The MACRA Ortho Handbook

by

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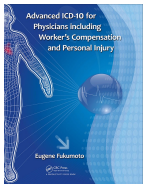

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General Instructions for Using the MACRA/MIPS Handbook

The purpose of this handbook is to provide medical practices with a method and methodology for reporting Quality Measures as specified by the Merit-Based Incentive Payment System (MIPS). MIPS is the name of a new program that will determine Medicare payment adjustments. It is an important part of the Medicare Access and CHIP Reauthorization Act (MACRA). Quality Measures are the largest component of MIPS. Your future Medicare reimbursement will be the result of four performance categories:

Quality 50% - for 2017 this component is 60%

Meaningful Use 25%

Clinical Practice Improvement 15%

Resource Use - for 2017 this component is zero (not used)

Our Handbook is focused on Quality Measures only. Other measures may be discussed in future publications.

For those of you who have used the Physician Quality Reporting System (PQRS), these Measures probably look very familiar. In fact, many of these are similar to, if not the same, Measures. MIPS is less confusing because it does not require the use of numerators and denominators to determine percentages. It just requires percentages. A major difference today is that when PQRS was introduced, practices did not have the advantages available via ICD-10.

ICD-10 gives tools for data capture and grouping previously not available. This Handbook presents many of the advantages given by ICD-10.

It is assumed that most practices will report these Measures via Registries. As of March 2017, CMS has not yet published a list of qualified Registries. However, practices must start the process of data capture. The first step is to determine which of the many Measures to report. The Handbook presents Measures and gives information on the subject matter, as well as how to report them. As shown, many of these Measures can be reported in multiple ways. Practices must choose which to report and how to report them.

Reporting is a collaborative effort. Practices must choose which Measures to report and the entire staff must be aware of the Measures chosen. As an example, if Smoking Cessation has been chosen to be reported, a Plan of Action must be devised. Some of the components could be as follows:

1. Intake and front desk personnel must know that patients have to asked if they smoke
2. Providers have to know which ICD-10 codes are appropriate for reporting, e.g., pregnant women have different coding requirements
3. Coders must know which Combination Codes may be relevant
4. Billers must be aware of the diagnostic codes that should be reported for this Measure

We have developed and presented mini 'superbills' or 'charge tickets' that present diagnosis code choices, as well as CPT and HCPCS codes appropriate for each Measure.

Quality Measures refer to Medicare defined groups of patients who receive treatment and/or services as described in Measure Descriptions and how the Practice reports compliance with Measures. An example of a Measure is:

> **Percentage of patients 18 – 75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.**

Practices that choose this Measure have to report the percentage of patients who had or have diabetes and hemoglobin A1c > 9%. The Measurement period is for a minimum of 90 consecutive days but can be greater up to and including the entire 2017 year

Our Handbook has three components for each Measure discussed:

1. A discussion of the Measure and what practices must know in order to properly collect and report data. Practices must know that all diabetes mellitus codes are Combination Codes. Heretofore, ICD-10 edits have not been strictly enforced so many practices may choose to just report unspecified or 'other' diabetes, e.g.,

E11.8 Type 2 diabetes with unspecified complications.

Use of this code is a billing error. All diabetes mellitus are combination codes which are defined as a single code used to classify two diagnoses, or a diagnosis with an associated manifestation or complication. You should assign only a combination code that fully identifies the diagnostic condition documented. Diabetes never comes alone. There are always manifestations or complications such as hypertension. If a patient has Type 2 diabetes and hypertension, appropriate coding could be:

E11.69	Type 2 diabetes with other specified complications-
	Use additional code to specify complication, e.g.
I10	Essential hypertension

You may ask, why bother? Carriers have not denied claims with E11.8. The difference here is that you are reporting data to Medicare in order to avoid a loss of revenue or to get a bonus reimbursement.

When you report, you must be able to explain and defend your reports. There is no real alternative if you choose to report.

Besides the issue of Combination Codes, it should be noted that there are different types of diabetes. In addition to Type 1, there are codes for Diabetes Due to Drugs and Chemicals, and Diabetes Due to Underlying Conditions, Other Specified Diabetes. It should also be noted that diabetes during pregnancy, childbirth and the puerperium (ICD-10 codes Chapter 5 O-) are in a completely different chapter of ICD-10.

You should also know that when Chapter 5 codes are used, they should be presented first followed by the specific code(s) for diabetes.

Since there are so many different types of diabetes and a greater number of Combination Codes, how can you capture all the patients in this population?

There is a single ICD-10 code that allows for this. If you choose to report this Measure, you only have to enter the appropriate ICD-10 code for this condition.

D58.2 Abnormal hemoglobin NOS

2. The second component for each Measure is what we term a Measure 'Template.' The 'Template' is basically a mini-Superbill or Charge Ticket. It can be used in a manner similar to a charge ticket. Practice members simply check off or circle the conditions that are present in the patients.

In the case of the Measure we have been discussing, the Template shows different possible diabetes codes. If you are going to report patients with diabetes, you must know what type of diabetes. Since there are multiple types of diabetes, you are given a "grid" showing different types of diabetes along with the types of sub-groups under each type. As an example, the 'grid' shows Type 2 diabetes with the types of complications that commonly occur. Each Type of diabetes shows hyperosmolarity, ketoacidosis, kidney problems, ophthalmic, etc., under each type.

As shown by the grid, if a patient has Type 2 diabetes with ophthalmic complications, you can see that the ICD10 code to choose is E11.3-. This code requires a 5th digit to specify which eye is affected. You can then choose 1, 2, 3 or 9 (left, right, bilateral or unspecified) as the fifth digit. The Template also explains that in the absence of a specified 'type' of diabetes, the default is Type 2. In other words, the Template will assist in choosing the correct Combination Code(s)

The Template also has a block to enter the Hemoglobin Level %. If the level is abnormal, e.g., greater than 9%, you are given the ICD10 code that specifies Abnormal Hemoglobin (D58.2).

By comparing the number of patients who had diabetes screening (shown by ICD-10 code Z13.1) with the number who had an Abnormal Hemoglobin level, you can compute the percentage to report.

We recommend that you report 'Z13.1' for all patients with diabetes during the Measurement Period. Patients who also have certain other diagnosis, such as D58.2, they can then be reported as a sub-set of diabetic patients and the totals for all diabetic patients (all with Z13.1) can then be compared to the total with D58.2 to determine the reporting percentage.

It should also be noted that the Templates for each patient can be kept as a hard copy reference. In the absence of an automatic report capability, you can simply count the number of patients who had a diabetes screening and record the number. You can also count and record the patients with abnormal hemoglobin. It should be noted that each 'Template' has a block for 'Patient Notes' so that conditions specific to the patient can be documented and retained as well.

Each Template has a place to enter a patient's date of birth and age. We recommend you use both blocks to make sure patients are in the correct category. As shown, this measure spans patients from 18 to 75 years of age.

3. Template instructions are the third component of the Handbook. The instructions give information on how to use the Template.

ICD-10, HCPCS and CPT Codes Are Used for the Handbook

We have shown how we use ICD10 diagnosis codes to capture and report data. We also use HCPCS and CPT codes for data capture and reporting. All of these codes are commonly used in medical billing software and can be used for Quality Measure reporting.

An example of CPT use is the Quality Measure:

> **Percentage of Patients 18 years and Older Screened for Tobacco Use whom Received Cessation Counseling.**

In 2017, two new codes were added to CPT as follows:

> 99406 - Smoking and tobacco use cessation counseling visits, intermediate, greater than 3 minutes up to ten minutes

99407 ; greater than 10 minutes

These services are covered under Medicare and most private carriers. If you bill for these services, you can get a count of the number of these CPT codes billed during the measurement period to use for reporting.

However, you must know the correct ICD-10 codes for Nicotine dependence to use for claims. You must also know that there are separate codes for smoking during pregnancy.

