

2008 PQRI Measure Specifications
Release Notes
Version 1.0

January 2008

CMS is pleased to announce the release of the 2008 PQRI Measure Specifications, Version 1.0. Measure developers, professional organizations, and other PQRI stakeholders have provided comment and clarifications for this version (1.0). The list below details the changes made from the 2007 PQRI Specifications.

Measure #1:

- Added to Description, “mellitus”
- Added to Instructions, “with diabetes mellitus” in the first sentence
- In the Instructions, replaced “It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.” with “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.”
- Revised Numerator Coding:
 - Moved **OR** following 3046F to set off as numerator performance code consistent with other measures.
 - Revised Numerator Coding Statement and deleted “Performed.” Now reads as “Most Recent Hemoglobin A1c Level > 9.0%”.
 - Moved 3046F-8P below 3046F and above 3044F.

Measure #2:

- Added to Description, “mellitus”
- Added to Instructions, “with diabetes mellitus” in the first sentence
- In the Instructions, replaced “It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.” with “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.”
- Revised Numerator Coding:
 - Moved **OR** following 3048F to set off as numerator performance code consistent with other measures.
 - Revised Numerator Coding Statement and deleted “Performed.” Now reads as “Most Recent LDL-C Level <100 mg/dL”
 - Moved 3048F-8P below 3048F and above 3049F.

Measure #3:

- Added to Description, “mellitus”
- Added to Instructions, “with diabetes mellitus” in the first sentence
- In the Instructions, replaced “It is anticipated that clinicians who provide services for the primary management of diabetes mellitus will submit this measure.” with “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.”
- Clarified Numerator Instructions, “To describe both systolic and diastolic blood pressure values, two CPT II codes must be reported – 1) one to describe the systolic value; AND 2) one to describe the diastolic value. If there are multiple blood pressures on the same date of service, use the lowest systolic and lowest diastolic blood pressure on that date as the representative blood pressure.

- Revised Numerator Coding:
 - Moved diastolic code 3078F and added **AND** after 3075F description to set off as numerator performance code consistent with other measures.
 - Revised Numerator Coding Statement and deleted “Performed.” Now reads as “Most Recent Blood Pressure Measurement < 140/80 mmHg”
 - Moved systolic code 3077F and diastolic codes 3079F and 3080F after **OR** to set off as numerator performance not met consistent with other measures.
 - Moved 2000F-8P below 3078F and above 3077F.

Measure #4:

- Added to Instructions, “There is no diagnosis associated with this measure.”
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary care for the patient will submit this measure.” with “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.”
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from denominator coding

Measure #5:

- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with heart failure will submit this measure.” with “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.”
- Added to Instructions, “...which may be current or historical”.
- Added Numerator Note: The correct combination of numerator codes 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.
- Added definition for “prescribed”

Measure #6:

- Added to Instructions, “with coronary artery disease” in the first sentence
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with coronary artery disease will submit this measure.” with “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.”
- Added definition for “prescribed”

Measure #7:

- Added to Instructions, “with prior myocardial infarction (MI)” in the first sentence
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with coronary artery disease with prior myocardial infarction (MI) will submit this measure.” with “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.”
- Added definition for “prescribed”

Measure #8:

- Added to Instructions, “...which may be current or historical”.
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with heart failure will submit this measure.” with “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.”
- Added definition for “prescribed”
- Removed CPT II codes 4006F, 4006F with 1P, 2P, 3P, 8P, 3021F, 3021F with 8P, and 3022F from numerator coding and replaced with G-codes G8395, G8396, G8450, G8451, and G8452 codes.

