

☞ Measure #185: Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older receiving a surveillance colonoscopy with a history of colonic polyp(s) in a previous colonoscopy, who had a follow-up interval of 3 or more years since their last colonoscopy documented in the colonoscopy report

INSTRUCTIONS:

This measure is to be reported each time a surveillance colonoscopy is performed during the reporting period. It is anticipated the clinician who performs the listed procedures, as specified in the denominator coding, will report on this measure. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73 or 74 will not qualify for inclusion into this measure.

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II codes **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, G-codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older receiving a surveillance colonoscopy with a history of colonic polyp(s) in a previous colonoscopy

Denominator Instructions: Clinicians who indicate that the colonoscopy procedure is incomplete or was discontinued should use the procedure number and the addition (as appropriate) of modifier 52, 53, 73, or 74. Patients who have a coded colonoscopy procedure that has a modifier 52, 53, 73, or 74 will not qualify for inclusion into this measure.

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for history of colonic polyp(s) (ICD-9-CM): V12.72

AND

Patient encounter during the reporting period (CPT or HCPCS): 44388, 44389, 44392, 44393, 44394, 45355, 45378, 45380, 45381, 45383, 45384, 45385, G0105

WITHOUT

CPT Category I Modifiers: 52, 53, 73 or 74

NUMERATOR:

Patients who had an interval of 3 or more years since their last colonoscopy

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Interval of Three or More Years Since Patient's Last Colonoscopy

CPT II 0529F: Interval of three or more years since patient's last colonoscopy, documented

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy for Medical or System Reasons

Append a modifier (**1P** or **3P**) to CPT Category II code **0529F** to report documented circumstances that appropriately exclude patients from the denominator.

0529F with 1P: Documentation of medical reason(s) for an interval of less than three years since the last colonoscopy (e.g., patients with high risk for colon cancer, last colonoscopy incomplete, last colonoscopy had inadequate prep, piecemeal removal of adenomas, or last colonoscopy found greater than 10 adenomas)

0529F with 3P: Documentation of system reason(s) for an interval of less than three years since the last colonoscopy (e.g., unable to locate previous colonoscopy report)

OR

Interval of Less Than Three Years Since Patient's Last Colonoscopy, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **0529F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0529F with 8P: Interval of less than three years since patient's last colonoscopy, reason not otherwise specified

RATIONALE:

Colonoscopy is the recommended method of surveillance after the removal of adenomatous polyps because it has been shown to significantly reduce subsequent Colorectal Cancer incidence. The timing of follow-up colonoscopy should be tailored to the number, size, and pathologic findings of the adenomatous polyps removed. The time interval for the development of malignant changes in adenomatous polyps is estimated at 5 to 25 years (ICSI, 2006). A randomized controlled trial of 699 patients showed that after newly diagnosed adenomatous polyps have been removed by

colonoscopy, follow-up colonoscopy at three years detects important colonic lesions as effectively as follow-up colonoscopy at both one and three years. (ICSI, 2006)

Performing colonoscopy too often not only increases patients' exposure to procedural harm, but also drains limited resources that could be more effectively used to adequately screen those in need. Recent evidence from four surveys indicated that postpolypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines (Rex et al, 2006). Some endoscopists in these studies performed colonoscopy in patients with only small hyperplastic polyps or a single tubular adenoma at one year. These surveys underscore the importance of measuring intervals between examinations in continuous quality improvement programs.

CLINICAL RECOMMENDATION STATEMENTS:

Patients with one to two small (1 cm) tubular adenomas with only low-grade dysplasia should undergo follow-up colonoscopy no earlier than five years later. Patients with advanced adenomatous lesions or >3 adenomas should have repeat colonoscopy in three years as long as all visualized polyps were completely removed, the colonoscopy was completed up the cecum, and the colonic preparation was adequate. A shorter interval of follow-up is recommended in those patients with numerous adenomatous (>10) polyps and in those whom the colonoscopy was incomplete or the preparation was inadequate. After a surveillance colonoscopy has normal results, repeat examinations should be done at five-year intervals. Patients with large, sessile adenomatous lesions removed in a piecemeal fashion should have a repeat examination within two to six months to exclude and remove any remnant polypoid tissue. (Grade 1a) (Davila et al, 2006)

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

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

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

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

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. The most recent quality code submitted will be used for performance calculation. There is no diagnosis associated with this measure. This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. BMI measured and documented in the medical record may be reported if done in the provider's office/facility or if BMI calculation within the past six months is documented in outside medical records obtained by the provider. For justification of BMI parameters for this measure please refer to the rationale and clinical recommendation statements. The documentation of a follow up plan should be based on the most recently calculated BMI.

