

2009 PQRI Measures – Rheumatology

Measure 24 (OP): Communication with the Physician Managing Ongoing Care Post Fracture

Reporting options: Claims-based and Registry

All patients aged 50 years and older treated for hip, spine, or distal radial fracture

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215, (office – established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
22305, 22310, 22315, 22318, 22319, 22325, 22326, 22327, 22520, 22521, 22523, 22524 (vertebral procedure)
25600, 25605, 25606, 25607, 25608, 25609 (radial procedure)
27230, 27232, 27235, 27236 27238, 27240, 27240, 27244, 27245, 27246, 27248(femoral procedure)

Numerator: 5015F - Documentation of communication that a fracture occurred and that the (CPT II) patient was or should be tested or treated for osteoporosis

Modifier: 1P - Documentation of **medial** reason(s) for **not** communicating with physician managing ongoing care of patient that a fracture occurred and that the patient was or should be tested or treated for osteoporosis

2P - Documentation of **patient** reason(s) for **not** communicating that a fracture occurred and that the patient was or should be tested or treated for osteoporosis with physician managing on-going care of patient

8P - **No** documentation of communication that a fracture occurred and that the patient was or should be tested or treated for osteoporosis, reason **not** otherwise specified

ICD-9: 733.12, 733.13, 733.14 (pathologic fracture)
805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, (cervical fracture)
805.2 (dorsal – thoracic fracture)
805.4 (lumbar fracture)
805.6, 805.8 (sacrum and coccyx fracture)
813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54 (radius and ulna fracture)
820.00, 820.01, 820.02, 820.03, 820.09, 820.20, 820.21, 820.22, 820.8, (femur fracture)

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

Reporting options: Claims-based, Registry, and Measure Group

All female patients aged 65 years and older

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office – established patient)

Numerator: G8399 – Patient with Central Dual-energy X-ray Absorptiometry (DXA) results (CPT II) documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

G8401 – Clinician documented that patient was **not** an eligible candidate for screening or therapy for osteoporosis for women measure

G8400 – Patient with central Dual-energy X-ray Absorptiometry (DXA) results not documented or not ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis **not** prescribed

Measure 40 (OP): Osteoporosis: Management Following Fracture

Reporting options: Claims-based and Registry

All patients aged 50 years and older with a fracture of the hip, spine, or distal radius

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office – established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
22305, 22310, 22315, 22318, 22319, 22326, 22327 (fracture or dislocation-spine)
22520, 22521, 22523, 22524, (vertebral body, embolization or injection)
25600, 25605, 25606, 25607, 25608, 25609 (fracture or dislocation- forearm or wrist)
27230, 27232, 27235, 27236, 27238, 27240, 27244, 27246,
27248 (fracture or dislocation – pelvis or hip joint)

Numerator: 3095F – Central dual energy X-ray absorptiometry (DXA) results documented (CPT II)

3096F – Central dual energy X-ray absorptiometry (DXA) ordered

4005F – Pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed

Modifier: 1P – Documentation of **medical** reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or **not** prescribing pharmacologic therapy for osteoporosis

Measure 40 continued:

2P - Documentation of **patient** reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or **not** prescribing pharmacologic therapy for osteoporosis

3P - Documentation of **system** reason(s) for not ordering or performing a central dual energy X-ray absorptiometry (DXA) measurement or **not** prescribing pharmacologic therapy for osteoporosis

8P – Central dual energy X-ray absorptiometry (DXA) measurement was **not** ordered or performed and a pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

ICD-9: 733.12, 733.13, 733.14 (pathologic fracture)
805.00, 805.01, 805.02, 805.03, 805.04, 805.05, 805.06, 805.07, 805.08, (cervical fracture)
805.2 (dorsal – thoracic fracture)
805.4 (lumbar fracture)
805.6, 805.8 (sacrum and coccyx fracture)
813.40, 813.41, 813.42, 813.44, 813.45, 813.50, 813.51, 813.52, 813.54 (radius and ulna fracture)
820.00, 820.01, 820.02, 820.03, 820.09, 820.10, 820.11, 820.13, 820.20, 820.21, 820.22, 820.8, 820.9 820.20, 820.21, 820.22, 820.8, (femur fracture)

Measure 41(OP): Pharmacologic Therapy

Reporting options: Claims-based and Registry

All patients aged 50 years and older with the diagnosis of osteoporosis

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office – established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)