Measure #9:

- In the Instructions, replaced “It is anticipated that clinicians who provide the primary management of patients with major depressive disorder will submit this measure.” with “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.”
- Added encounter codes 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 to denominator coding

Measure #10:

- Edited Description to read, “Percentage of final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with either a diagnosis of ischemic stroke or TIA or intracranial hemorrhage or at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage that includes documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction”
- Edited Instructions to read, “This measure is to be reported each time a CT or MRI is performed in a hospital or outpatient setting during the reporting period for patients with a diagnosis or symptom of ischemic stroke, TIA, or intracranial hemorrhage. It is anticipated that clinicians who provide the physician component of diagnostic imaging studies for patients with stroke, TIA, or intracranial hemorrhage in the hospital or outpatient setting will submit this measure. NOTE: Use of symptom codes is limited to those specified in the denominator coding..”
- Added Numerator Note: The correct combination of numerator codes 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.
- Edited Denominator statement to read, “All final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with either a diagnosis of ischemic stroke or TIA or intracranial hemorrhage OR at least one documented symptom consistent with ischemic stroke or TIA or intracranial hemorrhage”.
- Added to ICD-9 codes 368.12, 368.2, 386.2, 437.7, 780.02, 781.3, 781.4, 781.94, 782.0, 784.3, 784.5 to denominator coding.
- Added a symptom diagnosis code to the denominator coding section.

Measure #11:

- Added to Description, “transient ischemic attack”

Measure #12:

- Instructions changed to reflect “system” versus “medical” reason for exclusion when clinician reporting is not providing the primary management for primary open-angle glaucoma.
- Added modifier 3P to numerator exclusion coding.

Measure #13: RETIRED effective January 1, 2008**Measure #14**

- Instructions changed to reflect “system” versus “medical” reason for exclusion when clinician reporting is not providing the primary management for age-related macular degeneration.
- Added modifier 3P to numerator exclusion coding.

Measure #15 RETIRED effective January 1, 2008**Measure #16 RETIRED effective January 1, 2008**

Measure #17 RETIRED effective January 1, 2008

Measure #18:

- Instructions changed to reflect “system” versus “medical” reason for exclusion when clinician reporting is not providing the primary management for diabetic retinopathy.
- Added modifier 3P to numerator exclusion coding.

Measure #19:

- Added to Description, “mellitus”
- Added to Instructions, “with diabetic retinopathy” in the first sentence
- Instructions changed to reflect “system” versus “medical” reason for exclusion when clinician reporting is not providing the primary management for diabetic retinopathy.
- Added Numerator Note: The correct combination of numerator codes 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.
- Replaced modifier 1P with modifier 3P in the numerator exclusion coding
- Removed CPT II codes 2021F and 2021F with 8P from numerator coding and replaced with G-codes G8397 and G8398.

Measure #20:

- Clarified the Instructions to read as follows, “There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.”
- Clarified the Instructions by adding the following, “If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code.”
- Clarified the Numerator Instructions by adding, “Note: In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.”
- Removed procedure codes 43842, 48160 from denominator coding.
- Removed procedure code 47719 from denominator coding; deleted from 2008 CPT Code Book.
- Removed duplicate procedure codes 35021, 35216, 35246, 35276, 35311 from the cardiothoracic section and left them in the general thoracic section of the denominator coding.

Measure #21:

- Clarified the Instructions to read as follows, “There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.”
- Clarified the Instructions by adding the following, “If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code.”
- Clarified the Numerator Instructions by adding, “Note: In the event surgery is delayed, as long as the patient is redosed (if clinically appropriate) the numerator coding should be applied.”
- Removed procedure codes 43842, 48160 from denominator coding.
- Removed procedure codes 47719, 49200, 49201 from denominator coding; deleted from 2008 CPT Code Book.
- Removed duplicate procedure codes 33300, 33310, 33320, 35021, 35216, 35246, 35276, 35311 from the cardiothoracic section and left them in the general thoracic section of the denominator coding.

Measure #22:

- Clarified the Instructions to read as follows, "There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure."
- Clarified the Instructions by adding the following, "If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code."
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed procedure codes 43842, 48160 from denominator coding.
- Removed procedure code 47719 from denominator coding; deleted from 2008 CPT Code Book.

Measure #23:

- Clarified the Instructions to read as follows, "There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure."
- Clarified the Instructions by adding the following, "If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary for the same clinician to submit the CPT Category II code with each procedure. However, if multiple NPIs are reporting this measure on the same claim, each NPI should report the quality data code."
- Added a definition, "Mechanical prophylaxis does not include TED hose."
- Removed procedure code 43842 from denominator coding.
- Removed procedure codes 49200, 49201 from denominator coding; deleted from 2008 CPT Code Book.