Measure Reporting via Claims:

CPT codes, HCPCS (D- and G-) codes, and patient demographics are used to identify patients who are included in the measure's denominator. G-codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:

CPT codes, HCPCS (D- and G-) codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0108, G0270

NUMERATOR:

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

Definitions:

BMI – Body mass index (BMI), expressed as weight/height (BMI; kg/m²), is commonly used to classify overweight (BMI 25.0-29.9), obesity (BMI greater than or equal to 30.0) and extreme obesity (BMI greater than or equal to 40) among adults (CDC). BMI is calculated either as weight in pounds divided by height in inches squared multiplied by 703, or as weight in kilograms divided by height in meters squared. The National Institutes of Health (NIH) provides a BMI calculator table at http://www.nhlbi.nih.gov/guidelines/obesity/bmi_tbl.htm. (AHRQ Preventive Guidelines 2009)

Elderly BMI – Most experts suggest use of a higher BMI threshold for underweight elderly individuals, compared to what is used for the general population (Chernoff, Cook, Mahan). *International Dietetics and Nutrition Terminology* defines underweight in persons >65 years of age as a BMI of <23. This BMI value is one indicator of malnutrition when forming a nutrition diagnosis for the elderly population (American Dietetic Association). A BMI of <23 classifies an older adult (older than age 65) as underweight and may require nutrition intervention.

Calculated BMI – Requires that both the height and weight are actually measured. Values merely reported by the patient cannot be used.

Follow-up Plan – Proposed outline of treatment to be conducted as a result of abnormal BMI measurement. Such follow-up can include documentation of a future appointment, education referral, (such as, a registered dietician, nutritionist, occupational therapy, primary care physician, exercise physiologist, mental health professional, surgeon, etc.) prescription/administration of medications/dietary supplements, etc.

Not Eligible/Not Appropriate for BMI Measurement – Patients can be considered not eligible in the following situations:

- There is documentation in the medical record that the patient is over or under weight and is being managed by another provider
- If the patient has a terminal illness – life expectancy less than 6 months
- If the patient refuses BMI measurement
- If there is any other reason documented in the medical record by the provider explaining why BMI measurement was not appropriate

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

BMI Calculated, No Follow-up Plan Needed or BMI Calculated, Follow-up Plan Documented

G8420: Calculated BMI within normal parameters and documented

OR

G8417: Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record

OR

G8418: Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record

OR

Patient not Eligible for BMI Calculation for Documented Reasons

G8422: Patient not eligible for BMI calculation

OR

BMI not Performed and/or Calculated BMI Outside of Normal Parameters, Follow-up Plan not Documented, Reason not Specified

G8421: BMI not calculated

OR

G8419: Calculated BMI outside normal parameters, no follow-up plan documented in the medical record

RATIONALE:

In 2009, no U.S. state met the *Healthy People 2010* adult obesity prevalence target of 15 percent, and the number of states with an obesity prevalence ≥ 30 increased from zero in 2000 to nine in 2009 (CDC, 2010). Further, the report revealed that the overall self-reported obesity prevalence in the United States was 26.7 percent, an increase of 1.1 percentage points from 2007 to 2009 among adults aged 18 years or older (CDC, 2010).

Obesity continues to be a public health concern in the United States and throughout the world (Flegal, et al, 2005; Ogden, et al, 2007)). In the United States, obesity prevalence doubled among adults between 1980 and 2004 (Flegal, et al, 2002; Ogden, et al, 2006). Obesity is associated with increased risk of a number of conditions, including diabetes mellitus, cardiovascular disease, hypertension, and certain cancers, and with increased risk of disability and a modestly elevated risk of all-cause mortality. With obesity on the rise, the medical community anticipates an increase in the complications of obesity, including type 2 diabetes mellitus, hypertension, dyslipidemia, cardiovascular disease, obstructive sleep apnea, degenerative arthritis, non-alcoholic steatohepatitis, gallbladder disease and others.

Results from the 2005-2006 National Health and Nutrition Examination Survey (NHANES) indicate that an estimated 32.7 percent of U.S. adults 20 years and older are overweight, 34.3 percent are obese and 5.9 percent are extremely obese. Although prevalence of adults in the U.S. who are obese is still high, with about one-third of adults obese in 2007-2008, although new data suggest that the rate of increase for obesity in the U.S. in recent decades may be slowing (Flegal, et al, 2010).

