

Medicare Changes for 2009

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I. Medicare Premiums and Deductibles for 2009

	2008	2009
Part A Premium	<ul style="list-style-type: none"> • \$ 423 • \$ 233 	<ul style="list-style-type: none"> • \$443 / month for uninsured aged and disabled people not otherwise eligible for Part A. • \$ 244 / month for certain individuals eligible for reduced premiums
Part A Inpatient Deductible	<ul style="list-style-type: none"> • \$ 1,024 	<ul style="list-style-type: none"> • \$ 1,068.00 per benefit period
Inpatient Copay	<ul style="list-style-type: none"> • \$ 256 • \$ 512 • \$ 128 	<ul style="list-style-type: none"> • \$ 267– 61st through 90th day of benefit period • \$ 534 – lifetime reserve days • \$ 133.50 – 21st through 100th day of extended care services in a SNF
Part B Premium	<ul style="list-style-type: none"> • \$ 96.40 	<ul style="list-style-type: none"> • \$96.40 (1/4th the total cost) for people eligible for Social Security who earn less than \$85,000 a year) • May pay add'l 35, 50, 65 or 80% as an income-related monthly adjustment.
Part B Deductible	<ul style="list-style-type: none"> • \$ 135 	<ul style="list-style-type: none"> • \$ 135
Social Security	<ul style="list-style-type: none"> • 2.3% ↑ 	<ul style="list-style-type: none"> • 5.8% Increase (add'l \$63/mo for average retiree)

II. 2009 OIG Work Plan (See attached excerpts)

- Hospital Ownership of Physician Practices
- Physician Referrals to Home Health Agencies
- Physician Billing for Medicare Hospice Beneficiaries
- Place of Service Errors
- Evaluation and Management Services During Global Surgery Periods
- Medicare Practice Expenses Incurred by Selected Physician Specialties
- Services Performed by Clinical Social Workers
- Outpatient Physical Therapy Services Provided by Independent Therapists
- Medicare Payments for Colonoscopy Services
- Physicians' Medicare Services Performed by Nonphysicians ("**Incident To**" **Services**)
- Appropriateness of Medicare Payments for Polysomnography
- Long-Distance Physician Claims Requiring a Face-to-Face Visit
- Geographic Areas With a High Density of Independent Diagnostic Testing Facilities
- Patterns Related to High Utilization of Ultrasound Services
- Medicare Payments for Chiropractic Services Billed With the Acute Treatment Modifier
- Physician Reassignment of Benefits
- Medicare Payments for Unlisted Procedure Codes
- Laboratory Test Unbundling by Clinical Laboratories
- Variation of Laboratory Pricing
- Clotting Factor Furnishing Fee
- Medicare Billings With Modifier GY
- Medical Identity Theft in Medicare
- EPSDT Services
- Providers Billing More Time Than Is Feasible In A Day
- Medicare & Medicaid Credit Balances

II. Prepare For Audits

- a. Comprehensive Error Rate Testing (CERT). Targets providers with high cost, high volume, significant changes and/or grossly aberrant billing patterns. Letters have already gone out.
 - November 2007 Report on Paid Claims ranks *hospitals* within a referral region on a scale of 1 (best) to 5 (worst).
 - Tulsa/Muskogee/McAlester/Bartlesville region had an error rate of 0.03% (category 1)
 - Lawton/Duncan/Chickasha region had an error rate of 3.41% (category 5).
 - Oklahoma City had an error rate of 1.61% (category 4).
 - Contractor with highest error rate in 2008: Carriers (Part B). Highest error rates by:
 - TrailBlazer (Texas) - #9 with paid claims error rate of 4.5% and provider compliance error rate of 17.7%
 - Pinnacle (Includes OK) - #11 with paid claims error rate of 4.3% and provider compliance rate of 14.1%
 - Most Common Errors Discovered in Recent CERT Audits (Includes ALL types of claims):
 - No documentation (.1%) – Overpayments of \$785 million. Top 20 services denied for this reason include 99231, 99232, 99213 & 99214.
 - Insufficient documentation (.3%) – Overpayments of \$1.3 billion. Top 20 services denied for this reason include 10 E&M codes; 15% of them were 99211, another 13% were hospital visits.
 - Incorrect Coding (.7%) – Overpayments of \$3.9 billion. Top 20 services include 14 E&M codes, many misbilled by 1 level.
 - Provider Compliance Error rates by provider type (In order of projected improper payment amounts): Internal Medicine (19.5%), Cardiology (15.5%), Family Practice (18.3%), Orthopedic Surgery (21.8%), Pulmonology (18.2%) and GI (15.3%).
- b. Recovery Audit Contractors (RACs) will run computer programs to detect somewhat obvious mispayments. They will begin operation in 2009.
 - Paid based on a contingency fee
 - US divided into 4 regions (Oklahoma is in region C)
 - Region C awarded to Connolly Consulting Associates, Inc. of Wilton, Connecticut. Currently being contested.
 - Oklahoma RAC audits scheduled to begin in March 2009, but now on hold.
 - Cannot look at claims paid prior to October 1, 2007 but can look at claims from the current fiscal year.
 - Cannot look at level-of-care issues, claims previously reviewed by another contractor, hospice or home health services.
 - CMS limits the number of notes the RAC can request in a 45-day period.
 - Solo practitioner: 10 medical records
 - 2-5 practitioners: 20 medical records
 - 6-15 practitioners: 30 medical records
 - 16 or more practitioners: 50 medical records
- c. Program Safeguard Contractors (PSCs) were once called the Fraud Unit at most carriers.
 - Provider specific
 - Extrapolates errors across an entire payment period (up to 3 years)
 - Can be generated by referrals from OIG, RAC, or carriers based upon Probe Reviews, statistical analysis or patient complaints.
 - Assists in development of fraud cases for OIG & FBI
- d. Recommendation: Perform internal chart reviews **now**. Most common errors discovered:
 - Over coding – Focus on office and hospital E&M services (especially 99214 and rounds)
 - Under coding
 - Unbundling issues
 - Misuse of modifiers
 - Medical necessity & ABN issues
 - Incorrect coding of non-E&M services
 - Improper billing of physician extender services
 - Violations of basic documentation rules (pt IDs, signatures, etc.)
 - Inadequate physician documentation for hospital services.