Measure #24:

- Added to Instructions, "Claims data will be analyzed to determine unique occurrences." and "If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted"

Measure #25 RETIRED effective January 1, 2008

Measure #26 RETIRED effective January 1, 2008

Measure #27 RETIRED effective January 1, 2008

Measure #28:

- Added "regardless of age" to description and denominator statements
- Added to Instructions, "The Part B claim form place-of-service field must indicate that the encounter has taken place in the emergency department."
- Added place-of-service indicator = 23 to denominator coding

Measure #29: RETIRED effective January 1, 2008

Measure #30:

- Clarified the Instructions to read as follows, "It is anticipated that clinicians who provide anesthesia care for surgical procedures with an order for prophylactic antibiotics will submit this measure." and added "Only" CPT II codes are to be used.

- Added Numerator Instructions, “This measure seeks to identify the timely administration of prophylactic antibiotic. This administration should begin within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision.”

Measure #31:

- Added to Instructions, “Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted.”

Measure #32:

- Added to Description, “transient ischemic attack”
- Added to Instructions, “Part B claims data will be analyzed to determine a hospital discharge. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted.”

Measure #33:

- Added to Description, “transient ischemic attack”
- Added to Instructions, “Part B claims data will be analyzed to determine a hospital discharge. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted.”

Measure #34:

- Added to Instructions, “Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted.”
- Added Numerator Note: The correct combination of numerator codes 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.

Measure #35:

- Added to Instructions, “Part B claims data will be analyzed to determine a hospital stay. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted.”
- Added Numerator Note: The correct combination of numerator codes 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.

Measure #36:

- Added to Instructions, “Part B claims data will be analyzed to determine a hospital discharge. If multiple qualifying diagnoses are submitted on the same claim form, only one instance of reporting will be counted.”

Measure #37: RETIRED effective January 1, 2008

Measure #38: RETIRED effective January 1, 2008

Measure #39:

- Added to Instructions, “There is no diagnosis associated with this measure.”
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary care or care for treatment of fracture or osteoporosis will submit this measure.” with “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.”

- Added definition for “prescribed”
- Removed CPT II codes 3096F, 3095F, 4005F (including 1P, 2P, 3P, 8P) and replaced with G-codes G8399, G8400, and G8401.
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from denominator coding.

Measure #40:

- Added to Instructions, "Claims data will be analyzed to determine unique occurrences." and "If multiple fractures occurring on the same date of service are submitted on the same claim form, only one instance of reporting will be counted."
- In the Instructions, replaced "It is anticipated that clinicians who manage the primary or ongoing care for osteoporosis or osteoporosis related fracture(s) will submit this measure." with "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."
- Added to Numerator Instructions, "Modifiers may be appended to any of the CPT Category II codes for medical reasons, patient reasons, system reasons, or reasons not otherwise specified."
- Added definition for “prescribed”

Measure #41:

- Added definition for “prescribed”
- Removed encounter codes 99386, 99387, 99396, 99397, 99401, 99402, 99403, 99404 from denominator coding.

Measure #42: RETIRED effective January 1, 2008

Measure #43:

- Added “aged 18 years and older” to Measure Description.
- Included "isolated" in description, instructions, denominator and coding statement.
- Added to Instructions for clarification, a definition of “isolated” CABG to read, “CABG using arterial and/or venous grafts only.” and “Part B claims data will be analyzed to determine “isolated” CABG.”

Measure #44:

- Added “aged 18 years and older” to Measure Description.
- Included "isolated" in description, instructions, denominator and coding statement.
- Added to Instructions for clarification, a definition of “isolated” CABG to read, “CABG using arterial and/or venous grafts only.” and “Part B claims data will be analyzed to determine “isolated” CABG.”