In 2000, obesity was responsible for an estimated 400,000 deaths, compared to 300,000 in 1990 (Flegal, et al, 2005). Obesity places second only to smoking as the leading preventable cause of death in the United States. In addition, obesity is a significant contributor to premature death. In Caucasians ages 20 to 30 with a BMI >45 kg/m², it has been estimated that obesity decreases life expectancy by 13 years in men and 8 years in women (Fontaine, et al, 2003).

Poor nutrition or underlying health conditions can result in underweight. Results from the 2003-2006 National Health and Nutrition Examination Survey (NHANES), using measured heights and weights, indicate that an estimated 1.8% of U.S. adults are underweight. (Source: The National Center for Health Statistics (NCHS) Health E-Stat. Prevalence of Underweight Among Adults: United States, 2003-2006, Accessed September 15, 2010 at http://www.cdc.gov/nchs/data/hestat/underweight/underweight_adults.htm. A tremendous gap still exists between our knowledge of malnutrition and its sequelae and our actions in preventing and treating it. To date professionals in various disciplines have applied their own approaches to solving the problem. Yet the causes of malnutrition are multi-factorial and the solutions demand an integration of knowledge and expertise from the many different disciplines involved in geriatric care. Older people have special nutritional needs due to age and disease processes.

Elderly patients with unintentional weight loss are at higher risk for infection, depression and death. The leading causes of involuntary weight loss are depression (especially in residents of long-term care facilities), cancer (lung and gastrointestinal malignancies), cardiac disorders and benign gastrointestinal diseases. Medications that may cause nausea and vomiting, dysphagia, dysgeusia and anorexia have been implicated. Polypharmacy can cause unintended weight loss, as can psychotropic medication reduction (e.g., by unmasking problems such as anxiety). In one study it was found that a BMI of less than 22 kg per m² in women and less than 23.5 in men is associated with increased mortality. In another study it was found that the optimal BMI in the elderly is 24 to 29 kg per m². (Huffman, G. B., Evaluation and Treatment of Unintentional Weight Loss in the Elderly, *American Family Physician*, 2002 Feb, 4:640-650). Ranhoff, et al (2005), identified through an observational study that using a BMI < 23, resulted in a positive screen for malnutrition (sensitivity 0.86, specificity 0.71), giving 0.75 correctly classified subjects. Thus leading to the recommendation that a score of BMI < 23 should be followed by MNA-SF when the aim is to identify poor nutritional status in elderly.

In 1998 the medical costs of obesity were estimated to be as high as \$78.5 billion, with roughly half financed by Medicare and Medicaid (Finkelstein, et al, 2009). This analysis presents updated estimates of the costs of obesity for the United States across payers (Medicare, Medicaid, and private insurers), in separate categories for inpatient, non-inpatient, and prescription drug spending.

Finkelstein, et al (2009), found that the increased prevalence of obesity is responsible for almost \$40 billion of increased medical spending through 2006, including \$7 billion in Medicare prescription drug costs. We estimate that the medical costs of obesity could have risen to \$147 billion per year by 2008.

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

A Web search of the National Quality Measures Clearinghouse on the key words of BMI, body mass index, produced four measures, all focused on possible follow-up for overweight and obesity for a broader age range and/or related to a specific disease/condition. There were no measures that focused on underweight or a follow-up plan.

CLINICAL RECOMMENDATION STATEMENTS:

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

The US Preventive Health Services Task Force (USPSTF) (2003) recommends that clinicians screen all adult patients for obesity and offer intensive counseling and behavioral interventions to promote sustained weight loss for obese adults (Level Evidence B).

Institute for Clinical Systems Improvement (ICSI) (2009) Prevention and Management of Obesity (Mature Adolescents and Adults) provides the following guidance:

- Calculate the body mass index; classify the individual based on the body mass index categories. Educate patients about their body mass index and their associated risks. (*Annotation #1; Aim #1*)
- Weight management requires a team approach. Be aware of clinical and community resources. The patient needs to have an ongoing therapeutic relationship and follow-up with a health care team. Weight control is a lifelong commitment, and the health care team can assist with setting specific goals with the patient. (*Annotations #10, 13; Aim #4*)

There are no current clinical recommendations addressing Underweight or Unintentional Weight Loss in the elderly population that have been developed by professional organizations, societies or associations.