2017 HCPCS contains 'Temporary' codes for Procedures/Professional Services that describe specific services such as:

> G9016 - Smoking cessation, counseling, individual, in the absence of or in addition to any other evaluation and management service, per session (6-10 minutes)

When this code is entered into a billing and/or medical record system, most systems will allow reports that can be generated to count the number of patients who had this service.

It should also be noted that are often more than one way to group and report data. Practices are not restricted in their choices but should be able to explain and defend their methodology.

> **Percentage of Patients 18 Years and Older with Documentation of Pain Assessment using standardized tool(s) on each visit and documentation of a follow-up plan.**

Our Template gives a listing of common standardized tools such as the McGill Pain Questionnaire, Brief Pain Inventory, etc. It also shows follow-up plan actions that can be checked or circled.

When using HCPCS or CPTII codes, it is important to enter charge amounts of zero dollars or alternatively, $0.01 so that they are not accidentally billed to carriers and to quickly identify Quality measures.

Again, appropriate ICD-10 codes are specified for grouping and reporting purposes when these type codes are used.

You can Report with Available Resources such as Procedure and Diagnosis Codes

Our Handbooks and related Quality Measures are for ten or more measures based on practice types, such as Family and General Practices. These will give you a good idea of the methodology for reporting. You may be able to develop your own primers and templates. You do not need specialized software or consulting. If you wish to get a 'Primer' discussion, template and template instructions for other Measures, please contact us.

Implementing MACRA Quality Measures

A Primer for Orthopedics

Including MD's, DO's and DC's

MACRA Quality Measures have replaced the former 'Physician Quality Reporting System' (PQRS) Quality Measures. The MACRA measures are less complicated than for PQRS, but present similar challenges to providers. How do I capture the data needed? Since much of the data is diagnosis related, a thorough knowledge of ICD-10 is required. This report focuses on data capture needed for reporting. We will produce reports in the near future on other aspects of MACRA, such as Improvement Activities and the actual transmission of data.

Due to the large number of Quality Measures, we have selected the following Measures related to Orthopedics to give users an approach to measures in general. We plan to produce other measures as they are specifically requested. Measures considered 'High Priority' by Medicare are indicated with an asterisk.

Measure: Percentage of patients age 65 and older with a history of falls who had a risk assessment for falls documented within 12 months. *

This is a High Priority Measure. According to the Centers for Disease Control (CDC), falls are the leading cause of fatal and non-fatal injuries among adults 65 years and older. During 2014, approximately 27,000 older adults died because of falls. 2.8 million people were treated in emergency departments and about 800,000 were subsequently hospitalized. The CDC estimated that 29 million falls resulted in 7 million injuries.

When falls result in injury, diagnosis codes fall within the category of 'Injury, Poisoning and Certain Other Consequences of External Causes', which are located in Chapter 19 of ICD-10.

Since falls often result in injuries to the hip and lower back, the following examples could be applicable:

S30.0 Contusion of lower back and pelvis (contusion of buttocks)

S31.8- Open wound of buttocks

S32.0- Fracture of lumbar vertebra

S33.1- Subluxation and dislocation of lumbar vertebra

S34- Injury of lumbar and sacral spinal cord and nerves at abdomen, lower back and pelvis level

Chiropractors must be aware that there are separate ICD-10 codes for subluxation versus dislocation. Medicare covers subluxation of the vertebra, but not dislocation.

Since these are External Cause codes, all of them are 7 character codes. For those codes without an already assigned 5th or 6th character, a 'Place Holder' X is required, e.g.,

S30.0XXA Contusion of lower back and pelvis, initial encounter

In the above case, the seventh character can also be 'D' or 'S'. The seventh character 'D' is used when there is no longer active treatment, e.g., a post-operative visit

S30.0XXD Contusion of lower back and pelvis, subsequent encounter

The seventh character 'A' should be continued as the correct diagnosis if the patient is undergoing active treatment. An example could be for use with CPT Code '97116 - Gait Training' while the patient is recuperating from a fall.

When a fracture occurs, it is important to remember that the seventh character can be other than 'A', 'D' or 'S', depending on the type of fracture, e.g.,

S32.010B Wedge compression fracture of first lumbar vertebra, Initial Encounter

Here we specify the type of fracture, location and the seventh character B specifies that the fracture is an Open Fracture.

S32.010G Subsequent encounter for Wedge compression fracture of first lumbar vertebra, with Delayed Healing

The seventh character D' is used to specify delayed healing.

S32.010K Subsequent encounter for Wedge compression fracture of first lumbar vertebra, Non-union

The seventh character 'K' specifies that the fracture did not heal normally.

Whenever fractures occur, coders must recognize that the seventh character can be affected. In many cases, the correct seventh character cannot be determined without x-rays or other diagnostic reports.

A fracture not specified as 'Open' or 'Closed' should be coded as 'Closed'. A fracture not specified as 'Displaced' or 'Not Displaced', should be coded to Displaced.

A code from category M80-, not a traumatic fracture, should be used for any patient with known osteoporosis, if a fall would not usually break a normal healthy bone.

Multiple fractures are sequenced in accordance with the severity of the fracture.

The following codes can assist in identifying patients in this measure.

R29.6 Repeated Falls

Z91.81 History of Falling - at risk for falling

These codes should appear in the patient's medical record.

Standard 'Risk Assessment Tools' can be found on the internet under 'Minnesota Falls Prevention Initiative' and include the following:

The Dynamic Gait Index assesses the likelihood of falling in adults and requires about 15 minutes to administer

The Falls Efficacy Scale (FES) is a 10 item rating scale to assess confidence in performing daily activities without falling.

There are many other tools.

If you are able to count the number of patients with R29.6 and/or Z91.81 in your database, you can then compare that to the number of patients who have had a risk assessment. This would then give the percentage required for reporting.

Measure: Percentage of patients age 65 years and older with a history of falls who had a plan of care for falls documented within 12 months *

This is also a high priority measure. Since it is closely related to the previous measure, both can probably be reported if the other is chosen as a reporting measure.

MACRA has largely replaced the former Medicare 'Physicians Quality Reporting Measures' (PQRS) with Individual Quality Measures for MIPS Reporting, such as the ones listed in this guide. However, PQRS provides a description of 'Plan of Care' which includes:

1. Consideration of vitamin D supplementation and
2. Balance, strength and gait training

The medical record must include documentation that:

1. Balance, strength and gait training instructions were provided OR
2. There was a referral to an exercise program that includes at least one of the three components: balance, strength or gait OR
3. There was a referral to physical therapy.

It should be noted that CPT 2017 contains new codes for Physical Therapy Evaluations. It should also be noted that Gait Training (CPT 97116) and other therapy procedures are billable services that can assist in documenting and reporting for this Measure's reporting.

Category II CPT codes may be used to assist in reporting this Measure.

CPTII 0518F Falls plan of care documented. This code identifies patients for whom this measure was applicable.

CPTII 0518FIP The IP modifier specifies a Performance Exclusion, e.g., there is no plan of care for medical reasons, such as the patient is not ambulatory, bed ridden, immobile, confined to wheel chair, dependent of helper pushing wheelchair, etc.

CPTII 0518F8P The 8P modifier is used to report circumstances when the Plan of Care is not documented for reason(s) not otherwise specified.

Please note that these Category II codes are not covered by Medicare. They can be added with a charge amount of $0.01 for identification purposes only. Your billing system should allow you to produce a report of charges by CPT to allow identification of Falls Plans of Care.

Again you may wish to identify these patients using ICD-10 codes R29.6 and Z91.81.

R29.6 Repeated Falls

Z91.81 History of Falling

You can then count the number of patients with these ICD-10 code identifiers and then compare that number to the number of patients who had a Plan of Care. This in turn can give you the percentage of patients with a history of falls that have or had a Plan of Care.

Measure: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter

There are two classes of Body Mass Index (BMI) codes.

