The Physicians Advocacy Institute’s
Medicare Quality Payment Program (QPP)
Physician Education Initiative

2017 Transition Year Flexibility
Quality Category Options
2017 Transition Year Flexibility
Quality Category Options

2017 serves as a transition year for the MACRA Quality Payment Program (QPP) during which physicians have the flexibility to select the level of participation that best suits their practices. Under the QPP, physicians may choose to participate in an Advanced Alternative Payment Model (APM) or submit data to the Merit-Based Incentive Payment System (MIPS).

MIPS is a new program that consolidates and sunsets the previous quality reporting programs, including the Physician Quality Reporting System (PQRS), Value-based Payment Modifier (VM), and the Electronic Health Records (EHR) Incentive program (Meaningful Use), into one program. In 2017, MIPS has four weighted performance categories: quality (60%), based on PQRS; cost (0%), based on VM; advancing care information (25%), based on Meaningful Use; and improvement activities (15%), a new category not based on a previous program.

This resource provides guidance for the Quality category for individual and small group practices, which replaced the Medicare Physician Quality Reporting System known as PQRS.
What are my options for the Quality category?

<table>
<thead>
<tr>
<th>Avoid a Negative Payment Adjustment?</th>
<th>No Participation</th>
<th>Test Participation</th>
<th>Partial Year Participation</th>
<th>Full Year Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eligible for a Positive Payment Adjustment?</th>
<th>No</th>
<th>No</th>
<th>Yes (eligible for maximum adjustment)</th>
<th>Yes (eligible for maximum adjustment)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Length of the Reporting Period</th>
<th>N/A</th>
<th>N/A</th>
<th>Minimum 90-day reporting period</th>
<th>Full calendar-year reporting period</th>
</tr>
</thead>
</table>

By selecting test, partial, or full year participation option in 2017, physicians can avoid a -4% payment adjustment of their Medicare Part B fee-for-service (FFS) claims in 2019. However, only those physicians who participate using the partial or full year options will also be eligible to receive a positive payment adjustment of their Medicare Part B FFS claims in 2019.

**Test Participation – Submit something and avoid a penalty**

The threshold for avoiding a negative payment adjustment through the “Test” option is extremely low, and physicians are highly encouraged to at least participate using this option. Physicians who submit just a minimum amount of data will receive a “neutral” payment adjustment and avoid a negative payment adjustment of their Medicare Part B FFS payments.

Under this option, the minimum threshold for the Quality category is to submit data on at least 1 patient for 1 measure, which can be achieved by reporting using your Medicare Part B claims. However, it is recommended that you report data on more than 1 patient to ensure that the negative payment adjustment is avoided, and that there are no reporting or submission errors. The deadline for the claims data submission method for the Quality category is Feb. 28, 2018, but you do not have to wait until then to fulfill this minimum requirement. You may submit data through Medicare Part B claims for any patient encounter date in 2017.

**Partial and Full Year Participation – Submit data for at least 90 days to be eligible for a positive payment adjustment**

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1 This resource focuses on the quality category reporting options for individual and group practice reporting and does not address reporting requirements and scoring details for the...
With the partial year participation option, physicians are required to report data for at least 90 consecutive calendar days, and with the full year participation option, physicians must submit data for the full calendar year (Jan. 1, 2017 – Dec. 31, 2017). With both of these options, physicians can avoid the negative payment adjustment and be eligible to receive the maximum positive payment adjustment.

The quality category thresholds for the partial year and full year participation options are as follow:

- Minimum of 6 individual measures, including one outcome measure or a high-priority measure if an outcome measure is not available
  - Intermediate outcome measures count as an outcome measure
  - High-priority measures are defined as appropriate use, patient safety, efficiency, patient experience, and care coordination measures
- Or alternatively (to the 6 individual measures) report one specialty-specific measure set
- Report each measure for 50% of applicable patients (report data for that measure for at least 50% of the patients to whom the measure applies, discussed in detail below)

Physicians will receive 3-10 points for each measure they report, based on their performance for that measures compared to the benchmark. Physicians will automatically receive 3 points for submitting some information on a measure.

For groups of 16 or more and with ≥ 200 cases that meet the all-cause readmission measure, this measure will automatically be calculated using administrative claims data and would be counted in addition to the individual measures reporting requirement.

Additionally, bonus points can be earned by reporting additional high-priority measures, or reporting measures electronically using an electronic health record (EHR), qualified registry, or a qualified clinical data registry (QCDR).

CAHPS for MIPS Surveys (for groups of 2 or more eligible clinicians) or CMS Web Interface (for groups of 25 or more eligible clinicians).

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What measures to report?

**Specialty-Specific Measure Sets**

Reporting a specialty-specific measure set may be the least burdensome option if an applicable specialty-specific measure set exists.

There are 30 specialty measure sets available for 2017 reporting.

<table>
<thead>
<tr>
<th>Specialty-Specific Measure Sets</th>
<th>Allergy/Immunology</th>
<th>Emergency Medicine</th>
<th>Internal Medicine</th>
<th>Orthopedic Surgery</th>
<th>Preventive Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>Gastroenterology</td>
<td>Interventional Radiology</td>
<td>Otolaryngology</td>
<td>Radiation Oncology</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td>General Oncology</td>
<td>Mental/Behavioral Health</td>
<td>Pathology</td>
<td>Rheumatology</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>General Practice</td>
<td>Neurology</td>
<td>Pediatrics</td>
<td>Thoracic Surgery</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>General Surgery</td>
<td>Obstetrics/Gynecology</td>
<td>Physical Medicine</td>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Electrophysiology Cardiac Specialist</td>
<td>Hospitalists</td>
<td>Ophthalmology</td>
<td>Plastic Surgery</td>
<td>Vascular Surgery</td>
<td></td>
</tr>
</tbody>
</table>

If the measure set contains more than 6 measures, you are only required to report on 6 total measures (at least one of which must be an outcomes or high-priority measure).