◆ **Measure #113: Preventive Care and Screening: Colorectal Cancer Screening**

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. There is no diagnosis associated with this measure. Performance for this measure is not limited to the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

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

Measure Reporting via Registry:

CPT codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 50 through 75 years

Denominator Criteria (Eligible Cases):

Patients aged 50 through 75 years on date of encounter

AND

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

NUMERATOR:

Patients who had at least one or more screenings for colorectal cancer during or prior to the reporting period

Numerator Instructions: Patients are considered to have appropriate screening for colorectal cancer if any of the following are documented:

- Fecal occult blood test (FOBT) within the last 12 months
- Flexible sigmoidoscopy during the reporting period or the four years prior to the reporting period
- Colonoscopy during the reporting period or the nine years prior to the reporting period

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Colorectal Cancer Screening

CPT II 3017F: Colorectal cancer screening results documented and reviewed

OR

Colorectal Cancer Screening not Performed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **3017F** to report documented circumstances that appropriately exclude patients from the denominator.

3017F with 1P: Documentation of medical reason(s) for not performing a colorectal cancer screening

OR

Colorectal Cancer Screening not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **3017F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3017F with 8P: Colorectal cancer screening results were not documented and reviewed, reason not otherwise specified

RATIONALE:

Colorectal cancer is the second leading cause of cancer-related death in the United States. There were an estimated 135,400 new cases and 56,700 deaths from the disease during 2001.

Colorectal cancer (CRC) places significant economic burden on the society as well with treatment costs over \$6.5 billion per year and, among malignancies, is second only to breast cancer at \$6.6 billion per year (Schrag, 1999).

Colorectal cancer screening can detect pre-malignant polyps and early stage cancers. Unlike other screening tests that only detect disease, colorectal cancer screening can guide removal of pre-malignant polyps, which in theory can prevent development of colon cancer. Three tests are currently recommended for screening: fecal occult blood testing (FOBT), flexible sigmoidoscopy, and colonoscopy.

CLINICAL RECOMMENDATION STATEMENTS:

During the past decade, compelling evidence has accumulated that systematic screening of the population can reduce mortality from colorectal cancer. Three randomized, controlled trials demonstrated that fecal occult blood testing (FOBT), followed by complete diagnostic evaluation of the colon for a positive test, reduced colorectal cancer mortality (Hardcastle et al., 1996; Mandel & Oken, 1998; Kronborg; 1996). One of these randomized trials (Mandel et al., 1993) compared annual FOBT screening to biennial FOBT screening, and found that annual screening resulted in greater reduction in colorectal cancer mortality. Two case control studies have provided evidence that sigmoidoscopy reduces colorectal cancer mortality (Selby et al., 1992; Newcomb et al., 1992). Approximately 75% of all colorectal cancers arise sporadically (Stephenson et al., 1991). Part of the effectiveness of colorectal cancer screening is mediated by the removal of the precursor lesion—an adenomatous polyp (Vogtelstein et al., 1988). It has been shown that removal of polyps in a population can reduce the incidence of colorectal cancer (Winawer, 1993). Colorectal screening may also lower mortality by allowing detection of cancer at earlier stages, when treatment is more effective (Kavanaugh, 1998).

The U.S. Preventive Services Task Force (USPSTF) published an updated recommendation for colorectal cancer screening in 2008. The guideline strongly recommends that clinicians screen men and women ages 50 to 75 years of age for colorectal cancer (A recommendation). The USPSTF recommends not screening adults age 85 and older due to possible harms (D recommendation). The appropriateness of colorectal cancer screening for men and women aged 76 to 85 years old should be considered on an individual basis (C recommendation). While the approved modalities vary for patients 50 to 75 years old, the USPSTF found there is insufficient evidence to assess the benefits and harms of computed tomographic colonography (CTC) and fecal DNA (fDNA) testing as screening modalities for colorectal cancer for all patients (I statement).

▲ Measure #83: Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed

INSTRUCTIONS:

This measure should be reported on the first visit occurring during the reporting period for all patients with a diagnosis of hepatitis C seen during the reporting period. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure. The quality-data codes have been provided for registry only measures for use by registries that utilize claims data. It is not necessary to submit these codes for registry-based submissions. Do not report this measure via claims.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of hepatitis C seen for initial evaluation

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients for whom HCV RNA testing was ordered or previously performed

Numerator Options:

Ribonucleic acid (RNA) testing for Hepatitis C viremia ordered or results documented (3265F)

AND

Initial evaluation for condition (1119F)

OR

Documentation of medical reason(s) for not ordering or performing RNA testing for HCV (3265F *with* 1P)

OR

Documentation of patient reason(s) for not ordering or performing RNA testing for HCV
(3265F *with* 2P)

AND

Initial evaluation for condition (1119F)

OR

Subsequent evaluation for condition (1121F)

OR

RNA testing for HCV was not ordered or results not documented, reason not otherwise specified (3265F *with* 8P)

AND

Initial evaluation for condition (1119F)

RATIONALE:

HCV RNA testing is needed to establish and confirm diagnosis of chronic hepatitis C. HCV is an RNA virus of the Flaviviridae family. HCV replicates preferentially in hepatocytes but is not directly cytopathic, leading to persistent infection. During chronic infection, HCV RNA reaches high levels, generally ranging from 10⁵ to 10⁷ international units (IU)/mL, but the levels can fluctuate widely. However, within the same individual, RNA levels are usually relatively stable. (NIH)

After initial exposure, HCV RNA can be detected in blood within 1 to 3 weeks and is present at the onset of symptoms.