Numerator: 4005F – Pharmacologic therapy (other than minerals/vitamins) for osteoporosis (CPT II) prescribed

Modifier: 1P- Documentation of **medical** reason(s) for **not** prescribing pharmacologic therapy for osteoporosis

2P - Documentation of **patient** reason(s) for **not** prescribing pharmacologic therapy for osteoporosis

3P - Documentation of **system** reason(s) for not prescribing pharmacologic therapy for osteoporosis

Measure 41: continued

8P – Pharmacologic therapy for osteoporosis was not prescribed, reason not otherwise specified

ICD-9: 733.00, 733.01, 733.02, 733.03, 733.09 (osteoporosis)

Measure 108: Rheumatoid Arthritis (RA): Disease Modifying Anti-rheumatic Drug Therapy in Rheumatoid Arthritis

Reporting options: Claims-based, Registry, Measure Group

All patients aged 18 years and older with a diagnosis of rheumatoid Arthritis

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99211, 99212, 99213, 99214, 99215 (office – established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
99341, 99342, 99343, 99344, 99345 (home services – new patient)
99347, 99348, 99349, 99350 (home services – established patient)
99455, 99456 (work related or medical disability services)

Numerator: 4187F – Disease modifying anti-rheumatic drug therapy prescribed, dispensed, or administered (CPT II)

Modifier: 1P – Documentation of medical reason(s) for **not** prescribing, dispensing, or administering disease modifying anti-rheumatic drug therapy

8P - DMARD not prescribed, dispensed, or administered, reason **not** specified

ICD-9: 714.0, 714.1, 714.2, 714.81 (rheumatoid arthritis and other inflammatory polyarthropathies)

Measure 109: Osteoarthritis (OA): Function and Pain Assessment

Reporting options: Claims-based, and Registry

Patients aged ≥ 21 years on date of encounter

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office – established patient)
99241, 99242, 99243, 99244, 99245, (outpatient consult)

Measure 109: continued

Numerator: 1006F – Osteoarthritis symptoms and functional status assessed (may include the use of a standardized scale or the completion of an assessment questionnaire, such as an SF-36, AAOS Hip & Knee Questionnaire)
(CPT II)

Modifier: 8P – Osteoarthritis symptoms and functional status **not** assessed, reason **not** specified

ICD-9: 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98 (osteoarthrosis and allied disorders)

Measure 124: Health Information Technology (HIT): Adoption/Use of Electronic Health Information (EHR)

*Reporting options: Claims-based, and Registry
All patients over 18 on date of encounter*

CPT: 90801, 90802 (psychiatric diagnostic interview)
90804, 90805, 90806, 90807, 90808, 90809 (psychiatric therapeutic)
92002, 92004 (ophthalmological services – new patient)
92012, 92014 (ophthalmological services – established patient)
92541, 92542, 92543, 92544, 92548, (vestibular function tests)
92552, 92553, 92555, 92557, 92561, 92563, 92564, 92565
92567, 92568, 92569, 92577, 92579, 92582, 92584, 92586
92587, 92588, (audiologic function tests)
92601, 92602, 92603, 92604, 92620, 92621, 92625, 92625
92626, 92627 (evaluation and therapeutic services)
92640 (special diagnostic procedures)
95920, 96150, 96151, 96152 (health and behavior assessment)
97001, 97002, 97003, 97004 (physical therapy)
97750 (physical performance measure)
97802, 97803, 97804 (medical nutrition therapy)
98940, 98941, 98942 (chiropractic manipulative treatment)
99201, 99202, 99203, 99204, 99205 (office – new patient)
99211, 99212, 99213, 99214, 99215 (office – established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
D7140, D7210 (extraction)
G0101, G0108, G0109, G0270, G0271 (procedures/professional services)

Numerator: G8447 – Patient encounter was documented using a CCHIT certified EMR
(CPT II)

Measure 124: continued

G8448 – Patient encounter was documented using a non-CCHIT certified EMR.