Measure #45:

- Clarified the Instructions to read as follows, “There is no diagnosis associated with this measure. It is anticipated that clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure.”
- Clarified the Instructions section by adding the following, “If multiple surgical procedures were performed on the same date of service and submitted on the same claim form, it is not necessary to submit the CPT Category II code with each procedure.”
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed procedure codes 33300, 33310, 33320, 35021, 35216, 35246, 35276, and 35311 from denominator coding.

Measure #46:

- In the Instructions, replaced “It is anticipated that clinicians who provide primary on-going care will submit this measure when a patient is seen in the office within 60 days following discharge from an inpatient facility.” with “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.”
- Added to Instructions, “There is no diagnosis associated with this measure.”, “If multiple claims are submitted within 60 days of inpatient discharge, only one instance of reporting will be counted”, “Part B claims data will be analyzed to determine inpatient discharge date”, and “There are no reporting requirements for this measure if a patient has been seen in an outpatient setting and not discharged from an inpatient facility within 60-days prior to the outpatient visit.”
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from denominator coding.

Measure #47:

- Updated Description and Numerator statement to add, “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 in the medical record”
- Added to Instructions, “There is no diagnosis associated with this measure.”
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary care for the patient will submit this measure.” with “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.”
- Updated Instructions to add “(eg, inpatient, nursing home, ambulatory). For each of these settings, there should be documentation in the medical record(s) that advance care planning was discussed or documented.”, “There are no allowable performance exclusions for this measure.” and removed “2P- patient reasons.”
- Revised numerator coding:
 - Removed CPT II 1080F, 1080F-2P and 1080F-8P including all descriptions for the coding.
 - Added CPT II 1123F: Advance care planning discussed and documented; advance care plan or surrogate decision maker documented in the medical record and CPT II 1124F: Advance care planning discussed and documented in the medical record; patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan for numerator inclusion
 - Added CPT II 1123F-8P
- Updated Rationale
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from denominator coding.

Measure #48:

- Added to Instructions, “and is considered a general screening measure” and “There is no diagnosis associated with this measure.”
- In the Instructions, replaced “It is anticipated that clinicians who provide primary care for the patient will submit this measure.” with “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.”
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from denominator coding.

Measure #49:

- Removed diagnosis code 788.32 from denominator coding
- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from denominator coding.

Measure #50:

- Removed diagnosis code 788.32 from denominator coding.

- Removed encounter codes 99387, 99397, 99401, 99402, 99403, 99404 from denominator coding.

Measure #51:

- Added to the Instructions, “Do not limit the search for spirometry results to the reporting period.”
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary care services for the patient will submit this measure.” with “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.”
- Removed encounter codes 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403 and 99404 from denominator coding

Measure #52:

- In the Instructions, replaced “It is anticipated that clinicians who provide the primary care services for the patient will submit this measure.” with “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.”
- Added definition for “prescribed”
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed encounter codes 99385, 99386, 99387, 99395, 99396, 99397, 99401, 99402, 99403 and 99404 from denominator coding

Measure #53:

- In the Instructions, replaced “It is anticipated that clinicians who provide the primary care services for the patient will submit this measure.” with “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.”
- Added definition for “prescribed”
- Added Numerator Note: The correct combination of numerator codes 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.
- Added diagnosis code 493.91 to denominator coding.
- Removed encounter codes 99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396, 99401, 99402, 99403, 99404 from denominator coding.

Measure #54:

- Added to Description, Instructions and Numerator Statement to clarify as “a 12-Lead” electrocardiogram/ECG. The statement(s) now read “a 12-Lead electrocardiogram (ECG)” or “a 12-Lead ECG”
- Added to Instructions, “Claims data will be analyzed to determine the emergency department discharge.”
- Added to Instructions, “The Part B claim form place-of-service field must indicate that the encounter has taken place in the emergency department.”
- Added place-of-service indicator = 23 to denominator coding

Measure #55:

- Added to Description, Instructions and Numerator Statement to clarify as “a 12-Lead” electrocardiogram/ECG. The statement(s) now read “a 12-Lead electrocardiogram (ECG)” or “a 12-Lead ECG”
- Added to Instructions, “Claims data will be analyzed to determine the emergency department discharge.”
- Added to Instructions, “The Part B claim form place-of-service field must indicate that the encounter has taken place in the emergency department.”
- Added place-of-service indicator = 23 to denominator coding

Measure #56:

- Added to Instructions, “Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.”, “Claims data will be analyzed to determine unique occurrences.”, and “Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure’s denominator.”
- Clarified denominator coding by adding, “* Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure.”