IV. Recent Changes to Medicare

- Medicare will slash payments to hospitals for medical mistakes (“never events”) that result in patient harm and higher costs. CMS will no longer pay *hospitals* an increased rate for the added care resulting from such mistakes. Question: When will this be expanded to physicians? (This is all PQRI driven.)

Excerpt from Federal Register (2009 Final Rule)

“The preventable hospital-acquired conditions (HAC) payment provision for IPPS hospitals is another of our value-based purchasing initiatives. The principle behind the HAC payment provision (Medicare will not provide additional payments to hospitals to treat certain preventable conditions acquired during a beneficiary’s hospital stay) could be applied to the Medicare payment systems for other settings of care. Section 1886(d)(4)(D) of the Act requires the Secretary to select for the HAC IPPS payment provision conditions that are: (1) high cost, high volume, or both; (2) assigned to a higher paying Medicare Severity-Diagnosis Related Group (MS-DRG) when present as a secondary diagnosis; and (3) could reasonably have been prevented through the application of evidence-based guidelines.

The broad principle articulated in the HAC payment provision for IPPS hospitals (that is, Medicare not paying more for certain reasonably preventable hospital-acquired conditions) could potentially be applied to other Medicare payment systems for conditions that occur in settings other than IPPS hospitals. Other possible settings of care include, but are not limited to: hospital outpatient departments, ambulatory surgical centers, SNFs, HHAs, ESRD facilities, and physician practices.”

- Identity Theft “Red Flag Rules” went into effect November 1, 2008. These rules require anyone who extends credit (including hospitals and physicians) to have in place policies and procedures to guard against identity theft.
- CMS has banned unsolicited telemarketing and other marketing practices (sales presentations and application handouts at any place used to deliver health care) used to enroll patients in Medicare Advantage Plans.
- Reminder: Providers must start using the new ABN (waiver) form no later than 3/1/2008. It requires you to list the service likely to be denied, the probably reason for the denial and the beneficiary’s cost for the service. It can also be used for services that may not be covered by the plan (ex: routine physicals, cosmetic procedures, etc.)

V. CPT® changes for 2009

- a. Lots of changes for pediatrics. Codes for newborn care, attendance at delivery, pediatric critical care & ICU care have changed. See codes 99460-99480.
- b. Intermediate repair of lacerations no longer reference “layered closure”.
- c. New codes for disc arthroplasties and transurethral prostate surgery.
- d. New codes for all injection administration services. Now shown just preceding the codes for chemotherapy administration. Same code descriptions, but 90772 is 96372 (907 is now 963)
- e. Cardiology has numerous changes in coding for echocardiograms and electronic analysis of pacemakers and defibrillator systems.
- f. Almost 100 new Category II codes were added for PQRI reporting.

- g. There were 13 new Category III codes (emerging technology) added, and 22 codes were removed, most of which now have regular CPT® codes.
- h. Appendix H has extensive changes in coding and reporting under PQRI.

VI. Medicare Changes for 2009 –

- a. The medical community will see an *average increase of 1.1%* in reimbursement, in spite of the fact that the conversion factor will drop from \$38.0870 to \$36.0666. This is due to a change in the way they apply the budget neutrality adjustor in the payment formula. But not everyone is a winner. This change means that services & practices that are weighted toward physician work RVUs (FP, ER, psych) are likely to increase significantly while other services heavy in practice expense RVUs (CV, H/O, IDTFs) will see minimal increases and some decreases. The anesthesia conversion factor is set at \$20.9150.