To qualify, the system must be capable of all of the following:

- Generating a medication list
- Generating a problem list
- Entering laboratory tests as discrete searchable data elements

Measure 131: Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up

Reporting options: Claims-based, and Registry

All patients aged 18 years and older

CPT: 90801, 90802 (psychiatric diagnostic interview)
96116 (central Nervous system assessment)
96150 (health and behavior assessment)
97001, 97003 (physical therapy)
98940, 98941, 98942 (chiropractic manipulative treatment)

Numerator: G8440 – Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool AND a follow-up plan is documented

G8441 – **No** documentation of pain assessment (including location, intensity and description) prior to initiation of treatment

G8442 – Documentation that patient is **not** eligible for pain assessment

G8508 – Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; no documentation of a follow-up plan, patient not eligible

G8509 – Documentation of pain assessment (including location, intensity and description) prior to initiation of treatment or documentation of the absence of pain as a result of assessment through discussion with the patient including the use of a standardized tool; **no** documentation of a follow-up plan, reason not specified

Measure 142: Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications

Reporting options: Claim-based and Registry

All visits for patients age 21 years and older with OA

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office – established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)

Numerator: 1007F – Use of anti-inflammatory or analgesic over-the-counter (OTC) (CPT II) medications for symptom relief assessed

Modifier: 8P - Use of anti-inflammatory or analgesic (OTC) medications **not** assessed, Reason not otherwise specified

ICD-9: 715.00, 715.04, 715.09, 715.10, 715.11, 715.12, 715.13, 715.14, 715.15, 715.16, 715.17, 715.18, 715.20, 715.21, 715.22, 715.23, 715.24, 715.25, 715.26, 715.27, 715.28, 715.30, 715.31, 715.32, 715.33, 715.34, 715.35, 715.36, 715.37, 715.38, 715.80, 715.89, 715.90, 715.91, 715.92, 715.93, 715.94, 715.95, 715.96, 715.97, 715.98 (Osteoarthrosis and allied disorders)

Measure 148: Back Pain: Initial Visit

Reporting options: Measure Group only

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

CPT: 98940, 98941, 98942 (Chiropractic manipulative treatment)
99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
22210, 22214, 22220, 22222, 22224, 22226, (osteotomy of spine)
22532, 22533, 22534 (percutaneous vertebral augmentation)
22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600
22612, 22614, 22630, 22632 (arthrodesis)
22818, 22819 (kyphectomy)
22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846
22847, 22848, 22849 (spinal fixation)
63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017
63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045
63046, 63047, 63048 (laminotomy)

Measure 148: continued

63055, 63056, 63057, (transpedicular decompression)
63064, 63066 (costovertebral decompression)
63075, 63076, 63077, 63078 (discectomy)
63081, 63082, 63085, 63086, 63087, 63088, 63090,
63091 (vertebral corpectomy anterior or anterolateral approach)
63101, 63102, 63103 (vertebral corpectomy lateral extracavitary approach)
63170, 63172, 63173, 63180, 63185, 63190, 63194
63195, 63196, 63197, 63198, 63199, 63200 (laminectomy)

Numerator: 1130F – Back pain and function assessed, including all of the following:
(CPT II) Pain assessment AND functional status AND patient history,
including notation of presence or absence of “red flags” (warning
signs) AND assessment of prior treatment and response, AND
employment status

0526F – Subsequent visit for episode

Modifier: 8P – Back pain and function was **not** assessed during the initial visit, reason
not otherwise specified

ICD-9: 721.3, 721.41, 721.42, 721.90 (spondylosis and allied disorders)
722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39
722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.80
722.81, 722.82, 722.83, 722.90, 722.91, 722.92
722.93 (intervertebral disc disorders)
723.0 (other disorders of cervical region)
724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5
724.6, 724.70, 724.71, 724.79 (spinal stenosis, other than cervical)
738.4, 738.5 (other acquired deformity)
739.3, 739.4 (nonallopathic lesions, not elsewhere classified)
756.12 (anomalies of spine)
846.0, 846.1, 846.2, 846.3, 846.8, 846.9 (sprains and strains of sacroiliac region)
847.2 (sprains and strains of other and unspecified parts of back)

Measure 149: Back Pain: Physical Exam

Reporting options: Measure Group only

***Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the
clinician for the episode***

CPT: 98940, 98941, 98942 (Chiropractic manipulative treatment)
99201, 99202, 99203, 99204, 99205 (office – new patient)