If the measure set contains less than 6 measures, then you are only required to report on applicable measures. For example, a measure set may only have 4 measures, and only 3 of those 4 measures are applicable to your practice, then you are only required to report those 3 measures.

Additional details on these specialty-specific measure sets are available on CMS’s Quality Payment Program website: [https://qpp.cms.gov/measures/quality](https://qpp.cms.gov/measures/quality).
**Individual Measures**

There are a total of 271 MIPS individual measures, across all specialties and settings, available for 2017 reporting.

A list of all measures and a measures search tool that can help filter the measures by specialty are available on CMS’s QPP website: [https://qpp.cms.gov/measures/quality](https://qpp.cms.gov/measures/quality) (please see screenshot on next page).

**Select Measures**

![Select Measures](image)

Showing 271 Measures

- Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy - Avoidance of Inappropriate Use
- Acute Otitis Externa (AOE): Topical Therapy
- ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication

**Common Measures**

While more applicable, specialty-specific measures may be available for your practice, below are the measures that CMS has identified as being reportable by at least 10 different specialists. However, you do not have to report on these measures if they do not apply to you or if you prefer to report on other measures.

Measures
- # 47 – Care Plan
- #128 – Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

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As you evaluate which measures to report, these measures provide a good starting point. In the Appendix you will find the reporting specifications (extracted from official 2017 CMS measure specifications documents) for each of these measures for claims and registry reporting, along with flow-chart diagrams from CMS that walk you through the specifications and reporting.

**Determine which measures can be reported via the different mechanisms**

You have several option for reporting quality category measures data.

<table>
<thead>
<tr>
<th>Category</th>
<th>Reporting Mechanism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Individual: Claims, QCDR, Qualified Registry, EHR</td>
</tr>
<tr>
<td></td>
<td>Group: QCDR, Qualified Registry EHR, CMS Web Interface (groups of 25 or more eligible clinicians), CMS-approved survey vendor for CAHPS (used in conjunction with another reporting mechanism), Administrative Claims</td>
</tr>
</tbody>
</table>

However, not all measures can be reported using all reporting mechanisms. For example, some measures may not be available for claims reporting, but can be reported using a registry.

If reporting using the claims option, you will need to check CMS’s QPP website at [https://qpp.cms.gov/measures/quality](https://qpp.cms.gov/measures/quality) to identify measures that are reportable through the claims reporting mechanism. To obtain the list for claims measures, filter the list of measures by data submission method and select “claims”.

If reporting using an EHR, please check with your EHR vendor about which quality measures they allow you to report electronically using the EHR.

If reporting using a qualified registry or QCDR, you can see a list of the measures that can be reported on the respective qualified registry’s or QCDR’s website. Additionally, it is important to note that each QCDR can offer up to 30 non-MIPS measures, in addition to the 271 MIPS measures.
posted on CMS’s QPP website; these QCDR measures may be more applicable and meaningful for your practice.

**Measure Specifications**

For each quality measure, you should know what is being measured and why. It is highly recommended that you review the 2017 measure specifications for all measures you choose to report for the Quality category. Measures specifications provide a blueprint for each measure with detailed information such as the denominator criteria (patient population), numerator criteria (clinical action), documentation requirements (important for potential audits), and rationale with the evidence base and/or or intent for the measure, among other key information.

Each reporting mechanism has its own set of measure specifications per measure. If you need help understanding and interpreting measure specifications documents, refer to the guides in the Quality Measure Specifications Supporting Documents zip file located on the Education and Tools page on the CMS QPP website. Within the zip file, you will find guides for the claims, registry, and CMS Web Interface reporting mechanisms.

For measure specifications for non-MIPS measures for the QCDR reporting mechanism, contact your QCDR vendor.

For measure specifications for the EHR reporting mechanism, contact your EHR vendor.

**Benchmarks and Performance Scores**

In order to receive a performance score beyond 3 points per individual quality measure, you must meet the data completeness criteria of “50% of applicable patients,” meet the case minimum requirement of at least 20 cases per measure, and the measure must have a benchmark. The performance score is how often you completed/conducted the required clinical action, such as provide a service or achieve an outcome that is being measured for each quality measure.

The performance score for each measure determined by looking at the number of patients that meet the denominator criteria for whom the measure is reported and who are not excluded, and seeing for how many of those patients you performed a clinical action that could satisfy the measure (the numerator for the measure). Your numerator/denominator performance will then be compared to the benchmark for the measure, and you will receive points for that measure based on how you performed in relation to the benchmark.

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2 [https://qpp.cms.gov/resources/education](https://qpp.cms.gov/resources/education)
To review benchmarks for each measure, refer to the 2017 Quality Benchmarks zip file on the Education and Tools page on the CMS QPP website. For quality measures that are reportable through more than one reporting mechanism, please note that the benchmarks vary and selecting one method over another can impact your performance score.

**Note:** the “50% of applicable patients” requirement is not the same as the performance score which determines the number of points you will receive for each measure.

50% of applicable patients means that, out of all the patients to whom the measure applies (i.e. patient who meet the denominator criteria), the measure is reported for at least 50% of those patients. The quantity of patients you report on per measure will vary from measure to measure, and will depend on the patient criteria for each measure. Whether this includes patients from all payers or just Medicare Part B FFS patients depends on the reporting mechanism.

<table>
<thead>
<tr>
<th>Claims</th>
<th>QCDR, qualified registry, and EHR</th>
<th>CAHPS for MIPS Survey</th>
<th>CMS Web Interface</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicare Part B patients</td>
<td>• Patients from all payers, including Medicare (all-payer mix)</td>
<td>• Medicare Part B patients</td>
<td>• Medicare Part B patients</td>
</tr>
</tbody>
</table>

**How do I report data and by when?**

You have several reporting mechanisms available for reporting your quality category data. How you report the information will depend on the reporting mechanism you decide to choose. In the chart on next page, provides clarification on how the data is reported for each mechanism, and also includes some key points you may want to take into consideration as you determine the best reporting mechanism option for you/your practice.