Z68.5- Body Mass Index (BMI) pediatric are used for patients age 2 – 19 years of age

Z68- Body Mass Index codes are for adults 20 years and older. These codes are sub-grouped

Z68.1 Adult BMI 19 or less

Z68.2- Adult 20 – 29

Z68.3- Adult 30 – 39

Z68.4- Adult 40 or greater

A person with a BMI of 40 or more is considered morbidly obese. A person with a BMI of 35 or more with an obesity-related health problem, such as diabetes, is also considered morbidly obese.

E66.0 Obesity due to excess calories

It is important to note that this is a Risk Adjustment (RAF) Factor. When a patient

also has hypoventilation syndrome, use:

E66.2 Morbid (severe) obesity with alveolar hypoventilation

When a diagnosis for morbid obesity is assigned, it is important to list co-morbid conditions, such as diabetes, hypertension, hyperlipidemia, congestive heart failure, coronary artery disease, and degenerative joint disease.

A BMI of 19 or less can be a sign of malnutrition.

E44.0 Moderate protein-malnutrition

E44.1 Mild protein-calorie malnutrition

E45 Retarded development following protein-calorie malnutrition

E46 Unspecified protein-calorie malnutrition

Malnutrition can be suspected when there is a weight loss of 5% in three months, or 10% in 6 months, or if the BMI is < 17.9. ICD-10 codes 'E44-E46' are considered RAF factors when these conditions occur.

Cachexia 'R64 Cachexia - wasting syndrome' is considered to be a RAF factor.

There are a **number of published plans for Obesity Prevention and Management**. These can be found on the internet and include studies by recognized medical organizations, such as the University of Michigan guidelines.

A very important ICD-10 code for this measure is:

Z71.3 Dietary counseling and surveillance

If Code Z71.3 is properly used, it can be used to identify and count the number of patients who have had a follow-up plan. Another potentially useful ICD-10 code is:

Z72.4 Inappropriate diet and eating habits

Use of an ICD-10 code for BMI tracks 'the number of patients who had a BMI documented'. ICD-10 codes indicating obesity and malnutrition can then be used to determine patients who have BMI's outside of normal parameters. A very useful way to document these patients is to use an appropriate PQRS codes. These will be superseded by MIPS reporting, but may be added to your CPT codes with a charge amount of $0.00, if your billing software allows a zero charge amount. Alternatively, you may wish to use a charge amount of $0.01. A report of charges by CPT code can then be used to identify patients to be reported for this Measure.

G8417 BMI is documented above normal parameters and a follow-up plan is documented

G8418 BMI is documented below normal parameters and a follow-up plan is documented

The previous (superseded) PQRS Measure for BMI specified the following for normal parameters:

Age 65 years and older BMI > 23 and < 30 kg/m2

Age 18 – 64 years BMI > 18.5 and < 25 kg/m2

Measure: Percentage of patients 18 – 50 years of age with a diagnosis of low back pain who did not have an imaging study such as an X-ray, MRI or CT scan within 28 days of the diagnosis *

This is a high priority measure. In order to meet this measure, you first have to identify all of your patients who were diagnosed with low back pain. ICD-10 codes for low back pain include the following:

M43- Deforming dorsopathies

M46- Other inflammatory spondylopathies

M47 Spondylosis

M48 Other spondylosis

M50- Cervical disk disorders

M51- Thoracic, thorocolumbar and lumbosacral intervertebral disc disorders with myelopathy

M53- Other and unspecified dorsopathies

M54- Panniculitis

M96- Intraoperative and postprocedural complications of the musculoskeletal system not Elsewhere classified

M99 Biomechanical lesions, not elsewhere classified

S33- Dislocation and sprain of joints and ligaments of the lumbar spine and pelvis

Imaging studies can be identified by CPT codes, e.g.,

72100 Radiological examination, spine, lumbosacral; 2 or 3 views

Practices that bill for imaging can readily identify these services from the billing database. For those practices that use an outside imaging service, it is important that separate records be kept for patients with low back pain diagnosis codes.

Practices may also opt to use CPTII Code 1130F

CPTII 1130F Back pain and function assessed, including all of the following: 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

By using 1130F, you can then count the patients who had low back pain and a functional study. If a practice uses the convention that this code is only for use for patients who did not have an imaging procedure within 28 days of diagnosis, you can compare this number to the total with diagnosis codes of low back pain to get the reporting percentage.

Comparing the number of patients with low back pain diagnosis codes who have also had low back imaging CPT procedures can allow for reporting of this Measure.

Measure: Percentage of patient visits for patients age 21 years and older with a diagnosis of osteoarthritis (OA) with assessment for function and pain *

This is a high priority measure. Osteoarthritis diagnosis ICD-10 codes are located in Sections M15-M19.

M15- Polyosteoarthritis.

M16- Osteoarthritis of the hip

M17- Osteoarthritis of knee

M18- Osteoarthritis of first carpometacarpal joint

M19- Other and unspecified osteoarthritis

M19.1- Post-traumatic osteoarthritis of other joints

M19.2- Secondary arthritis of other joints

The American College of Rheumatology has published a list of short form questionnaires which patients can complete in a very few minutes. These also specify that there is training required to administer these tests:

McGill Pain Questionnaire

Oxford Knee Score

Western Ontario and McMaster Universities Osteoarthritis Index

There are many other published function and pain assessment measures for these conditions.

The following ICD-10 codes may be relevant to this measure:

Z82.61 Family history of arthritis

Z82.62 Family history of osteoporosis

Z82.69 Family history of other disease of the musculoskeletal system and connective tissue

Z87.31- Personal history of (healed) non-traumatic fracture

Z87.39 Personal history of other disease of the musculoskeletal system and connective tissue

M25- Other joint disorder

Measure: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred

When patients are referred to another provider, it is customary that the referring provider receives a report from the provider to whom the patient was referred. These patients can be identified via use of the following ICD-10 code:

Z71.2 Person consulting for explanation of examination or test findings

A Z code represents reasons for encounters. A corresponding procedure code must accompany a Z code if a procedure is performed. A procedure may simply be an office visit. Here, it would be appropriate to use a diagnosis code(s) that prompted the referral, as well as Z71.2.

ICD-10 codes Z77-Z79 identify persons with potential health hazards related to family and personal history and certain conditions influencing health status.

The code Z71.2 can be used to identify the number of patients referred to other providers during the measurement period. You must then track the number of reports for these patients. The number of reports received can then be compared to the total number of patients who were referred to other providers to determine the Measurement percentage.

If oral reports are received, these should be documented in the patient record, as well as written reports from providers.

Measure: Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present *

This is a high priority measure. The American Pain Foundation (2009) reported that Pain affects more Americans than diabetes, heart disease and cancer combined. It is the number one reason people seek medical care.

This measure replaces the former PQRS 'Measure 131 - Pain Assessment and Follow-up'. Measure 131 specified that there is no diagnosis associated with this measure.

Standardized Tools include the following:

Brief Pain Inventory (BPI)

Faces Pain Scale (FPS)

McGill Pain Questionnaire (MPQ)

Multidimensional Pain Inventory

Neuropathic Pain Scale (NPS)

Oswestry Disability Index (ODI)

Roland Morris Disability Questionnaire (RMDQ)

Verbal Descriptor Scale (VDS)

Verbal Numeric Rating Scale (VNRS) and

Visual Analog Scale (VAS)

A Follow-Up Plan requires a documented outline of care for a positive pain assessment. This must include:

A planned follow-up appointment, or

A referral, or

A notification to other care providers as applicable, or

An indication that the initial treatment plan is still in effect

These plans may include pharmacologic and/or educational interventions.

There are major challenges in reporting this measure. As stipulated in PQRS Measure 131, there are no diagnosis codes associated with the Measure. This is not surprising, since there are a great many diagnosis codes for pain. Appendix 1 gives a Listing of Types of Pain, which is only a general guide. Specific patient diagnosis must be assigned by an examining health care professional.