Measure 149: continued

99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
22210, 22214, 22220, 22222, 22224, 22226, (osteotomy of spine)
22532, 22533, 22534 (percutaneous vertebral augmentation)
22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600
22612, 22614, 22630, 22632 (arthrodesis)
22818, 22819 (kyphectomy)
22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846
22847, 22848, 22849 (spinal fixation)
63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017
63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045
63046, 63047, 63048 (laminotomy)
63055, 63056, 63057, (transpedicular decompression)
63064, 63066 (costovertebral decompression)
63075, 63076, 63077, 63078 (discectomy)
63081, 63082, 63085, 63086, 63087, 63088, 63090,
63091 (vertebral corpectomy anterior or anterolateral approach)
63101, 63102, 63103 (vertebral corpectomy lateral extracavitary approach)
63170, 63172, 63173, 63180, 63185, 63190, 63194
63195, 63196, 63197, 63198, 63199, 63200 (laminectomy)

Numerator: 2040F - Physical examination on the date of the initial visit for low back (CPT II) pain performed, in accordance with specifications

0526F - Subsequent visit for episode

Modifier: 8P – Physical exam was **not** performed during the initial visit, reason not otherwise specified

ICD-9: 721.3, 721.41, 721.42, 721.90 (spondylosis and allied disorders)
722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39
722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.80
722.81, 722.82, 722.83, 722.90, 722.91, 722.92
722.93 (intervertebral disc disorders)
723.0 (other disorders of cervical region)
724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5
724.6, 724.70, 724.71, 724.79 (spinal stenosis, other than cervical)
738.4, 738.5 (other acquired deformity)
739.3, 739.4 (nonallopathic lesions, not elsewhere classified)
756.12 (anomalies of spine)
846.0, 846.1, 846.2, 846.3, 846.8, 846.9 (sprains and strains of sacroiliac region)
847.2 (sprains and strains of other and unspecified parts of back)

Measure 150: Back Pain: Advice for Normal Activities

Reporting options: Measure Group only

Patients aged 18 through 79 years with a diagnosis of back pain at the initial visit to the clinician for the episode

CPT: 98940, 98941, 98942 (Chiropractic manipulative treatment)
99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
22210, 22214, 22220, 22222, 22224, 22226, (osteotomy of spine)
22532, 22533, 22534 (percutaneous vertebral augmentation)
22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600
22612, 22614, 22630, 22632 (arthrodesis)
22818, 22819 (kyphectomy)
22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846
22847, 22848, 22849 (spinal fixation)
63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017
63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045
63046, 63047, 63048 (laminotomy)
63055, 63056, 63057, (transpedicular decompression)
63064, 63066 (costovertebral decompression)
63075, 63076, 63077, 63078 (discectomy)
63081, 63082, 63085, 63086, 63087, 63088, 63090,
63091 (vertebral corpectomy anterior or anterolateral approach)
63101, 63102, 63103 (vertebral corpectomy lateral extracavitary approach)
63170, 63172, 63173, 63180, 63185, 63190, 63194
63195, 63196, 63197, 63198, 63199, 63200 (laminectomy)

Numerator: 4245F – Patient counseled during the initial visit to maintain or resume (CPT II) normal activities

0526F – Subsequent visit for the episode

Modifier: 8P – Advice for normal activities **not** performed during the initial visit, reason not otherwise specified

ICD-9: 721.3, 721.41, 721.42, 721.90 (spondylosis and allied disorders)
722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39
722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.80
722.81, 722.82, 722.83, 722.90, 722.91, 722.92
722.93 (intervertebral disc disorders)
723.0 (other disorders of cervical region)
724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5
724.6, 724.70, 724.71, 724.79 (spinal stenosis, other than cervical)

Measure 150: continued

738.4, 738.5 (other acquired deformity)
739.3, 739.4 (nonallopathic lesions, not elsewhere classified)
756.12 (anomalies of spine)
846.0, 846.1, 846.2, 846.3, 846.8, 846.9 (sprains and strains of sacroiliac region)
847.2 (sprains and strains of other and unspecified parts of back)