Antibodies to HCV are detected by enzyme immunoassay (EIA) in only 50 to 70 percent of patients at the onset of symptoms, increasing to more than 90 percent after 3 months.

The clinical utility of serial HCV viral levels in a patient is predicated on continued use of the same specific quantitative assay that was used in the initial determination of the viral level. While there is little correlation between disease severity or disease progression with the absolute level of HCV RNA, quantitative determination of the HCV level provides important information on the likelihood of response to treatment in patients undergoing antiviral therapy.

CLINICAL RECOMMENDATION STATEMENTS:

HCV ribonucleic acid (RNA) testing should be performed in:

- a. patients with a positive anti-HCV test (Grade II-2);
- b. patients for whom antiviral treatment is being considered, using a quantitative assay (Grade II-2);
- c. patients with unexplained liver disease whose anti-HCV test is negative and who are immunocompromised or suspected of having acute HCV infection (Grade II-2). (AASLD)

The diagnosis of chronic hepatitis C infection is often suggested by abnormalities in ALT levels and is established by EIA followed by confirmatory determination of HCV RNA. (NIH)

▲ Measure #84: Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

If reporting Measure #84: Hepatitis C: RNA Testing Before Initiating Treatment, also report Measure #85: Hepatitis C HCV Genotype Testing Prior to Treatment.

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of antiviral treatment

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Criteria (Eligible Cases):

Patients aged \geq 18 years on date of encounter

AND

Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients for whom quantitative HCV RNA testing was performed within 6 months prior to initiation of antiviral treatment

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

RNA Testing Performed within Six Months

(Two CPT II codes [3218F & 4150F] are required on the claim form to submit this numerator option)

CPT II 3218F: RNA testing for Hepatitis C documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C

AND

CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

OR

RNA Testing not Performed within Six Months for Medical Reason

(Two CPT II codes [3218F-1P & 4150F] are required on the claim form to submit this numerator option)

Append a modifier (**1P**) to CPT Category II code **3218F** to report documented circumstances that appropriately exclude patients from the denominator.

3218F with 1P: Documentation of medical reason(s) for not performing RNA testing within six months prior to initiation of antiviral treatment for Hepatitis C (e.g., if patient is first seen by physician after initiation of treatment)

AND

CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:

(One CPT II code [4151F] is required on the claim form to submit this numerator option)

CPT II 4151F: Patient not receiving antiviral treatment for Hepatitis C

OR

RNA Testing not Performed within Six Months, Reason not Specified

(Two CPT II codes [3218F-8P & 4150F] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **3218F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3218F with 8P: RNA testing for Hepatitis C was not documented as performed within six months prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified

AND

CPT II 4150F: Patient receiving antiviral treatment for Hepatitis C

RATIONALE:

Establish baseline level against which to monitor virologic response and indicate likelihood of response. The clinical utility of serial HCV viral levels in a patient is predicated on continued use of the same specific quantitative assay that was used in the initial determination of the viral level. While there is little correlation between disease severity or disease progression with the absolute level of HCV RNA, quantitative determination of the HCV level provides important information on the likelihood of response to treatment in patients undergoing antiviral therapy. (NIH)

CLINICAL RECOMMENDATION STATEMENTS:

HCV RNA testing should be performed in patients with a positive anti-HCV test (Grade II-2), patients for whom antiviral treatment is being considered, using a quantitative assay (Grade II-2), patients with unexplained liver disease whose anti-HCV test is negative and patients who are immune compromised or suspected of having acute HCV infection (Grade II-2). (AASLD)

All candidates for antiviral therapy should be tested for HCV RNA with a quantitative amplification assay, which provides both a baseline level against which to monitor virologic response and a prognostic indicator of the likelihood of response. (AGA)

The diagnosis of chronic hepatitis C infection is often suggested by abnormalities in ALT levels and is established by EIA followed by confirmatory determination of HCV RNA. (NIH)

▲ Measure #85: Hepatitis C: HCV Genotype Testing Prior to Treatment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

If reporting Measure #85: Hepatitis C HCV Genotype Testing Prior to Treatment, also report Measure #84: Hepatitis C: RNA Testing Before Initiating Treatment.