Since the Measure specifies that pain assessment must be on each visit for pain, a practice must determine how to identify each visit for pain assessment. One possible way is to assign an ICD-10 code to identify these visits, e.g.,

Z51.89 Encounter for other specified afteracare

This code specifies that you also list the condition requiring care, such as:

G56.0 Carpal tunnel syndrome

M25.5- Joint pain, etc.

Use of the Z51 code can be used to identify specific patients and document the dates of pain assessments.

An alternative to Z51 is the use of HCPCS code G8730.

G8730 Pain assessment documented as positive using a standardized tool and a follow-up plan is documented

Measure: 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

When this measure is to be reported, the first step is to identify tobacco users. It is important to note that this Measure does not specify cigarettes only. Patients should be asked if they use tobacco products. A positive response should result in one or more of the following ICD-10 codes being place in their medical record:

Z71.6	Tobacco use counseling
Z72.0	Tobacco use NOS
F17.21-	Nicotine dependence, cigarettes
F17.22-	Nicotine dependence, chewing tobacco
F17.29	Nicotine dependence, other tobacco product
Z87.891	History of tobacco dependence
O99.330	Smoking (tobacco) complicating pregnancy, unspecified trimester
O99.331	Smoking (tobacco) complicating pregnancy, first trimester
O99.332	Smoking (tobacco) complicating pregnancy, second trimester
O99.333	Smoking (tobacco) complicating pregnancy, third trimester
O99.334	Smoking (tobacco) complicating childbirth
O99.335	Smoking (tobacco) complicating the puerperium
P04.2 #	Newborn (suspected to be) affected by exposure in utero to tobacco use
P96.81 #	Newborn exposure to environmental tobacco smoke

P04.2 and P96.81 are not used for this measure, since the measure is for patients 18 years and older, but are presented here for information purposes.

Smoking and tobacco use have become so important that the 2017 CPT lists the following new CPT codes:

99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes

99407 Smoking and tobacco use cessation - counseling visit; intensive, greater than 10 minutes

These new CPT codes are covered under Medicare.

Use of CPT codes 99406 and/or 99407 along with ICD-10 codes 'F17.2 - Nicotine dependence' will allow ready identification for reporting the Measure.

Measure: Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated

Many practices may think they can identify patients with high blood pressure simply by running a report for patients with ICD-10 diagnosis code 'I10 - Essential (primary) hypertension', which includes high blood pressure. Practices that take this approach may report based solely on this diagnosis code, but would not meet the true purpose of the measure. Codes for hypertension should be chosen with other factors in mind. An example is shown below.

Hypertension	Heart Disease	Heart Failure	Kidney Disease	ICD-10 Code
yes	no	no	no	I10 Essential (primary) hypertension
yes	yes	no	no	I11.9 Hypertensive heart disease without heart failure
yes	yes	yes	no	I11.0 Hypertensive heart disease with heart failure. *
yes	no	no	yes	I12.9 Hypertensive chronic kidney disease with Stage 1 through Stage 4 chronic kidney disease or unspecified chronic kidney disease. **
yes	no	no	yes	I12.0 Hypertensive chronic kidney disease with Stage 5 or end stage chronic renal disease. **
yes	yes	yes	yes	I13.0 Hypertensive heart and chronic kidney disease with heart failure and Stage 1 through 4 chronic kidney disease or unspecified chronic Kidney disease. * and **
yes	yes	yes	yes	I13.2 Hypertensive heart and chronic kidney disease with heart failure and Stage 5 or end stage renal disease. * and **
yes	yes	no	yes	I13.10 Hypertensive heart and chronic kidney without heart failure and Stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease. **
yes	yes	no	yes	I13.11 Hypertensive heart and chronic kidney disease without heart failure and with Stage 5 chronic kidney or end stage renal disease. **

An Asterisk * indicates an additional code for type of heart failure. Two asterisks ** indicates a need for stage of kidney disease.

Heart failure ICD-10 codes include:

I50.1 left ventricular failure

I50.2- systolic (congestive) heart failure - need 5th digit

I50.3- diastolic (congestive) heart failure - need 5th digit

I50.4- combined systolic and diastolic heart failure - need 5th digit

I50.9 heart failure unspecified-

This code is considered to be a RAF code

5th digits 0 Unspecified

1 Acute

2 Chronic

3 Acute or chronic

Kidney disease codes include the following:

N18.1 Chronic kidney disease, stage 1

N18.2 Chronic kidney disease, stage 2

N18.3 Chronic kidney disease, stage 3

N18.4 Chronic kidney disease, stage 4

N18.5 Chronic kidney disease, stage 5

N18.6 End stage renal disease

N18.1 through N18.6 are all considered to be RAF codes

I13.10 is considered to be a RAF code

In addition to using one or more of the above ICD-10 codes for hypertension, practices can identify patients for this measure using the following Encounter Status codes:

Z01.30 Encounter for examination of blood pressure without abnormal findings

Z01.31 Encounter for examination of blood pressure with abnormal findings. (This code requires an additional code(s) to identify abnormal findings).

This measure should be reported a minimum of once per reporting period for patients seen during that period.

The following definitions are listed for PQRS 'Measure 317: Preventive Care and Screening for High Blood Pressure and Follow-up':

Blood Pressure Classifications: Normal, Pre-hypertensive, First Hypertensive, Second Hypertensive

For Normal BP, no follow-up is required for Systolic BP < 120mmHg and Diastolic BP < 80 mmHg

Pre-hypertensive: BP = 120-139 mmHg or diastolic BP 80-89 mmHg AND recommended lifestyle modifications OR referral to alternate/primary care provider

First Hypertensive: BP > 140 mmHg OR diastolic BP > 90 mmHg. This condition calls for follow-up within four weeks and recommended lifestyle modifications OR referral to alternate/primary care provider

Second Hypertensive: BP > = 140 mmHg or diastolic BP >= 90 mmHg. This condition requires recommended lifestyle modifications AND one or more Secondary Hypertensive Reading Interventions OR referral to alternate/primary care provider

Recommended Lifestyle Modifications include the following:

Weight reduction

Dietary approaches to stop hypertension - (DASH) Eating Plan

Dietary Sodium Restriction

Increased physical activity

Moderation in alcohol consumption

Second Hypertensive Reading Interventions include:

Anti-hypertensive pharmacologic therapy

Laboratory tests

Electrocardiogram (ECG)

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

The 2014 PQRS Registry provided the following information:

The route of administration documents the way the medication enters the body, which include the following: Oral, sublingual, subcutaneous, injections and/or topical.

A patient is NOT eligible if the following is documented:

Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

The following HCPCS codes are relevant to this Measure:

G8427 Eligible clinician attests to documenting in the medical record they obtained, updated, or reviewed the patient's current medications

G8428 Current list of medications not documented as obtained, updated, or reviewed by the eligible clinician, reason not given

G8430 Eligible clinician attests to documenting in the medical record the patient is not eligible for a current list of medications being obtained, updated or reviewed by the eligible clinician.

These codes may be used by practice with a zero or $0.01 dollar amount to track and report this Measure.

ICD-10 provides important tools for providers when patients do not take medications properly or if they had an adverse side effect(s). A possible example could be as follows:

Let us suppose that a patient was prescribed to use Kionex (sodium plystrene sulfonate), which is used to help your body get rid of excess potassium in the blood.

If, in this case, the patient had an adverse effect because he intentionally used less than the prescribed amount and also stated that he could not afford the prescribed quantity, ICD-10 provides the following:

T50.3X6D Underdosing of electrolytic, caloric and water balance agents and

Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship

T50- codes require a 7th digit. In this case, the patient's condition was determined after the initial encounter.

Next use the Table of Drugs and Chemicals in ICD-10 (Volume 2- 331) to locate Sodium polystyrene sulfonate. Under the column for Underdosing, you will find T50.3X6.