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3 [https://qpp.cms.gov/resources/education](https://qpp.cms.gov/resources/education)

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A list of CMS-qualified registries for the 2017 performance period is available [here](https://qpp.cms.gov/docs/QPP_MIPS_2017_Qualified_Registries.pdf). The list of CMS-approved QCDR vendors for the 2017 performance period is pending.

The deadline for the claims reporting mechanism is February 28, 2018.

The deadline for the QCDR, registry and EHR reporting mechanisms is March 31, 2018 (or sooner depending on the vendors’ own deadlines).
Where can I go for more information?

For additional information on the quality category, please see PAI QPP Tutorial #3 on the quality and cost categories, available on the video library page, and other resources available on PAI’s QPP website.

Additionally, visit the CMS QPP website’s quality category page,\(^5\) as well as the Education & Tools page,\(^6\) for more information.

\(^5\) [https://qpp.cms.gov/measures/quality](https://qpp.cms.gov/measures/quality)

\(^6\) [https://qpp.cms.gov/resources/education](https://qpp.cms.gov/resources/education)
## Appendix

### # 47 – Care Plan

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage of patients 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Mechanisms</td>
<td>Claims, registry</td>
</tr>
</tbody>
</table>
| Which patients does this measure apply to? | Patient is at least 65-years-old  
You have reported one of the following CPT or HCPCS codes for the patient: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402, G0438, G0439  
AND NOT FOR REGISTRY REPORTING ONLY (included in claims reporting)  
Patient is receiving hospice services at any time during the reporting period |
| What do you need to report if using claims? | Report code G9692 if the patient is receiving hospice services at any time during the reporting period (not an option for registry reporting)  
Report CPT II Code 1123F if you discussed Advance Care Planning with the patient and the advance care plan or surrogate decision maker is documented. You will need to document the advance care plan or the surrogate decision maker in the patient’s medical record  
Report CPT II Code 1124F if you discussed Advance Care Planning with the patient, but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan. You will need to document this in the patient’s medical record.  
- If the patient’s cultural and/or spiritual beliefs preclude a discussion of advance care planning, you may include the following documentation:  
  - That the patient’s cultural and/or spiritual beliefs preclude a discussion on advance care planning, as it would be viewed as harmful to the patient’s beliefs and thus harmful to the physician-patient relationship  
Report CPT II Code 1123F with 8P if you did not discuss Advance Care Planning with the patient, and do not provide a reason as to why not |

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7 All flowcharts and diagram are from the CMS Quality Measure Specification documents available at: https://qpp.cms.gov/resources/education.

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2017 Registry Individual Measure Flow
#47 NQF #0326: Care Plan

Start

Denominator

Patient Age at Date of Service ≥ 65 Years

No

Not Included in Eligible Population/Denominator

No

Encounter Codes as Listed in Denominator

(1/1/2017 thru 12/31/2017)

Denominator Exclusion

Yes

Patient Using Hospice Services Any Time During the Measurement Period G9992 or equivalent

Include in Eligible Population/Denominator (8 patients)

Numerator

Advance Care Planning Discussed and Documented; Advance Care Plan or Surrogate Decision Maker Documented in the Medical Record

Yes

Data Completeness Met + Performance Met 1123F or equivalent (3 patients)

No

Advance Care Planning Discussed and Documented in Medical Record, Patient Did Not Wish or was Not Able to Name a Surrogate Decision Maker or Provider an Advance Care Plan

Yes

Data Completeness Met + Performance Met 1124F or equivalent (1 patient)

No

Advance Care Planning Not Documented; Reason Not Specified

Yes

Data Completeness Met + Performance Not Met 1123F-BP or equivalent (3 patients)

No

Data Completeness Not Met

Quality Data Code or equivalent not reported (1 patient)

SAMPLE CALCULATIONS:

Data Completeness =
Performance Met (a = 4 patients) + Performance Not Met (c = 3 patients) = 7 patients
Eligible Population / Denominator (d = 8 patients) = 87.60%

Performance Rate =
Performance Met (a + c = 4 patients) = 57.14%
Data Completeness Numerator (7 patients) = 7 patients

* See the posted Measure Specification for specific coding and instructions to report this measure.
NOTE: Reporting Frequency: Patient-process

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

<table>
<thead>
<tr>
<th>Description</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Mechanisms</td>
<td>Claims, registry</td>
</tr>
<tr>
<td>Which patients does this measure apply to?</td>
<td>Patient is at least 18-years-old AND Patient’s BMI is outside of normal parameters: • Normal parameters: $18.5, \text{kg/m}^2 &lt; \text{BMI} &lt; \text{kg/m}^2$ AND You have reported one of the following CPT or HCPCS codes for the patient: 90791, 90792, 90832, 90834, 90837, 96150, 96151, 96152, 97161, 97162, 97163, 97165, 97166, 97167, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447 AND NOT FOR REGISTRY REPORTING ONLY (included in claims reporting) Patient who is not eligible for a BMI calculation or a follow-up plan because the patient is receiving palliative care, is pregnant, or refuses measurement of height and/or weight or refuses follow-up AND WITHOUT for both Claims and Registry Telehealth modifier: GQ, GT</td>
</tr>
<tr>
<td>What do you need to report if using claims? If using a registry, select one of the following options</td>
<td>Report code G8422 if the patient’s BMI is not documented because the patient is not eligible for BMI calculation (not an option for registry reporting) • Patient is not eligible for a BMI calculation if one or more of the following is documented: o Patient receiving palliative care o Patient is pregnant o Patient refuses measurement of height and/or weight or refuses follow-up Report code G8938 if the patient’s BMI is documented outside of normal parameters, but a follow-up plan is not documented because the patient is not eligible (not an option for registry reporting) • Patient is not eligible if one or more of the following reasons is documented: o Patient receiving palliative care o Patient is pregnant</td>
</tr>
<tr>
<td>Definitions/Examples</td>
<td>Follow-Up Plan is a proposed outline of treatment to be conducted because the BMI is outside of normal parameters. A follow-up plan may include, but is not limited to:</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
|                      | • Documentation of education  
• Referral (for example a registered dietitian, nutritionist, occupational therapist, physical therapist, primary care provider, exercise physiologist, mental health professional, or surgeon)  
• Pharmacological interventions  
• Dietary supplements  
• Exercise counseling  
• Nutrition counseling |