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom HCV genotype testing was performed prior to initiation of antiviral treatment

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients for whom HCV genotype testing was performed within 6 months prior to initiation of antiviral treatment

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis C Genotype Testing Performed

(One CPT II code & one G-code [3266F & G8459] are required on the claim form to submit this numerator option)

CPT II 3266F: Hepatitis C genotype testing documented as performed prior to initiation of antiviral treatment for Hepatitis C

AND

G8459: Clinician documented that patient is receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:

(One G-code [G8458] is required on the claim form to submit this numerator option)

G8458: Clinician documented that patient is not an eligible candidate for genotype testing; patient not receiving antiviral treatment for Hepatitis C

OR

Genotype Testing not Performed, Reason not Specified

(One CPT II code & one G-code [3266F-8P & G8459] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **3266F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3266F with 8P: Hepatitis C genotype testing was not documented as performed prior to initiation of antiviral treatment for Hepatitis C, reason not otherwise specified

AND

G8459: Clinician documented that patient is receiving antiviral treatment for Hepatitis C

RATIONALE:

To guide treatment decisions regarding duration of therapy and likelihood of response. There are 6 HCV genotypes and more than 50 subtypes. These genotypes differ by as much as 31 to 34 percent in their nucleotide sequences, whereas subtypes differ by 20 to 23 percent based on full-length genomic sequence comparisons. Genotype determinations influence treatment decisions. Patients with genotypes 2 or 3 have better response rates to re-treatment than those with genotype 1. (NIH)

CLINICAL RECOMMENDATION STATEMENTS:

HCV genotype should be determined in all HCV-infected persons prior to treatment in order to determine the duration of therapy and likelihood of response (Grade I). (AASLD)

Information on the genotype of the virus is important to guide treatment decisions. Genotype 1, most commonly found in the United States, is less amenable to treatment than genotypes 2 or 3. (NIH)

All candidates for antiviral therapy should be tested for HCV RNA with a quantitative amplification assay and should be tested for HCV genotype. (AGA)

▲ Measure #86: Hepatitis C: Antiviral Treatment Prescribed

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who were prescribed peginterferon and ribavirin therapy within the 12-month reporting period

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of chronic hepatitis C

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were prescribed peginterferon and ribavirin therapy within the 12 month reporting period

Definition:

Prescribed – May include prescription given to the patient for peginterferon and ribavirin therapy at one or more visits in the 12-month period OR patient already taking peginterferon and ribavirin therapy as documented in current medication list.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Peginterferon and Ribavirin Therapy Prescribed

CPT II 4153F: Combination peginterferon and ribavirin therapy prescribed

OR

Peginterferon and Ribavirin Therapy not Prescribed for Medical, Patient or System Reasons

Append a modifier (**1P, 2P or 3P**) to CPT Category II code **4153F** to report documented circumstances that appropriately exclude patients from the denominator.

4153F with 1P: Documentation of medical reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (e.g., patient was not a candidate for therapy, could not tolerate).

4153F with 2P: Documentation of patient reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (e.g., patient declined).

4153F with 3P: Documentation of system reason(s) for not prescribing peginterferon and ribavirin therapy within 12 month reporting period (e.g., patient has no insurance coverage, therapy not covered).

OR

Peginterferon and Ribavirin Therapy not Prescribed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4153F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4153F with 8P: Combination peginterferon and ribavirin therapy was not prescribed, reason not otherwise specified

RATIONALE:

Assure that antiviral therapy is prescribed for all patients with confirmed Hepatitis C.

The current standard of care for the treatment of previously untreated patients with chronic hepatitis C is combination pegylated interferon (PEG-IFN) alfa by subcutaneous injection once a week and oral ribavirin daily. For patients with contraindications to ribavirin but who have indications for antiviral therapy, PEG-IFN represents the best available treatment. (AGA)

Current contraindications to therapy include decompensated cirrhosis, pregnancy, uncontrolled depression or severe mental illness, active substance abuse in the absence of concurrent participation in a drug treatment program, advanced cardiac or pulmonary disease, severe cytopenias, poorly controlled diabetes, retinopathy, seizure disorders, immunosuppressive treatment, autoimmune diseases, or other inadequately controlled comorbid conditions. (AGA)

CLINICAL RECOMMENDATION STATEMENTS:

The treatment of choice is peginterferon plus ribavirin (Grade I). (AASLD)