'Z91.1- Patient's noncompliance with medical treatment and regimen' has a sub-category for 'patient's intentional underdosing of medication regime due to financial hardship.'

When patients have an adverse reaction to medications, ICD-10 provides a mechanism to report this condition. In the case of Kionex, if the patient had an adverse reaction such as fecal impaction, the following could be appropriate:

K56.41 Fecal impaction

T50.3X5S Adverse effect of electrolytic, caloric and water balance agents

Again, a 7th character is required for codes in the T50- subcategory. Since the adverse reaction was a result of the adverse effect, the 7th character is S to designate that is was 'sequela' to taking the medication.

An important point which is unsaid in this measure is drug abuse. If this measure is chosen, it should be understood that providers should be prepared to document abuse and/or unusual usage. The following ICD-10 codes can be relevant.

Z71.51 Drug abuse counseling and surveillance of drug abuser

Use additional code for drug abuse or dependence (F11-F16, F18-F19)

Z79.4 Long term (current) use of Insulin

Z79.51 Long term (current) use of inhaled steroid

Z79.52 Long term (current) use of systemic steroid

Z79.8- Other long term (current) drug therapy

Measure: Percentage of patients aged 50 years and older treated for a fracture with documentation of communication between the physician treating the fracture and the physician or other clinician managing the patient's on-going care, that a fracture occurred and that the patient was or should be considered for osteoporosis treatment or testing. The measure is reported by the physician who treats the fracture and who therefore is held accountable for the communication. *

This is a high priority measure. This measure is to be reported after each occurrence of a fracture during the reporting period.

Patients with fractures should have documentation in the medical record of communication from the clinician treating the fracture to the clinician managing the patient's on-going care that the fracture occurred and that the patient was or should be treated for osteoporosis.

There are a great number of possible diagnosis codes that can be used to describe fractures. Most traumatic fractures would be specified by codes in Chapter 19 of ICD-10 'Injury, Poisoning and Certain Other Consequences of External Causes (S00 – T88)'.

Coding of fractures can be extremely complex due to the different 7th characters for open versus closed fractures. The treating physician can communicate this via the appropriate diagnosis code reported to the clinician providing on-going care.

When a patient has been treated for a fracture, he can be identified using an appropriate ICD-10 code such as:

Z87.81	Personal history of (healed) traumatic fracture or
Z87.310	Personal history of (healed) osteoporosis fracture or
Z87.311	Personal history of (healed) other pathological fracture or
Z87.312	Personal history of (healed) stress fracture

When a patient has been screened for osteoporosis, the following ICD-10 code can be used to document the screening:

Z13.820	Encounter for screening of osteoporosis

If the provider who performs the screening determines that osteoporosis is present, he can then document this by using the appropriate ICD-10 code(s) 'M15-M19'.

The provider who determines that osteoarthritis is present should specify 'post-traumatic' versus 'non post-traumatic' osteoarthritis codes.

A code from M80- , not a traumatic fracture code, should be used for any patient with known osteoporosis who suffers a fracture, even if the patient had a minor fall or trauma, if that fall or trauma would not usually break a normal, healthy bone.

Aftercare Z codes should be used for aftercare for traumatic fractures. For aftercare of a traumatic fracture, assign the acute fracture code with the appropriate 7th character.

Percentage of Patients 65 and Older
with a History of Falls and Risk Assesment within 12 months

Patient Name:_____ DOB:____ Age:__ Date:___

History of Falls Z91.81:____

Falls Risk Assessment- components *	Check if Done *
History of fall circumstances	
Review of medications and doses	
Evaluation of gait and balance	
Evaluation of mobility levels	
Evaluation of lower extremity joint function	
Examination of vision	
Examination of neurological function:	
muscle strength	
proprioception	
reflexes	
tests of cortical, extrapyramidal and cerebellar function	
Cognitive evaluation	
Screening for Depression	
Assessment of postural blood pressure	
Assessment of heart rate and rhythm and blood pressure responses to carotid sinus stimulation if appropriate	
Assesment of home environment	
Assessment of osteoporosis risk	
Other:	
Direct intervention on identified risk- Notations:	

Encounter for Screening of other
Musculoskeletal disorder Z13.828:_____

Patient Specific Notes:

MACRA Template Instructions for Patients Age 65 and Older with a History of Falls and Risk Assessment within 12 Months

This Template shows ICD-10 Code Z91.81 in the upper right corner. This code should be entered into the practice's medical record and/or billing software. This ICD-10 code uniquely identifies patients with a History of Falls. If you count the number of patients with this ICD-10 code compared to the number who had a Risk Assessment, you can then compute the percentage of the identified population who had a Risk Assessment.

This Template shows different components of Falls Risk Assessment. You may choose to check or circle the ones completed. For practices with Electronic Medical Record (EMR) software, you may wish to document these in the EMR system as well.

If you perform the Risk Assessments, or enough of them to feel confident that an adequate screening was done, you may also wish to enter the following ICD-10 code into your EMR and/or billing software:

Z13.828 Encounter for screening of other musculoskeletal disorder

By counting the number of qualified patients (age 65 years and older) with a History of Falls Z91.81 and comparing this to the number of patients who also had an ICD-10 code of Z13.828, you can compute the percentage required.

Please note that as a quality check: the practice as a group must choose to use BOTH codes as required. Also any patient who has Z13.828 in the record should have Z91.81.

It should be noted that practices may opt to use different strategies and/or other codes.

Percentage of Patients age 65 Years and Older with a History of Falls who had a Plan of Care Documented

Provider:_____

Patient Name:_____ DOB:_____ Date:_____

History of Falls Z91.18_____

Plan of Care:

Consideration of Vitamin D Supplementation:_____

Balance, strength or gait training instructions provided or

Referral to an exercise program that includes at least one of the three

There was a referral to physical therapy

Refered to:_____

CPT	Descripton
97161-4	Physical Therapy evualtions
97116	Gait Training
97112	Neuromuscular re-education

CPTII

0518F	**Falls plan of Care documented**
0518F1P	No plan of Care Performance Exclusion
05188P	Plan of care not documented no reason specified

Patient Specific Notes:

MACRA Template Instructions for Patients Age 65 and Older with a History of Falls who Had a Plan of Care Documented

This Template shows ICD-10 code 'Z91.81' in the upper right corner. This code can be entered into the practice's medical record system and/or billing software. This ICD-10 Code uniquely identifies patients with a History of Falls. If you count the number of patients with this ICD-10 code and compare this number to the number of patients who also had a Plan of Care, you can compute the percentage of the identified population who had a Plan of Care.

Again, it is important to document the date of birth to include only those patients who are 65 years and older in reporting this Measure.

If the patient had balance, strength or gait training or was referred for these, the appropriate action can be indicated via a check mark or circling the activity.

If actual physical therapy is provided, eligible providers can bill for this using an appropriate CPT code(s).

By using CPTII code 0151F, you can indicate in your medical record and/or billing system that a plan of care is documented. For this Measure, use of both 0518F and 'Z91.18' should be used. For billing system purposes CPT II 0151F can be entered as a zero charge item if your billing system allows for zero charge services. Alternatively, it can be 'billed' at $0.01. This service is not generally covered by payers and should not result in any unexpected payment.

Please note that 'Z91.81' can also be used in the Measure for patients 65 years and older with a History of Falls and a Risk Assessment. The combination of codes 'Z91.81' and CPT II 0151F, can be used to distinguish between the two measures.

In order to calculate the percentage for reporting this Measure, practices will have to total all patients with a diagnosis of 'Z91.81' in the reporting period. This total is then compared to the number of patients who had a Falls Plan of Care Document (CPTII 051F) to determine the percentage who had a Falls Plan of Care Documented. Alternately, you may wish to subtract the number of patients who did not have a Plan of Care documented (CPTII 05181P plus 05188P).