- Patient refuses measurement of height and/or weight or refuses follow-up

**Report code G8420** if the patient’s BMI is documented within normal parameters and no follow-up plan is required

**Report code G8417** if the patient’s BMI is documented above normal parameters and a follow-up plan is documented

**Report code G8418** if the patient’s BMI is documented below normal parameters and a follow-up plan is documented

**Report code G9716** if the patient’s BMI is documented as being outside of normal limits but a follow-up plan is not completed for a documented reason

- A medical reason could include, but is not limited to, the following patients as deemed appropriate by the physician:
  - Elderly Patients (65 or older) for whom weight reduction/weight gain would complicate other underlying health conditions such as the following examples:
    - Illness or physical disability
    - Mental illness, dementia, confusion
    - Nutritional deficiency, such as Vitamin/mineral deficiency
  - 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

**Report code G8421** if BMI is not documented and no reason is provided as to why not

**Report code G8419** if BMI is documented outside of normal parameters, but no follow-up plan is documented and no reason is provided as to why not
2017 Claims Individual Measure Flow
#128 NQF #0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Denominator

Start

Patient Age at Date of Service ≥ 18 Years

No

Not Included in Eligible Population/Denominator

Yes

Encounter Codes as Listed in Denominator* (1/1/2017 thru 12/31/2017)

No

Telehealth Modifier: GQ, GT

Yes

Include in Eligible Population/Denominator (8 patients) d

Numerator

BMI Not Documented, Patient Not Eligible**

Yes

Data Completeness Met + Denominator Exclusion G8422 (2 patients) x1

No

BMI Documented Outside of Normal Limits, Follow-Up Plan Not Documented, Patient Not Eligible**

Yes

Data Completeness Met + Denominator Exclusion G8508 (0 patients) x2

No

BMI*** Documented as Normal, No Follow-Up Plan** Required

Yes

Data Completeness Met + Performance Met G8430 (1 patient) a1

No

BMI*** Documented as Above Normal Parameters, And Follow-Up Plan** Documented

Yes

Data Completeness Met + Performance Met G8417 (1 patient) a2

No

BMI*** Documented As Below Normal Parameters, And Follow-Up Plan** Documented

Yes

Data Completeness Met + Performance Met G8418 (1 patient) a3

No

Go To Next Page

* See the posted Measure Specification for specific coding and instructions to report this measure.
** See the posted Measure Specification for specific BMI and follow-up plan definitions, eligibility exclusion criteria, and denominator exception criteria for this measure.
NOTE: Reporting Frequency: Patient-Intermediate

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2017 Claims Individual Measure Flow
#128 NQF #0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

SAMPLE CALCULATIONS:

Data Completeness:
Denominator Exclusion (x1^x2=2 patients) + Performance Met (x3^x4=3 patients) + Denominator Exception (b=x1 patients) + Performance Not Met (c^c^2=2 patients) = 7 patients = 87.50% Eligible Population / Denominator (9=6 patients)

Performance Rate:
Performance Met (x3^x4=3 patients) = 3 patients = 60.00%

* See the posted Measure Specification for specific coding and instructions to report this measure.
** See the posted Measure Specification for specific BMI and follow-up plan definitions, eligibility exclusion criteria, and denominator exception criteria for this measure.

NOTE: Reporting Frequency: Patient-Intermediate

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2017 Registry Individual Measure Flow
#128 NQF #0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

Denominator

Start

Patient Age at Date of Service ≥ 18 Years

No

Not included in Eligible Population/Denominator

Yes

Encounter Codes as Listed in Denominator*
(1/1/2017 thru 12/31/2017)

No

Denominator Exclusions

Telehealth Modifier: GQ, GT

No

BMI Not Documented, Patient Not Eligible** G8420 or equivalent

Yes

BMI Documented Outside of Normal Limits, Follow-Up Plan Not Documented, Patient Not Eligible** G8438 or equivalent

No

Include in Eligible Population/Denominator

(8 patients)

Numerator

BMI** Documented as Normal, No Follow-Up Plan** Required

Yes

Data Completeness Met + Performance Met G8420 or equivalent (2 patients) a1

No

BMI** Documented as Above Normal Parameters, And Follow-Up Plan** Documented

Yes

Data Completeness Met + Performance Met G3417 or equivalent (2 patients) a2

No

BMI** Documented As Below Normal Parameters And Follow-Up Plan** Documented

Yes

Data Completeness Met + Performance Met G8418 or equivalent (1 patient) a3

No

Go To Next Page

* See the posted Measure Specification for specific coding and instructions to report this measure.
** See the posted Measure Specification for specific BMI and follow-up plan definitions, eligibility exclusion criteria, and denominator exception criteria for this measure.
NOTE: Reporting Frequency: Patient-Intermediate

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2017 Registry Individual Measure Flow

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

Numerator

Go To Next Page

BMI Documented Outside of Normal Limits, Follow-Up Plan Not Completed, Documented Reason**

Yes ➤ Data Completeness Met + Denominator Exception G9716 or equivalent (0 patients)  b

No

BMI Not Documented, Reason Not Given

Yes ➤ Data Completeness Met + Performance Not Met G8421 or equivalent (1 patient)  c1

No

BMI** Documented Outside of Normal Parameters, Follow-Up Plan** Not Documented, Reason Not Given

Yes ➤ Data Completeness Met + Performance Not Met G8419 or equivalent (1 patient)  c2

No

Data Completeness Not Met: Quality/Data Code or equivalent not reported (1 patient)

SAMPLE CALCULATIONS:

Data Completeness*  Performance Met (a + a* + a** + 3 patients) - Denominator Exception (b = 0 patients) = Performance Not Met (c + c* + c**) = 7 patients = 87.80%  Eligible Population / Denominator (308 patients) = 6 patients

Performance Rate**  Performance Met (a + a* + a** = 5 patients)  Data Completeness Numerator (7 patients) - Denominator Exception (b = 0 patients) = 5 patients = 71.43%  7 patients

* See the posted Measure Specification for specific coding and instructions to report this measure.
** See the posted Measure Specification for specific BMI and follow-up plan definitions, eligibility exclusion criteria, and denominator exception criteria for this measure.