Measure 151: Back Pain: Advice Against Bed Rest

Reporting options: Measure Group only

Patients aged 18 through 79 years on date of encounter

CPT: 98940, 98941, 98942 (Chiropractic manipulative treatment)
99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
22210, 22214, 22220, 22222, 22224, 22226, (osteotomy of spine)
22532, 22533, 22534 (percutaneous vertebral augmentation)
22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600
22612, 22614, 22630, 22632 (arthrodesis)
22818, 22819 (kyphectomy)
22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846
22847, 22848, 22849 (spinal fixation)
63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017
63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045
63046, 63047, 63048 (laminotomy)
63055, 63056, 63057, (transpedicular decompression)
63064, 63066 (costovertebral decompression)
63075, 63076, 63077, 63078 (discectomy)
63081, 63082, 63085, 63086, 63087, 63088, 63090,
63091 (vertebral corpectomy anterior or anterolateral approach)
63101, 63102, 63103 (vertebral corpectomy lateral extracavitary approach)
63170, 63172, 63173, 63180, 63185, 63190, 63194
63195, 63196, 63197, 63198, 63199, 63200 (laminectomy)

Numerator: 4248F – Patient counseled during the initial visit for an episode of back pain (CPT II) against rest lasting 4 days or longer

0526F – Subsequent visit for episode

Modifier: 8P – Advice against bed rest was **not** performed during the initial visit, reason not otherwise specified

Measure 151: continued

ICD-9: 721.3, 721.41, 721.42, 721.90 (spondylosis and allied disorders)
722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39
722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.80
722.81, 722.82, 722.83, 722.90, 722.91, 722.92
722.93 (intervertebral disc disorders)
723.0 (other disorders of cervical region)
724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5
724.6, 724.70, 724.71, 724.79 (spinal stenosis, other than cervical)
738.4, 738.5 (other acquired deformity)
739.3, 739.4 (nonallopathic lesions, not elsewhere classified)
756.12 (anomalies of spine)
846.0, 846.1, 846.2, 846.3, 846.8, 846.9 (sprains and strains of sacroiliac region)
847.2 (sprains and strains of other and unspecified parts of back)

Measure 154: Falls: Risk Assessment

Reporting options: Claim-based and Registry

All patients aged 65 years and older who have a history of falls

CPT: 97001, 97002, 97003, 97004 (physical therapy)
99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
99304, 99305, 99306 (initial nursing facility care)
99307, 99308, 99309, 99310 (subsequent nursing facility care)
99324, 99325, 99326, 99327, 99328 (domiciliary, rest home care – new patient)
99334, 99335, 99336, 99337 (domiciliary, rest home care – established patient)
99341, 99342, 99343, 99344, 99345 (home services – new patient)
99347, 99348, 99349, 99350 (home services - established patient)

Two CPT II codes are required on the claim form to submit this numerator options

Numerator: 3288F - Falls risk assessment documented
(CPT II)

1100F – Patient screened for future fall risk; documentation of two or more
falls in the past year or any fall with injury in the past year
➤ If **YES** also report Measure #154

Modifier: 1P – Documentation of medical reason(s) for **not** completing a risk assessment
for falls

8P – **No** documentation of falls status

Measure 155: Falls: Plan of Care

Reporting options: Claims-based, Registry

All patients aged 65 years and older who have a history of falls

This is a two-part measure which is paired with Measure #154: Falls Risk Assessment. This measure should be reported if CPTII code 1100F “Patient screened for future falls risk; documentation of two or more falls in the past year or any fall with injury in the past year” is submitted for Measure #154.

CPT: 97001, 97002, 97003, 97004 (physical therapy)
99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
99304, 99305, 99306 (initial nursing facility care)
99307, 99308, 99309, 99310 (subsequent nursing facility care)
99324, 99325, 99326, 99327, 99328 (domiciliary, rest home care – new patient)
99334, 99335, 99336, 99337 (domiciliary, rest home care – established patient)
99341, 99342, 99343, 99344, 99345 (home services – new patient)
99347, 99348, 99349, 99350 (home services - established patient)

Numerator: 0518F – Falls plan of care documented
(CPT II)

Modifier: 1P – Documentation of medical reason(s) for **no** plan of care for falls

8P – Plan of care **not** documented, reason not otherwise specified

Measure 176: Rheumatoid Arthritis (RA): Tuberculosis Screening

Reporting options: Claims-based, Registry, Measure Group

All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA) who are receiving a first course of therapy using a biologic DMARD

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
99341, 99342, 99343, 99344, 99345 (home services – new patient)
99347, 99348, 99349, 99350 (home services - established patient)
99455, 99456 (work related or medical disability evaluation services)

Measure 176: continued

Two CPT II codes may be required on the claim form to submit this numerator options

Numerator: 4195F – Patient receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis (CPTII)

- If answer is **NO** report **4196F** and stop
- If answer is **YES** report **4195F** and **3455F**