Percentage of Patients 18 years and Older
with BMI Documented during previous 6 months with BMI Outside Normal Parameters
with a Documented Follow-up Plan during the Encounter of during the Previous six months

Provider:_____ **Z71.3 Dietary Couseling and Surveillance**

Patient Name:_____ DOB:_____

BMI:_____ Age:____

Follow-up Plan- as a result of BMI out of normal parameters

Done

Documentation of Education
Referral (e.g., register dietian, nutritionist, other provider
Referral Provider Name: _____
Pharmacolgical interventions
Dietary supplements
Exercise Counseling
Nutrition Counseling

Z72.4 Inappropriate diet and eating habits: _____

Not Eligible for BMI Calcuation or Follow-up
Patient Receving Pallative Care:_____
Patient is pregnant:_____
Patient Refuses BMI Measurement
Other documented reason

When Z71.3 is used, an additional code for BMI (Z68-) is also required.

If BMI is 35-40 (Z68.35 - Z68.39) and the patient is diabetic, his BMI is considered abnormal

Diabetes diagnosis code(s):_____

Patient Specific Notes:

MACRA Template Instructions for Patients 18 Years and Older with BMI Documented Outside Normal Parameters with Documented Follow-up

The Measure requires that practices capture a patient's Body Mass Index (BMI Z68-). When the BMI is 19 or less or 40 or greater, the BMI is outside of normal parameters. However, it can also be outside of normal if a patient is diabetic or hypertensive and has a BMI of 35 or greater. In these cases, the diagnostician must decide whether the patient should be included as part of the population with BMI outside of normal parameters.

Practices can group and identify patients belonging to this population via use of ICD-10 code:

Z71.3 Dietary Counseling and Surveillance

The code should be used for patients with BMI's outside of normal parameters and who have had counseling. The type of counseling can be checked off or circled on the Template for this Measure. If a patient refuses to have a BMI Calculation or Follow-up, 'Z71.3' should not be used. Instead, a practice may opt to use 'Z72.4 - Inappropriate diet and eating habits'.

The type of follow-up and/or education can also be checked off or circled on the template as documentation.

The total number of patients with BMI's outside of normal can be computed as follows:

1. BMI 19 or Less 'Z68.1' plus
2. BMI 40 or greater 'Z68.4- 'plus
3. BMI 35 to 39.9 Z68.35-Z68.39 with a diagnosis of diabetes

This sum can then be compared to the total number of patients with diagnosis code 'Z71.3' to give the reporting percentage.

Percentage of Patients 18 - 50 years of Age
with a Diagnosis of Low Back Pain who did NOT have an Imaging Study
within 28 days of Diagnosis

Patient Name:_____ DOB:_____

Age:_____

Provider:_____ Date:_____

Low Back Pain M54.9:_____

Done

Documentation of Education
Referral, e.g., physical therapy
Exercise Couseling

CPTII 1130F back pain and function assessed, including patient history, notation or presence or absence of 'red flats' and assessment of prior treatment and response and employment status

Not eligible for imaging study reason:

Patient Specific Notes:

MACRA Template Instructions for Patients with Low Back Pain who did NOT have an Imaging Study with 28 Days of Diagnosis

This Measure includes patients in the age range of 18 to 50 years of age, so it is important to document the patient age on the date of service.

There are a great number of ICD-10 codes that can be used to indicate low back pain. In this Measure, we specify: M54.9 Dorsalgia, unspecified (Low back pain NOS)

Use of this ICD-10 code can be used in addition to other codes for back pain. Practices can specify the use of this diagnosis code for this MACRA measure to distinguish patients who are part of the population for this Measure who have had imaging.

Practices can also list the following CPT II code for this Measure.

1130F Back pain and function assessed, including all of the following: 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

CPT II Codes are generally not covered for reimbursement. These codes can be entered into a practice's billing system at a zero charge if the billing software allows for a zero charge. Or, it can be entered at a charge of $0.01 for informational purposes. If a reimbursable Evaluation and Management (E&M) occurs on the same date, that charge should also be entered into the billing system.

For patients who have had imaging procedures, providers bill for these services with CPT codes in the 70010-79999 series. Patients in this Measure should not have any imaging services rendered within 28 days of assigning ICD-10 code 'M54.9'. An important audit step here would be to check for imaging services billed by the provider or by another provider within 28 days of the date of service when diagnosis code 'M54.9' is specified.

When documentation of Education or referrals to other providers are made, the date can be documented on the Template for this Measure.

Practices can count the number of patients with CPTII 1130F and/or diagnosis code 'M54.9' to determine the population of patients for this measure. This number can then be compared to the number of patients with other diagnosis codes for low back pain. It should be noted that patients with a diagnosis of external caused back pain (S codes) should be carefully reviewed to determine if they were injured as a result of work or other accident. CPT II 1130F includes work related causes and may require the use of imaging procedures.

Percentage of Patients age 21 years and Older
with Diagnosiss of Osteoarthritis with Asessment for Function and Pain

Provider: Date:_____

Patient Name:_____ DOB:_____ **Z13.828 Encounter for Screening for Other Musculoskeletal Disorder:_____**

Age:_____

CPTII 1006F Osteoarthritis symptoms and functional status assessed___

HCPCS	Description
G8730	Pain assessment documented as positive with standardized tool and follow-up plan is documented
G8731	Pain asessment is documented as negative, no follow-up plan is required
G8939	Pain assessment documented as positive, follow-up plan not doucmented, patient not eligible

Pain Assessment Tools:
Brief Pain Inventory
Faces Pain Scale
McGill Pain Questionnaire
Multidimentional Pain Inventory
Neuropathic Pain Scale
Numeric Rating Scale
Oswestry Disability Index
Roland Morris Disability Questionnaire
Verbal Descriptor Scale
Verbal Numeric Rating Scale
Visual Analog Scale
Other

Done **CPTII 1502F Patient queried about pain and pain interference with function using a valid and reliable instrument:_____**

Follow-up Plan

Appointment Scheduled Date:

Referral to other provider:
Pharmacologic intervention
Education provided to patient:_____

Patient Not Eligible:
Severe mental and/or physical incapacity - patient cannot express himself understandably
Patient is in urgent or emergent situation and delay would jeopardize health status

Patient Specific Notes:

MACRA Template Instructions for Patients age 21 Years and Older with a Diagnosis of Osteoarthritis with Assessment for Function and Pain

The diagnosis code 'Z13.820 - Encounter for Screening for other Musculoskeletal Disorder' can be used to identify patients for the Measure. The record should also specify the specific ICD-10 code(s) for osteoarthritis.

One of the three listed HCPCS Codes for assessments should be chosen. This code along with 'Z13.820' can be used to identify patients for this Measure. The number of patients with this combination of 'Z13.820' and G8730, or G8731 or G8739 can then be compared to the total number of patients with a diagnosis code(s) in the range M16-M19 (Osteoarthritis) to determine the percentage of patients with a diagnosis of Osteoarthritis with Assessment for Function and Pain.

When Pain Assessment tools are used, the specific tool can be checked or circled on the Template. You can also specify another assessment tool(s) by placing the name(s) in the block for 'Other.'

Alternatively, you can use CPTII 1006F

CPTII 1006F Osteoarthritis symptoms and functional status assessed [may include the use of standardized scale or completion of an assessment questionnaire such as the SF-3G, AAOS Hip & Knee Questionnaire (OA)]. This CPTII code can be used to identify the population who had a diagnosis of Osteoarthritis and also an Assessment. The number of patients with this CPT code can then be compared to the total number of patients with a diagnosis of osteoarthritis.

You may also choose CPTII 1502F - Patient Queried about pain and pain interference with function using a valid and reliable instrument.

In order to report this Measure, you can count the number of patients with Diagnosis Code 'Z13.828' and compare it to the total number of patients with CPTII 1006F or the total number of patients with CPTII 1502F.