NOTE: Reporting Frequency: Patient-Intermediate

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### #130 – Documentation of Current Medications in the Medical Record

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage of visits for patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list <strong>must</strong> include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND <strong>must</strong> contain the medications’ name, dosage, frequency and route of administration.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Mechanisms</td>
<td>Claims, registry</td>
</tr>
<tr>
<td>Which patients does this measure apply to?</td>
<td>Patient is at least 18-years-old AND You have reported one of the following CPT or HCPCS codes for the patient: 90791, 90792, 90832, 90834, 90837, 90839, 92002, 92004, 92012, 92014, 92507, 92508, 92526, 92537, 92538, 92540, 92541, 92542, 92544, 92545, 92547, 92548, 92550, 92557, 92567, 92568, 92570, 92585, 92588, 92626, 96116, 96150, 96151, 96152, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97532, 97802, 97803, 97804, 98960, 98961, 98962, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99221, 99222, 99223, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99495, 99496, G0101, G0108, G0270, G0402, G0438, G0439</td>
</tr>
<tr>
<td>What do you need to report if using claims? If using a registry, select one of the following options</td>
<td><strong>Report code G8427</strong> if you attest to documenting in the medical record that you obtained, updated, or reviewed the patient’s current medications. This code should also be reported if the patient is not currently taking any medications <strong>Report code G8430</strong> if you attest to documenting in the medical record that the patient is not eligible for a current list of medications being obtained, updated, or reviewed because the 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 <strong>Report code G8428</strong> if the current list of medications is not documented as obtained, updated, or reviewed for a reason not given</td>
</tr>
<tr>
<td>Definitions/Examples</td>
<td>Current medications are the medications the patient is presently taking including all prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements with each medication’s name, dosage, frequency, and route of administration (how the medication enters the body, e.g., oral, sublingual, subcutaneous injections, topical, etc.)</td>
</tr>
</tbody>
</table>
2017 Claims Individual Measure Flow

#130 NQF #0419: Documentation of Current Medications in the Medical Record

DATA COMPLETENESS:

\[
\text{Data Completeness} = \frac{\text{Performance Met (a=4 visits)} + \text{Denominator Exception (b=1 visit)} + \text{Performance Not Met (c=2 visits)}}{\text{Eligible Population} / \text{Denominator (d=8 visits)}} = \frac{7 \text{ visits}}{8 \text{ visits}} = 87.50\%
\]

\[
\text{Performance Rate} = \frac{\text{Performance Met (a=4 visits)}}{\text{Data Completeness Numerator (7 visits) – Denominator Exception (b=1 visit)}} = \frac{4 \text{ visits}}{6 \text{ visits}} = 66.67\%
\]

*See the posted Measure Specification for specific coding and instructions to report this measure.

NOTE: Reporting Frequency: Visit

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The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.

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2017 Registry Individual Measure Flow
#130 NQF #0419: Documentation of Current Medications in the Medical Record

**SAMPLE CALCULATIONS:**

Data Completeness:  
\[
\text{Performance Met (d=4 visits) + Denominator Exception (b=1 visit) + Performance Not Met (c=2 visits)} = 7 \text{ visits} = \frac{87.50\%}{8 \text{ visits}}
\]

Performance Rate:  
\[
\text{Performance Met (d=4 visits) = 4 visits} = \frac{66.67\%}{6 \text{ visits}}
\]

*See the posted Measure Specification for specific coding and instructions to report this measure.

NOTE: Reporting Frequency: Visit

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#226 – Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

<table>
<thead>
<tr>
<th>Description</th>
<th>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</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reporting Mechanisms</th>
<th>Claims, registry</th>
</tr>
</thead>
</table>

| Which patients does this measure apply to for claims reporting? | Patient is at least 18-years-old AND You have reported one of the following CPT or HCPCS codes for the patient: 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 96160, 96161 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99351, 99355, 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99411, 99412, 99429, G0438, G0439 AND WITHOUT Telehealth Modifier: GQ, GT |

| Which patients does this measure apply to for registry reporting? | Patient is at least 18-years-old AND You have reported at least two CPT patient encounters during the performance period: 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, , 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99351, 99352, 99353, 99354, 99355, 99356, 99357, 99358, 99359, 99360, 99361, 99362, 99363, 99364, 99365, 99366, 99367, 99368, 99369, 99370, 99371, 99372, 99373, 99374, 99375, 99376, 99377, 99378, 99379, 99380, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99388, 99389, 99390, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99411, 99412, 99429, G0438, G0439 OR You have reported one of the following CPT or HCPCS codes for the patient: 90791, 90792, 90832, 90834, 90837, 90845, 92002, 92004, 92012, 92014, 92521, 92522, 92523, 92524, 92540, 92557, 92625, 96150, 96151, 96152, 96160, 96161 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99351, 99352, 99353, 99354, 99355, 99356, 99357, 99358, 99359, 99360, 99361, 99362, 99363, 99364, 99365, 99366, 99367, 99368, 99369, 99370, 99371, 99372, 99373, 99374, 99375, 99376, 99377, 99378, 99379, 99380, 99381, 99382, 99383, 99384, 99385, 99386, 99387, 99388, 99389, 99390, 99391, 99392, 99393, 99394, 99395, 99396, 99397, 99401, 99402, 99403, 99404, 99406, 99407, 99411, 99412, 99429, G0438, G0439 AND WITHOUT Telehealth Modifier: GQ, GT |