Measure #57:

- Added to instructions, “Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.”, “Claims data will be analyzed to determine unique occurrences.”, and “Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure’s denominator.”
- Clarified denominator coding by adding, “* Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure.”

Measure #58:

- Added to instructions, “Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.”, “Claims data will be analyzed to determine unique occurrences.”, and “Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure’s denominator.”
- Clarified denominator coding by adding, “* Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure.”

Measure #59:

- Added to instructions, “Each unique occurrence is defined as a 45-day period from onset of community-acquired bacterial pneumonia.”, “Claims data will be analyzed to determine unique occurrences.”, and “Clinicians utilizing the critical care code must indicate the emergency department place-of-service code in order to be counted in the measure’s denominator.”
- Added definition for “prescribed”
- Clarified denominator coding by adding, “* Clinicians utilizing the critical care code must indicate the emergency department place-of-service (23) on the Part B claim form in order to report this measure.”

Measure #60: RETIRED effective January 1, 2008

Measure #61: RETIRED effective January 1, 2008

Measure #62: RETIRED effective January 1, 2008

Measure #63: RETIRED effective January 1, 2008

Measure #64:

- Added to Instructions, “with asthma” in the first sentence
- In the Instructions, replaced “It is anticipated that clinicians who provide the primary care services with a diagnosis of asthma will submit this measure.” with “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.”
- Added diagnosis code 493.91 to denominator coding.
- Removed encounter codes 99383, 99384, 99385, 99386, 99393, 99394, 99395, 99396, 99401, 99402, 99403, 99404 from denominator coding.

Measure #65:

- Updated the Description and Numerator Statement to be consistent with other avoidance of inappropriate use measure. Added to the Description “prescribed” and “on or within 3 days of the initial date of service”. Added to the Numerator Statement “not” dispensed and “on or within 3 days of the initial date of service”.
- Added to Instructions, "Claims data will be analyzed to determine unique occurrences."
- In the Instructions, “It is anticipated that clinicians who provide the care to all patients 3 months-18 years of age with a diagnosis of upper respiratory infection would have documentation of having appropriate treatment will submit this measure.” with “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.”
- Updated Numerator Instructions to be consistent with other avoidance of inappropriate use measures.
- Rearranged the numerator coding to be consistent with other avoidance of inappropriate use measure structures.
- Changed CPT II code to append the modifier 1P to from 4124F to 4120F in the numerator coding.
- Removed encounter codes 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99499 from denominator coding.

Measure #66:

- Added to Instructions, "Claims data will be analyzed to determine unique occurrences."
- In the Instructions, “It is anticipated that clinicians who provide the care to all patients 2 through 18 years of age with a diagnosis of pharyngitis will submit this measure.” with “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.”
- Added Numerator Note: The correct combination of numerator codes 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.
- Removed encounter codes 99382, 99383, 99384, 99385, 99392, 99393, 99394, 99395, 99401, 99402, 99403, 99404, 99411, 99412, 99420, 99429, 99499 from denominator coding.

Measure #67: No change

Measure #68:

- Added to Instructions, “all MDS” in the first sentence
- Added Numerator Note: The correct combination of numerator codes 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.

Measure #69:

- Clarified the Description and Numerator Statement to read “...within the 12 month reporting period” instead of “within 12 months”
- Added to Instructions, “not in remission”

Measure #70: No change

Measure #71:

- Multiple specification updates with revised coding
- Added Numerator Note: The correct combination of numerator codes 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.

Measure #72:

- Multiple specification updates with revised coding

- Added Numerator Note: The correct combination of numerator codes 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.

Measure #73:

- Multiple specification updates with revised coding

Measure #74: No change