If you choose CPTII 1502F, it can be helpful to check or indicate the specific test(s) used.

Category II Codes are generally not payable. When these are used with billing software, you should also use Category I CPT codes for Evaluation and Management (E&M) Services in order to get reimbursement for the E&M service.

Percentage of Patients with Referrals Regardless of Age
for which the Referring Provider Receives a Report from the Provider to whom the Patient was Referred

Provider:_____

Patient Name:_____ DOB:___

Age:_____

Z71.0 Persons encountering health services to consult on behalf of another person

Condition(s) including diagnosis code(s), if known, requiring Referral

Referral Provider Name and specialty

5020F Treatment summary report communicated to physician(s) or other qualified health care profiessionals managing coninuing care and to the patient within 1 month of completing treatment

Report Received Date:
Written report date
Verbal report date:

Use modifer 3P if reproting is late or 8P if no report is received

Notes on report(s) received:

Patient Specific Notes:

MACRA Template Instructions for Percentage of Patients with Referrals for Which the Referring Provider Receives a Report

Patients in this group can be identified by use of ICD-10 code 'Z71.0 - Persons encountering health services on behalf of another person'.

A practice may use ICD10 code 'Z71.0' to track all patients who were referred to other providers, if this code is adopted for use as a convention.

When a report is received from the referred provider and the patient is seen to explain and discuss the report, CPTII code 5020F can be used to document this.

> 5020F Treatment summary report communicated to physician(s) or other qualified health care professional(s) managing continuing care and to the patient within 1 month of completing treatment.

If a report is not received, then CPTII makes provisions via modifier '8P - Action not performed'.

If a report is received later than one month, CPTII modifier 3P can be used to indicate Performance Measure Exclusion due to ‘system reasons.’

In order to report this Measure, the total number of patients who were referred to other providers is then compared to the total number of reports received (indicted by CPTII 5020F) to determine the reporting percentage.

Percentage of Patiets 18 Years and Older with Documentation of Pain Assessment using Standardized Tool(s) on Each Visit and Documentation of a Follow-up Plan

Provider:_____

Patient Name:_____ DOB:_____ Date:_____

Age:_____ **G8730 Pain Assessment documented as Positive using a standardized tool and a follow-up plan is documented**

Standardized Tools:

Brief Pain Inventory
Faces Pain Scale
McGill Pain Questionnaire
Multidemensional Pain Inventory
Neuropathic Pain Scale
Oswestry Disabiliy Index
Roland Morris Disability Questionnaire
Verbal Descriptor Scale
Visual Analog Scale
Other test(s)

Z51.89 Encounter for other specified Aftercare_____

Follow-up Plan

Follow-up Appointment
Scheduled Date:_____

Referral to:_____
Specialty of Referral Provider

Notification to Other Provider
Other Provider Name:_____

Notification Reason:_____

Pharmacological Intervention
Presription(s):

Education provided to Patient:

Pain Diagnosis Code(s)

Patient Specific Notes:

MACRA Template Instructions for Patients 18 Years and Older with Documentation of Pain Assessment Using a Standardize Tool(s) on Each Visit and Documentation of a Follow-up Plan

For this Measure we make use of HCOCS Code G8730 Pain Assessment Documented as Positive Using a Standardized Tool and a Follow-up Plan is Documented. This code can be used to identify all patients for this measure.

Please note that the Measure specifies that there should be a Pain Assessment for each visit. Use of ICD-10 code 'Z51.89 - Encounter for other specified aftercare' can be used for each visit during which a Pain Assessment was performed. Alternatively, practices can opt to use HCPCS Code G8730 for each visit when a standardized tool was used.

The combination of HCPCS Code G8730 and ICD-10 code 'Z51.89' can be used to produce reports for reporting this Measure.

When Standardized Tools are used, they can be checked-off or circled on templates.

Other data that can be entered include:

Follow-up appointment date

Referral to another provider(s)

Pharmacological intervention (prescriptions)

Education provided

Pain Diagnosis code(s)

Practices may also use CPTII Code 0521F

0521F Plan of care to address pain documented. CPTII provides for modifiers for services not performed or performed at a non-standard level. If this code is used, and a Standardized Tool is NOT given, one way to document this is to use modifier 2P or 8P.

Modifier 2P can be used if a patient declines a test.

Modifier 8P can be used to indicate that an action was not performed

In order to determine the reporting percentage, count all patients with HCPCS code G8730 and compare this number to the patients who were seen, but declined or were otherwise not given a Standardized Test during an encounter.

Percentage of Patients 18 years and Older Screened for Tobacco Use who Received Cessation Counseling

Provider:_____

Patient Name:_____ DOB:_____ Date:_____

Age:_____

Z71.6 Tobacco Use Counseling____

This meausre does not include patients under 18 years of age

ICD-10

F17.20-	Nicotine dependence, unspecified *	* 6th digit required
F17.21-	Nicotine dependence, ciagarettes*	1= nicotine dependence uncomplicated
F17.22	Nicotine dependence, chewing tobacco*	2 = dependence in remission
F17.29	Nicotine dependence, other tobacco product *	3 = with withdrawal 8 = induced disorders 9 = unspecified induced disorders

O99.330	Smoking (tobacco) complicating pregnancy, unspecified trimester**
O99.331	Smoking (tobacco) complicating pregnancy, 1st trimester**
O99.332	Smoking (tobacco) complicating pregnancy, 2nd trimeser**
O99.333	Smoking (tobacco) complicating pregnancy, 3rd trimester **
O99.334	Smoking (tobacco) complicating childbirth**
O99.335	Smoking (tobacco) complicating the puerperium**

Z72.0	Tobacco use NOS	** a secondary code from Category F17 or Z72.0 should also be used to identify the type of dependence

CPT

99406 Smoking and tobacco use cessation counseling visits, intermediate, greater than 3 minutes up to ten minutes

99407 : greater than 10 minutes

(both CPT codes are covered by Medicare)

Patient Specific Notes:

MACRA Template Instructions for Patients 18 Years and Older Screened for Tobacco Use who Received Cessation Counseling

Patients in this population can be identified by use of ICD-10 code 'Z71.6 - Tobacco Use Counseling'. When patients are seen and receive counseling, this ICD-10 code can be entered into the medical record and/or billing software to indicate that counseling was provided.

In addition to Z71.6, the appropriate diagnosis code F17.2- should also be entered. These appear on the Template for this Measure and should appear in the medical record. Pregnant women who smoke should also have the appropriate diagnosis code from Chapter 15 of ICD-10, 'Pregnancy, Childbirth and the Pueperium'. When codes from Chapter 15 are appropriate, they appear first followed by other ICD-10 codes.

When patients are identified as tobacco users, they can also be identified by use of ICD-10 code 'Z72.0 - Tobacco Use NOS'.

The ratio of patients with code Z71.6 to Z72.0 can then be used to give the Percentage of Patients Screened for Tobacco Use who received Cessation Counseling.

Alternatively, practices may choose to use CPT codes 99406 and/or 99407 to identify patients who received cessation counseling. In this case, the sum of patients with CPT codes 99406 and 99407 are then compared to the number of patients with ICD-10 code Z72.0 to determine the percentage to report.

Please note, this measure is for tobacco use and does not appear to include marijuana use.