<p>| What do you need to report if using claims? If using a registry, select one of the following options | Report CPT II Code 4004F if the patient is screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user Report CPT II Code 1036F if the patient is screened for tobacco use and is not a current tobacco user |</p>
<table>
<thead>
<tr>
<th>Definitions/Examples</th>
<th>Tobacco use includes any type of tobacco</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Tobacco cessation intervention includes brief counseling of 3 minutes or less, and/or pharmacotherapy</td>
</tr>
</tbody>
</table>

**Report CPT II Code 4004F with 1P** if the patient is not screened for tobacco use due to a medical reason (e.g., limited life expectancy, or other medical reasons)

**Report CPT II Code 4004F with 8P** if the patient is not screened for tobacco use, or was screened for tobacco use but did not document tobacco cessation intervention, and no reason was provided as to why not
2017 Claims Individual Measure Flow
#226 NQF #0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Denominator

Start

Patient Screened for Tobacco Use AND Received Tobacco Cessation Intervention

Yes

Data Completeness Met + Performance Met
a
(1 patient)

No

Current Tobacco Non-User

Yes

Data Completeness Met + Performance Met
b
1036F-1P
(2 patients)

No

Encounter as Listed in Denominator (1/1/2017 thru 12/31/2017)

Yes

Documented Medical Reason(s) for not Screening for Tobacco Use

Yes

Data Completeness Met + Denominator Exception
b
4004F-1P
(2 patients)

No

Patient Age at Date of Service ≥ 18 Years

Yes

Telehealth Modifier: GQ, GT

No

Include in Eligible Population/Denominator (8 patients)

Not Included in Eligible Population/Denominator

No

Numerator

SAMPLE CALCULATIONS:

Data Completeness

\[
\text{Performance Met (a) + Denominator Exception (b=2 patients) + Performance Not Met (c=2 patients)} = 7 \text{ patients} = \frac{87.50\%}{8 \text{ patients}}
\]

Performance Rate

\[
\text{Performance Met (a) + Denominator Exception (b=3 patients)} = \frac{3 \text{ patients}}{8 \text{ patients}} = 60.00\%
\]

* See the posted Measure Specification for specific coding and instructions to report this measure.

** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention or tobacco status is unknown report 4004F-8P

NOTE: Reporting Frequency: Patient-process

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2017 Registry Individual Measure Flow
#226 NQF #0028: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Denominator

Start

Patient Age at Date of Service ≥ 18 Years

Not Included in Eligible Population/Denominator

At Least One Preventive Encounter as Listed in Denominator* (1/1/2017 thru 12/31/2017)

At Least Two Preventive Encounters as Listed in Denominator* (1/1/2017 thru 12/31/2017)

Telehealth Modifier: GQ, GT***

Include in Eligible Population/Denominator (9 patients)

Numerator

Patient Screened for Tobacco Use AND Received Tobacco Cessation Intervention

Current Tobacco Non-User

Documentation of Medical Reason(s) for not Screening for Tobacco Use

Tobacco Screening OR Tobacco Cessation Intervention Not Performed. Reason Not Specified

Data Completeness Met + Performance Met 4004F or equivalent (1 patient) a1

Data Completeness Met + Performance Met 1036F or equivalent (2 patients) a2

Data Completeness Met + Denominator Exception 4004F-1P or equivalent (2 patients) b

Data Completeness Met + Performance Not Met** 4004F-6P or equivalent (2 patients) c

Data Completeness Not Met Quality-Data Code or equivalent not reported (1 patient)

SAMPLE CALCULATIONS:

Data Completeness =  
\[ \frac{\text{Performance Met (a + b = 1 patients)} + \text{Denominator Exception (b=2 patients)} + \text{Performance Not Met (c=2 patients)}}{\text{Eligible Population / Denominator (d=8 patients)}} \]  
\[ = \frac{7 \text{ patients}}{8 \text{ patients}} = 87.50\% \]

Performance Rate =  
\[ \frac{\text{Data Completeness Numerator (7 patients)} - \text{Denominator Exception (b=2 patients)}}{\text{Eligible Population / Denominator (d=8 patients)}} \]  
\[ = \frac{5 \text{ patients}}{8 \text{ patients}} = 60.00\% \]

* See the posted Measure Specification for specific coding and instructions to report this measure.

** In the event that a patient is screened for tobacco use and identified as a user but did not receive tobacco cessation intervention or tobacco status is unknown report 4004F - 6P

***All encounters should be without the telehealth modifier in order to be denominator eligible.

NOTE: Reporting Frequency: Patient-process

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#317 – Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

<table>
<thead>
<tr>
<th>Description</th>
<th>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</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Mechanisms</td>
<td>Claims, registry</td>
</tr>
</tbody>
</table>

Which patients does this measure apply to?

- Patient is at least 18-years-old AND
- You have reported one of the following CPT or HCPCS codes for the patient: 90791, 90792, 90832, 90834, 90837, 90839, 90845, 90880, 92002, 92004, 92012, 92014, 96118, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99281, 99282, 99284, 99285, 99287, 99302, 99303, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, D7140, D7210, G0101, G0402, G0438, G0439, AND NOT FOR REGISTRY REPORTING ONLY (included in claims reporting)
- If the patient is not eligible due to active diagnosis of hypertension AND WITHOUT for Claims and Registry
- Telehealth Modifier: GQ, GT

What do you need to report if using claims?

