percent) were current smokers—24.1 percent of men and 19.2 percent of women (CDC, 2005a). An estimated 70% of these smokers said they wanted to quit (CDC, 2005a).

An estimated 45.9 million adults were former smokers in 2003, representing 50.3 percent of those who had ever smoked (CDC, 2005a). For the second consecutive year, more adults had quit than were still smoking. A large number of clinical trials have demonstrated the effectiveness of counseling in increasing cessation rates, and the effectiveness of bupropion and NRT has been demonstrated (Fiore, 2000). A meta-analysis of 7 studies found that physician advice to quit is associated with a 30% increase in cessation rates (Fiore, 2000). Counseling and medication are each associated with a doubling of cessation rates (Fiore, 2000).