The current standard of care for the treatment of previously untreated patients with chronic hepatitis C is a combination of pegylated interferon (PEG-IFN) alfa by subcutaneous injection once a week and oral ribavirin daily. For patients with contraindications to ribavirin but who have indications for antiviral therapy, PEG-IFN represents the best available treatment. (Category I) (AGA summ)

Current contraindications to therapy include decompensated cirrhosis, pregnancy, uncontrolled depression or severe mental illness, active substance abuse in the absence of concurrent participation in a drug treatment program, advanced cardiac or pulmonary disease, severe cytopenias, poorly controlled diabetes, retinopathy, seizure disorders, immunosuppressive treatment, autoimmune diseases, or other inadequately controlled comorbid conditions (Category I). (AGA)

Combination therapy results in better treatment responses than monotherapy, but the highest response rates have been achieved with pegylated interferon in combination with ribavirin. (NIH)

▲ Measure #87: Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for chronic hepatitis C (ICD-9-CM): 070.54

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients for whom quantitative HCV RNA testing was performed at 12 weeks from the initiation of antiviral treatment

Definition:

12 Weeks from Initiation – Patients for whom testing was performed between 11-13 weeks from the initiation of antiviral treatment will meet the numerator for this measure.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Hepatitis C Quantitative RNA Testing at 12 weeks

(One CPT II code & one G-code [3220F & G8461] are required on the claim form to submit this numerator option)

CPT II 3220F: Hepatitis C quantitative RNA testing documented as performed at 12 weeks from initiation of antiviral treatment

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks for Medical or Patient Reasons

(One CPT II code & one G-code [3220F-xP & G8461] are required on the claim form to submit this numerator option)

Append a modifier (**1P or 2P**) to CPT Category II code **3220F** to report documented circumstances that appropriately exclude patients from the denominator.

3220F with 1P: Documentation of medical reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment

3220F with 2P: Documentation of patient reason(s) for not performing quantitative HCV RNA at 12 weeks from initiation of antiviral treatment

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:

(One G-code [G8460] is required on the claim form to submit this numerator option)

G8460: Clinician documented that patient is not an eligible candidate for quantitative RNA testing at week 12; patient not receiving antiviral treatment for Hepatitis C

OR

Hepatitis C Quantitative RNA Testing not Performed at 12 Weeks, Reason not Specified

(One CPT II code & one G-code [3220F-8P & G8461] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **3220F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

3220F with 8P: Hepatitis C quantitative RNA testing was not documented as performed at 12 weeks from initiation of antiviral treatment, reason not otherwise specified

AND

G8461: Patient receiving antiviral treatment for Hepatitis C

RATIONALE:

Monitor effectiveness of antiviral therapy. An early virologic response (EVR), during the first 12 weeks of therapy, is a valuable clinical milestone. In the absence of an EVR, the likelihood of an SVR is 0–3%. If the only goal of therapy is to achieve an SVR, therapy can be discontinued after 12 weeks if an EVR is not achieved. Potentially, histologic benefit can accrue even in the absence of an SVR; therefore, some authorities treat beyond 12 weeks even in patients who have not achieved an EVR. For documentation of a virologic response at the end of therapy (end-of-treatment response) or an SVR \geq 6 months after completing therapy, a more sensitive quantitative assay with a lower limit of \leq 50 IU/mL, if available, or a qualitative HCV RNA assay is recommended.

CLINICAL RECOMMENDATION STATEMENTS:

Baseline and 12-week monitoring of HCV RNA levels should be performed with the same quantitative amplification assay. An early virologic response (EVR), defined as a $\geq 2\text{-log}_{10}$ reduction in HCV RNA levels during the first 12 weeks of therapy, is a valuable clinical milestone (Category I). (AGA)

Clinical and virologic monitoring during therapy should be conducted at intervals ranging from once a month to once every 3 months. Frequent hematologic monitoring is necessary to identify marked anemia, neutropenia, and thrombocytopenia; monitoring of thyroid stimulating hormone level is indicated to identify hypothyroidism or hyperthyroidism (Category I). (AGA)

▲ Measure #89: Hepatitis C: Counseling Regarding Risk of Alcohol Consumption

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of hepatitis C who were counseled about the risks of alcohol use at least once within 12-months.