Patient 18 Years and Older Screened for High Blood Pressure with Follow-up Plan Document
Measurement Period: _____

Patient Name:_____ DOB:_____ Age:_____

Provider Name:_____

Hyertension	Heart Disease	Heart Failure	Kidney Disease	ICD-10 Code
yes	no	no	no	I10 Essential (primary) hypertension
yes	yes	no	no	I11.9 Hypertensive heart disease without heart failure
yes	yes	yes	no	I11.0 Hypertensive heart disease with heart failure *
yes	no	no	yes	I12.9 Hypetensive chronic kidney disease with stage 1 through 4 chronic or unspecified kidney disease **
yes	no	no	yes	I12.0 Hypertensive chronic kidney disease with Stage 5 or End Stage renal disease **
yes	yes	yes	yes	I13.0 Hypertensive heart and chronic kidney unpsecified or diseae stage 1 though 4 * **
yes	yes	no	yes	I13.10 Hypertensive heart and unpsecified or chronic kidney disease stage 1 through 4 ** RAF
yes	yes	no	yes	I13.11 Hypertensive heart and chronic kidney disease without heart failure and Stage 5 or End Stage renal disease **

Z01.31 Encounter for examination of high blood pressure with abnormal findings_____

* additional code needed for heart failure

** kidney disease stage required

			5th digit
Hear Faiure codes	I50.1	left ventricular failure	0 = unspecified
	I50.2	systolic (congestive) heart failure needs 5th digit	1 = acutes
	I50.3	diastolic (congestive) heart failure needs 5th digit	2 = chronic
	I50.4	combined systolic and diastolic heart failure- 5th digit required	3 = acute on chronic
	I50.9	heart failure unspecified RAF	

Kidney disease Codes	N18.1	Chronic kidney disease, stage 1 RAF
	N18.2	Chronic kidney disease, stage 2 RAF
	M18.3	Chronic kidney disease, stage 3 RAF
	N18.4	Chronic kidney disease, stage 4 RAF
	N18.5	Chronic kidney disease, stage 5 RAF
	N18.6	End stage renal disease RAF

4050F Hypertension plan of care documented as Appropriate:_____

Z01.30 Encounter for examination of blood pressure without abnormal findings Z01.31 ..with abnormal findings

Blood Pressure Classifications

Normal systolic <120 mmHg and diastolic < 80 mmHg no follow-up **pre-hypertensive** BP= 120-139 or diastolic 80-89 referral recommended

First Hypertensive BP > 140 or diastolic > 90 need follow-up within 4 weeks with lifestyle modifications recommended

Second Hypertensive BP > 140 or diastolic > 90 needs lifestyle modications and one or more secondary Hypertesnive readings or referral

MACRA Template Instructions for Patients Screened for High Blood Pressure with Follow-up Plan and a Recommended Follow-up Plan is Documented

The patient population for this group can be documented by use of ICD-10 code 'Z01.31 - Encounter for Examination of High Blood Pressure with Abnormal Findings'. Please note that the template specifies that if the patient has normal blood pressure (Systolic < 120 mmHg and Disastolic < 80 mmHg), no follow-up is required. These patients can be identified via ICD-10 code 'Z01.30 - Encounter for Examination of Blood Pressure without abnormal findings'.

It is important to note that this measure specifies Hypertension, not just Essential Hypertension (I10). Providers should use the appropriate Combination Code(s) when reporting this measure. When hypertension is accompanied by Heart Failure and/or Kidney Disease, additional codes are required for diagnosis reporting. The appropriate codes can be checked or circled on the template to determine what code(s) to use for reporting.

Follow-up plans are based on the patient's blood pressure and are specified on the Template.

As shown at the bottom of the Template:

BP = 120-139 or diastolic 80-89, a Referral is recommended

BP > 140 or diastolic > 90 follow-up within 4 weeks with lifestyle modifications recommended

BP > 140 or diastolic > 90 Second hypertensive reading, need lifestyle modifications and one or more secondary hypertensive readings or referral.

By circling or checking one of these on the Template, you can indicate the follow-up plan recommended for the patient.

An efficient way to report this measure is to count the number of patients with ICD-10 diagnosis 'Z01.31' and the number of patients with ICD10 diagnosis 'Z01.30'. The total of these compared to the number with 'Z01.31' can give the reporting percentage needed.

You can document that a plan of care was developed and documented via CPTII Code 4050F

4050F Hypertension plan of care is documented as appropriate

Percentage of Patients 18 years and Older for which the Eligible Professional Attests to Documenting a List of Current Medications Using all Available Resources

Provider:_____

Patient Name:_____ DOB:_____ Date:_____ Age:_____

List of Current Medications
All known prescriptions

Name	Dosage	Frequency	Route of Administration

Over the Counter

Herbals

Vitamin(s)

Mineral(s)

Nutritional

G8427 Eligible clinician attests to documenting in the medical record they obtained, updated or reviwed the patient's current medications
or
G8430 Eligible professional attests that the patient is not eligible for a current list of medications
G8428 Current list of medications not documented, updated or reviewed, reason not given

MACRA Template Instructions for Attestation of Documenting a List of Current Medications for Patients 18 Years and Older Using all Available Resources

For each patient that the clinician attests to documenting current medications, patients in the group can be identified using HCPCS Code G8427 Clinician Attests to documenting in the medical record, they obtained, updated or reviewed the patient's current medications.

The number of patients with HCPCS Code G8427 can then be compared to the total number of patients in the measurement period to compute a percentage with G8427. Alternatively, a practice may choose to also use code G8428 and/or G8429 to give a more detailed breakdown.

It would be prudent to document adverse effects of medications, long term drug use or possible abuse of medications.

CPTII also provides an alternative 1159F

1159F Medication list documented in the medical record

In order to report, practices must count the number of patients seen per date of service and compare that total to the number of patients who had a medication review on the same date.

Percentage of Patients 50 Years and Older Treated for Fracture with Communication from the Treating Provider to Clinician Managing On-Going Care

Provider:_____

Patient Name:_____ DOB:_____ Date:_____

Age:_____

Date of Fracture:

CPTII 5015F Documentation of communication that a fracture occurred and that the patient should be considered for treatment of osteoporsis___

Type of Fracture:

Closed
Open Type I or II
Open NOS
Open Type IIIA, IIIB or IIIC
Open fracture with routine healing
Closed fracture with Delayed healing
Open fracture with Delayed healing
Closed fracture with malunion
Open fracture type I or II with malunion
Open fracture type II!A, IIIB or IIIC with malunion

Diagnosis Code(s) for Fracture:

ICD-10 Code(s) for Encounters if applicable

Z04.1	Encounter for examination following transport accident
Z04.2	Encounter for examination following work accident
Z04.3	Encouter for examination following other accident
Z87.81	Personal history of (healed) traumatic fracture
Z87.310	Personal history of (healed) osteoporosis fracture
Z87.311	Personal history of (healed) other pathological fracture
Z87.312	Personal history of (healed) stress fracture
Z13.820	Encounter for screening of osteoporosis
M17.3-	Post-traumatic osteoarthritis- knee
M19.1-	Post-traumatic osteoarthritis- other joints

Reported to:_____ Report Date:_____

Patient Specific Notes:

MACRA Instructions for Template of Percentage of Patients 50 Years and Older Treated for Fracture with Communication from the Treating Physician to Clinician Managing On-Going Care with Consideration for Osteoporosis Testing

The reporting physician can identify all patients for the Measure using CPT II Code 5015F Documentation of communication that a fracture occurred and that the patient should be considered for treatment of osteoporosis.

There are many types of fractures and descriptions thereof. ICD-10 has specific diagnosis codes for the types of fractures listed on the Template. When a fracture type is not specified as open or closed, the convention is to use 'Closed'. Therefore, the treating physician should specify the type. He can also later report to the On-going care clinician if there is delayed healing or mal-union.

If the treating physician screens for osteoporosis, he should document the screening via ICD-10 code 'Z13.820 - Encounter for Screening of osteoporosis' and specify the type of Osteoporosis (M15-M19).

He can also document the date of reporting and on-going care provider name on the template. Most Electronic Medical Record (EMR) systems should have this capability.

It is important to document if a fracture occurred as a result of a work or other type of accident in the event of litigation.

Communication of a fracture should always occur. In the event a patient presents with a fracture or healed fracture, a percentage can be computed based on the number of reports received versus the total number of patients with fractures or healed fractures during the Measurement Period.