If using a registry, select one of the following options

- Report code G9744 if the patient is not eligible due to active diagnosis of hypertension (not an option for registry reporting)
- Report code G8783 if you document a normal blood pressure reading, and follow-up is not required
- Report code G8950 if you document a pre-hypertensive or hypertensive blood pressure reading, AND the appropriate follow-up (described below) is documented
- Report code G9745 if you document a reason for why you did do not screen the patient for high blood pressure, or for why you did screen the patient for high blood pressure but did not recommend a follow-up
  - Documented reason would be one of the following:
    - Patient refuses to participate (either blood pressure measurement or follow-up)
    - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the
patient’s health status. This may include but is not limited to severely elevated blood pressure when immediate medical treatment is indicated

**Report code G8785** if you do not screen/document the patient for high blood pressure, but do not provide a reason as to why not

**Report code G8952** if you documented a pre-hypertensive or hypertensive blood pressure reading, but did not provide a reason for why the follow-up was not documented

<table>
<thead>
<tr>
<th>Definitions/Examples</th>
<th>Both the systolic and diastolic blood pressure measurements are required for inclusion. If there are multiple blood pressures on the same date of service, use the most recent as the representative blood pressure.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BP Classification and Follow-Up Interventions:</strong></td>
<td></td>
</tr>
<tr>
<td>• <strong>Normal:</strong> Systolic BP &lt; 120 mmHg AND Diastolic BP &lt; 80 mmHg</td>
<td></td>
</tr>
<tr>
<td>o No follow-up required</td>
<td></td>
</tr>
<tr>
<td>• <strong>Pre-hypertensive:</strong> Systolic BP of 120 – 139 mmHg OR Diastolic BP of 80 – 89 mmHg</td>
<td></td>
</tr>
<tr>
<td>o Follow-up with rescreen every year AND</td>
<td></td>
</tr>
<tr>
<td>o Recommended life style changes OR Referral to alternate/primary care provider</td>
<td></td>
</tr>
<tr>
<td>• <strong>First hypertensive:</strong> Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg</td>
<td></td>
</tr>
<tr>
<td>o Follow-up with rescreen more than once a day AND</td>
<td></td>
</tr>
<tr>
<td>o Recommended life style changes OR Referral to alternate/primary care provider</td>
<td></td>
</tr>
<tr>
<td>• <strong>Second hypertensive:</strong> Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg AND a most recent BP reading within the last 12 months Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg</td>
<td></td>
</tr>
<tr>
<td>o Follow-up with recommended lifestyle changes AND</td>
<td></td>
</tr>
<tr>
<td>o One or more of the following: anti-hypertensive pharmacologic therapy; laboratory tests; and/or electrocardiogram (ECG)</td>
<td></td>
</tr>
</tbody>
</table>

**Recommended life style changes** include one or more of the following:

- Weight reduction
- Dietary approaches to stop hypertension (DASH) eating plan
- Dietary sodium restriction
- Increased physical activity
- Moderation in alcohol (ETOH) consumption
2017 Claims Individual Measure Flow

#317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

![Flowchart diagram showing the process for calculating the data completeness for the measure.]

**SAMPLE CALCULATIONS:**

\[
\text{Data Completeness}_\text{Numerator} = \frac{\text{Performance Met (a' + a'' = 3 patients) + Denominator Exclusion (x = 2 patients) + Performance Not Met (c' + c'' = 2 patients)}}{\text{Eligible Population} / \text{Denominator (c = 6 patients)}} = \frac{7 \text{ patients}}{8 \text{ patients}} = 87.50\%
\]

\[
\text{Performance Rate} = \frac{\text{Performance Met (a' + a'' = 3 patients)}}{\text{Data Completeness Numerator (7 patients) – Denominator Exclusion (x = 2 patients)}} = \frac{3 \text{ patients}}{5 \text{ patients}} = 60.00\%
\]

* See the posted Measure Specification for specific coding and instructions to report this measure.
** See the posted Measure Specification for recommended specific blood pressure screening intervals, as well as definitions for exclusion criteria for this measure.

NOTE: Report Frequency: Patient-process
2017 Registry Individual Measure Flow
#317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

- **Data Completeness Met + Performance Met G0763 or equivalent (4 patients)**
  - a

- **Data Completeness Met + Performance Met G0950 or equivalent (1 patient)**
  - a

- **Data Completeness Met + Denominator Exception G0745 or equivalent (2 patients)**
  - b

- **Data Completeness Met + Performance Not Met G0765 or equivalent (2 patients)**
  - c

- **Data Completeness Met + Performance Not Met G0952 or equivalent (0 patients)**
  - c

**SAMPLE CALCULATIONS:**

<table>
<thead>
<tr>
<th>Data Completeness</th>
<th>Performance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance Met (a² + a = 5 patients) + Denominator Exception (b≥2 patients) + Performance Not Met (c² - c ≥ 2 patients) = 9 patients</td>
<td>90.00%</td>
</tr>
</tbody>
</table>

Eligible Population / Denominator (d=10 patients) = 10 patients

<table>
<thead>
<tr>
<th>Data Completeness Numerator (9 patients) – Denominator: Exception (b=2 patients) = 7 patients</th>
<th>Performance Met (a² + a = 5 patients)</th>
</tr>
</thead>
</table>

* See the posted Measure Specification for specific coding and instructions to report this measure.
** See the posted Measure Specification for documented mean 5) if a patient is considered a Denominator Exception or a Denominator Exception.
*** See the posted Measure Specification for recommended specific high blood pressure screening intervals, as well as definitions for exclusion criteria for this measure.