INSTRUCTIONS:

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

Measure Reporting via Claims:

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

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

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of hepatitis C

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for hepatitis C (ICD-9-CM): 070.51, 070.54, 070.70

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were counseled about the risks of alcohol use at least once within the 12 month reporting period

Definition:

Counseling – May include documentation of a discussion regarding the risks of alcohol, or notation to decrease or abstain from alcohol intake.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Counseling Regarding Risk of Alcohol Consumption

CPT II 4158F: Patient counseled about risks of alcohol use

OR

Counseling Regarding Risk of Alcohol Consumption not Performed, Reason not Specified

Append a reporting modifier (**8P**) to CPT Category II code **4158F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4158F with 8P: Patient counseled about risks of alcohol use not performed, reason not otherwise specified

RATIONALE:

Minimize progression of liver disease. Higher levels of alcohol promote the development of progressive liver disease, with strong evidence for the detrimental effects of 30 g/day in men (~ equivalent to 2 beers, 2 glasses of wine, or 2 mixed drinks) and 20 g/day in women. Lower amounts of alcohol also may increase the risk of liver damage associated with HCV. (NIH)

CLINICAL RECOMMENDATION STATEMENTS:

Higher levels of alcohol use play an important role in promoting the development of progressive liver disease, with strong evidence for the detrimental effects of 30 g/day in men (~ equivalent to 2 beers, 2 glasses of wine, or 2 mixed drinks) and 20 g/day in women. Lower amounts of alcohol also may increase the risk of liver damage associated with HCV. (NIH)

Abstinence should be recommended before and during antiviral treatment in alcoholic persons, and treatment of alcohol abuse should be linked with efforts to treat hepatitis C in alcoholic patients. A safe level of alcohol consumption in patients with hepatitis C has not been established (Category II-1b). (AGA)

▲ Measure #90 Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy

2011 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:

Percentage of female patients aged 18 through 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment who were counseled regarding contraception prior to the initiation of treatment

INSTRUCTIONS:

This measure is to be reported a minimum of once per reporting period for all patients with a diagnosis of chronic hepatitis C seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with chronic hepatitis C who are receiving antiviral treatment. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure Reporting via Claims:

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

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

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:

All women aged 18 through 44 years and all men aged 18 years and older with a diagnosis of chronic hepatitis C who are receiving antiviral treatment

Denominator Criteria (Eligible Cases):

Patients (females aged 18 through 44 years or males aged \geq 18 years) on date of encounter

AND

Diagnosis for chronic hepatitis (ICD-9-CM): 070.54

AND

Patient encounter during the reporting period (CPT): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

NUMERATOR:

Patients who were counseled regarding contraception prior to the initiation of treatment

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Counseling Regarding Contraception Received

(One CPT II code & one G-code [4159F & G8463] are required on the claim form to submit this numerator option)

CPT II 4159F: Counseling regarding contraception received prior to initiation of antiviral treatment

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

Counseling Regarding Contraception not Received for Medical Reason

(One CPT II code & one G-code [4159F-1P & G8463] are required on the claim form to submit this numerator option)

Append a modifier (**1P**) to CPT Category II code **4159F** to report documented circumstances that appropriately exclude patients from the denominator.

4159F with 1P: Documentation of medical reason(s) for not counseling patient regarding contraception

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

OR

If patient is not eligible for this measure because patient is not receiving antiviral treatment, report:

(One G-code [G8462] is required on the claim form to submit this numerator option)

G8462: Clinician documented that patient is not an eligible candidate for counseling regarding contraception prior to antiviral treatment; patient not receiving antiviral treatment for Hepatitis C

OR

Counseling Regarding Contraception not Received, Reason not Specified

(One CPT II code & one G-code [4159F-8P & G8463] are required on the claim form to submit this numerator option)

Append a reporting modifier (**8P**) to CPT Category II code **4159F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

4159F with 8P: Counseling regarding contraception not received prior to initiation of antiviral treatment, reason not otherwise specified

AND

G8463: Patient receiving antiviral treatment for Hepatitis C documented

RATIONALE:

Ribavirin is contraindicated in pregnancy. Therefore, counseling regarding strict precautions and contraception in women of childbearing age and their sexual partners and in HCV-infected men with female partners of childbearing age needs to be provided to those receiving treatment for chronic hepatitis C prior to the initiation of treatment. Although this measure only captures data related to counseling prior to therapy it should be subsequently re-enforced during treatment and for a period of 6 months after treatment.

CLINICAL RECOMMENDATION STATEMENTS:

Because of the concern of birth defects from the use of ribavirin, it is imperative that persons who receive the drug use strict contraception methods both during treatment and for a period of 6 months after treatment. (AASLD)

Ribavirin is contraindicated in pregnancy, necessitating strict precautions and contraception in women of childbearing age and their sexual partners and in HCV-infected men with female partners of childbearing age. (AGA)