4196F – Patient **not** receiving first-time biologic disease modifying anti-rheumatic drug therapy for rheumatoid arthritis

3455F – TB screening performed and results interpreted within six months prior to initiation of first-time biologic disease modifying anti-rheumatic drug therapy for RA

Modifier: 1P – Documentation of medical reason for not screening for TB or interpreting results (i.e., patient positive for TB and documentation of past treatment; patient has recently completed a course of anti-TB therapy)

8P – TB screening **not** performed or results **not** interpreted, reason not otherwise specified

ICD-9: 714.0, 714.1, 714.2
714.81 (rheumatoid arthritis and other inflammatory polyarthropathies)

Measure 177: Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity

Reporting options: Claims-based, Registry, and Measures Group

All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
99341, 99342, 99343, 99344, 99345 (home services – new patient)
99347, 99348, 99349, 99350 (home services - established patient)
99455, 99456 (work related or medical disability evaluation services)

Numerator: 3470F – Rheumatoid arthritis (RA) disease activity, low (CPT II)

3471F – Rheumatoid arthritis (RA) disease activity, moderate

3472F – Rheumatoid arthritis (RA) disease activity, high

Measure 177: continued

Modifier: 8P – Disease activity **not** assessed and classified, reason not otherwise specified

ICD- 714.0, 714.1, 714.2
714.81 (rheumatoid arthritis and other inflammatory polyarthropathies)

Measure 178: Rheumatoid Arthritis (RA): Functional Status Assessment

Reporting options: Claims-based, Registry, and Measures Group

Patients for whom a functional status assessment was performed at least once within 12 months

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
99341, 99342, 99343, 99344, 99345 (home services – new patient)
99347, 99348, 99349, 99350 (home services - established patient)
99455. 99456 (work related or medical disability evaluation services)

Numerator: 1170F – Functional status assessed
(CPT II)

Modifier: 8P – Functional status **not** assessed, reason not otherwise specified

ICD-9: 714.0, 714.1, 714.2
714.81 (rheumatoid arthritis and other inflammatory polyarthropathies)

Measure 179: Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis

Reporting options: Claims-based, Registry, Measures Group

All patients 18 years and older with a diagnosis of rheumatoid arthritis (RA)

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
99341, 99342, 99343, 99344, 99345 (home services – new patient)
99347, 99348, 99349, 99350 (home services - established patient)
99455. 99456 (work related or medical disability evaluation services)

Measure 179: continued

Numerator: 3475F – Disease prognosis for rheumatoid arthritis assessed, poor prognosis (CPT II) documented

3476F – Disease prognosis for rheumatoid arthritis assessed, good prognosis documented

Modifier: 8P – Disease prognosis for rheumatoid arthritis not assessed and classified, reason not otherwise specified

ICD- 9: 714.0, 714.1, 714.2
714.81 (rheumatoid arthritis and other inflammatory polyarthropathies)

Measure 180: Rheumatoid Arthritis (RA): Glucocorticoid Management

Reporting options: Claims-based, Registry, and Measures Group

Patients who have been assessed for glucocorticoid use and for those on prolonged doses of prednisone ≥ 10 mg daily (or equivalent) with improvement or no change in disease activity, documentation of a glucocorticoid management plan within 12 months

CPT: 99201, 99202, 99203, 99204, 99205 (office – new patient)
99212, 99213, 99214, 99215 (office- established patient)
99241, 99242, 99243, 99244, 99245 (outpatient consult)
99341, 99342, 99343, 99344, 99345 (home services – new patient)
99347, 99348, 99349, 99350 (home services - established patient)
99455. 99456 (work related or medical disability evaluation services)

Numerator: 4192F – Patient not receiving glucocorticoid therapy (CPT II)

4193F - Patient receiving < 10 mg daily prednisone, or RA disease activity is worsening, or glucocorticoid use is for less than 6 months

OR

Two CPTII codes are required on the claim form to submit this numerator option

4194F – Patient receiving ≥ 10 mg daily prednisone (or equivalent) for longer than 6 months, and improvement or no change in disease activity

0540F – Glucocorticoid Management Plan documented

Modifier: 8P - Glucocorticoid dose was **not** documented, reason not otherwise specified

ICD-9: 714.0, 714.1, 714.2
714.81 (rheumatoid arthritis and other inflammatory polyarthropathies)