NOTE: Report Frequency: Patient level

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#402 – Tobacco Use and Help with Quitting Among Adolescents

<table>
<thead>
<tr>
<th>Description</th>
<th>The percentage of adolescents 12 to 20 years of age with a primary care visit during the measurement year for whom tobacco use status was documented and received help with quitting if identified as a tobacco user.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Mechanisms</td>
<td>Registry only</td>
</tr>
</tbody>
</table>
| Which patients does this measure apply to? | Patient is 12- to 20-years-old AND
You have reported one of the following CPT or HCPCS codes for the patient: 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439 |
| Which options to report/select in the registry? | **Code G9458** if the patient is documented as a tobacco user AND receives tobacco cessation intervention if identified as a user
- Tobacco cessation intervention includes one or more of the following:
  - Advice given to quit smoking or tobacco use
  - Counseling on the benefits of quitting smoking or tobacco use
  - Assistance with or referral to external smoking or tobacco cessation support programs
  - Current enrollment in smoking or tobacco use cessation program

**Code G9459** if the patient is not currently a tobacco user

**G9460** if you did not perform the tobacco assessment, or if you did perform the tobacco assessment but did not perform the tobacco cessation intervention, and did not provide a reason as to why not |
| Definitions/Examples | **Tobacco use status** means any documentation of smoking or tobacco use status, including ‘never’ or ‘non-use’

**Tobacco user** includes any documentation of active or current use of tobacco products, including smoking |
2017 Registry Individual Measure Flow

#402: Tobacco Use and Help with Quitting Among Adolescents

**Denominator**

Start

Patients Aged 12-20 Years on Date of Encounter

Encounter As Listed in Denominator* (1/1/2017 thru 12/31/2017)

Not Included in Eligible Population/Denominator

No

Include in Eligible Population/Denominator (8 patients)

**Numerator**

Data Completeness Met + Performance Met G9450 or equivalent (2 patients)

Patient Documented as Tobacco User and Received Tobacco Cessation Intervention if Identified as a Tobacco User

Currently a Tobacco Non-User

Tobacco Assessment or Tobacco Cessation Intervention Not Performed, Reason Not Given

Data Completeness Met + Performance Met G9459 or equivalent (2 patients)

Data Completeness Met + Performance Not Met G9460 or equivalent (3 patients)

Data Completeness Not Met Qualify Code or equivalent not reported (1 patient)

**SAMPLE CALCULATIONS:**

**Data Completeness**

Performance Met (a 1st 4 patients) + Performance Not Met (c=3 patients) = 7 patients = 87.50%

Eligible Population / Denominator (d=8 patients) = 8 patients

**Performance Rate**

Performance Met (a 1st 4 patients) = 4 patients = 57.14%

Data Completeness Numerator (7 patients) = 7 patients

*See the posted Measure Specification for specific coding and instructions to report this measure.

NOTE: Reporting Frequency: Patient-process

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#431 – Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months AND who received brief counseling if identified as an unhealthy alcohol user</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporting Mechanisms</td>
<td>Registry only</td>
</tr>
<tr>
<td>Which patients does this measure apply to?</td>
<td>Patient is at least 18-years-old AND You have reported two of the following CPT or HCPCS patient encounters: 90791, 90792, 90832, 90834, 90837, 90845, 96150, 96151, 96152, 97165, 97166, 97167, 97168, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0270, G0271 OR You have reported one of the following CPT or HCPCS codes for the patient: 96160, 96161, 99385*, 99386*, 99395*, 99396*, 99397*, 99401*, 99402*, 99403*, 99404*, 99411*, 99412*, 99429*, G0438, G0439 AND WITHOUT Telehealth modifier: GQ, GT</td>
</tr>
</tbody>
</table>
| Which options to report/select in the registry? | **Code G9621** if the patient is screened for alcohol use using a systematic screening method AND is identified as an unhealthy alcohol user AND received brief counseling

- Brief counseling refers to one or more of the following counseling sessions (5-15 minutes):
  - Feedback on alcohol use and harms
  - Identification of high-risk situations for drinking and coping strategies
  - Increased motivation and development of a personal plan to reduce drinking

**Code G9622** if the patient is screened for alcohol use using a systematic screening method AND is not identified as an unhealthy alcohol user
| **Code G9623** if you do not conduct a screening for alcohol use for a medical reason  
| • Medical reasons include limited life expectancy or other medical reasons |
| **Code G9624** if you do not conduct a screening for alcohol use using a systematic screening method, or if you did conduct a screening for alcohol use using a systematic screening method but did not perform a brief counseling, and did not provide a reason as to why not |

| **Definitions/Examples** | **Systematic screening method** means one of the following:  
| • Audit screening instrument (score ≥ 8)  
| • Audit-C screening instrument (score for men ≥ 4, score for women ≥ 3)  
| • Single question screening – how many times in the past year have you had 5 (for men) or 4 (for women and adults over 65) or more drinks in a day? (response ≥ 2) |
2017 Registry Individual Measure Flow
#431 NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

**Denominator**

- Start
- Patient Age at ≥ 18 Years
- Not Included in Eligible Population/Denominator
  - No
  - Yes
    - At Least One Preventive Encounter as Listed in Denominator* (1/1/2017 thru 12/31/2017)
      - No
      - Yes
        - Telehealth Modifier: GQ, GT**
          - Yes
          - No
            - Include in Eligible Population/Denominator (6 patients)

**Numerator**

- Patient Identified as an Unhealthy Alcohol User Using a Systematic Screening Method AND Received Brief Counseling
  - No
  - Yes
    - Patient Not Identified as an Unhealthy Alcohol User When Screened for Unhealthy Alcohol Use Using a Systematic Screening Method
      - No
      - Yes
        - Documentation of Medical Reason(s) for Not Screening for Unhealthy Alcohol Use
          - No
          - Yes
            - Telehealth Modifier: GQ, GT**
              - Yes
              - No
                - Include in Eligible Population/Denominator (6 patients)

**Data Completeness**

- Performance Met (a + a = 4 patients) / Denominator Exception (b = 1 patient) / Performance Not Met (c = 3 patients) = 8 patients / 100.00%
- Eligible Population / Denominator (d = 8 patients) = 8 patients

**Performance Rate**

- Performance Met (a + a = 4 patients) / Data Completeness Numerator (8 patients) / Denominator Exception (b = 1 patient) = 4 patients / Data Completeness Not Met (6 patients) = 57.14%

SAMPLE CALCULATIONS:

*See the posted Measure Specification for specific coding and instructions to report this measure.
**All encounters should be without the telehealth modifier in order to be denominator eligible.

Note: Reporting Frequency: Patient-Process