Impact on Practices:

– Anesthesiology	3%	– Hematology/Oncology	-1%
– Cardiology	-2%	– Internal Medicine	2%
– Diagnostic Testing Facilities	-6%	– Neurosurgery	0%
– Emergency Medicine	4%	– OB/GYN	0%
– Family Practice	4%	– Orthopedic Surgery	0%
– General Surgery	3%	– Psychiatry	4%

- b. There have been adjustments to the Malpractice RVUs for 204 procedures that included PC and TC components.
- c. They have again applied the 1.000 floor to the GPCI for physician work when calculating this year’s fee schedule. This restores that GPCI to its 2006 value. Remember, the higher the GPCI, the higher your reimbursement.

GPCI for Oklahoma:	2006	2007	2008	2009
Physician Work	1.000	.964	.964	1.000
Practice Expense (Overhead)	.854	.856	.853	.850
Malpractice	.382	.359	.503	.627

Note: There are currently 93 different pricing areas under Medicare. In 2009, Oklahoma is one of 56 pricing areas with a Physician Work GPCI of 1.000. The GPCI for all other regions is higher. (Alaska = 1.500. DC, New Jersey, New York City and parts of California = 1.032†)

Note: Only 8 areas had a Practice Expense GPCI lower than Oklahoma’s: Arkansas, Missouri (x2), Montana, North Dakota, Puerto Rico, South Dakota and Wyoming.

Note: In 2006 and 2007, only Puerto Rico and South Dakota had lower malpractice GPCIs, meaning our malpractice insurance was much less costly. In 2009, 26 pricing areas had lower Malpractice GPCIs. This included Oregon, California, Nebraska, Kansas, Iowa, Indiana, Wisconsin, Minnesota, New Hampshire, Vermont, Maine, Tennessee, Alabama and others.

- d. Telehealth:
 - CMS has developed HCPCS codes G0406 to G0408 for practices to use when billing follow-up inpatient consultations via telehealth. RVUs for these equate to the RVUs for 99231-99233. These codes are not meant to be used for ongoing management of the patient. Modifier –GT must be added to the codes.
 - The originating site facility fee for 2009 has been increased to \$23.72.
 - Renal dialysis centers that are affiliated with hospitals, community mental health centers and skilled nursing facilities have been added to the list of approved telehealth originating sites.
- e. CMS will discontinue separate payment (under the MPFS) for the IVIG preadmission-related services represented by code G0332.
- f. Ten diagnostic imaging procedures have been added to the list of services subject to the 25% Multiple Procedure Payment Reduction. The list includes cardiac MRIs, MRIs of the breast, jaw and brain, and some ultrasound exams of the scrotum and kidney.

- g. Four new codes have been developed for Prostate Saturation Biopsy: Instead of using 88305, use G0146, G0147, G0148 or G0149 to report this service. CMS has already assigned RVUs to these codes for pricing purposes.
- h. Practices that get medications through the Competitive Acquisition Program (CAP) will not be able to do so for now. CMS has announced a postponement of CAP for 2009 due to some contractual issues. There will not be a CAP enrollment this fall, and medications will not be available from a CAP vendor after 12/31/2008.
- i. Physicians who furnish services in areas that are designated as HPSAs as of 12/31 of the prior year, but which are not included on the list of zip codes receiving automated HPSA bonus payments, should use the AQ modifier. If they fail to use the modifier, no bonus payment is issued since it isn't on the automated list. Remember that HPSA bonus payments are only made for *physician services*.
- j. Legislation requires a 1% update to the composite rate for ESRD services provided during 2009. This required them to recalculate the drug add-on adjustment, which is now scheduled to be 15.2% for 2009. This includes a zero update to the per-treatment drug add-on amount. ESRD facilities are reminded that 2009 is the final year of the 4-year transition period, so each facility's composite payment rate will be based entirely on its applicable new CBSA-based wage index value.
- k. Proposed rules requiring physician or NPP organizations that do testing to enroll as IDTFs and maintain IDTF quality performance standards have been tabled until CMS has a chance to review the numerous public comments.
- l. Entities that furnish mobile testing services must enroll in Medicare as an IDTF and meet all IDTF quality performance standards. In addition, they must bill for the mobile diagnostic services they furnish unless that service is part of a hospital services and furnished under arrangement with a hospital. The mobile IDTF must provide documentation of that arrangement with their enrollment and/or re-enrollment package.
- m. Enrollment Changes:
 - Any organization (clinic, physician, NPP, IDTF, etc.) whose enrollment or re-enrollment is revoked must submit all outstanding claims for services not previously submitted within 60 days of the effective date of revocation.
 - The effective date of billing privileges for (clinic or solo) physicians and NPPs is the later of 1) the filing date of a properly completed enrollment application that can be processed to approval or 2) the date that that physician/NPP first saw patients at the new practice location. Once the enrollment application is approved, you can bill for no more than 30 days prior to that effective date. Until now, practices could retroactively bill up to 27 months prior to the effective date. The time limit will be moved to 90 days for practices operating in a Presidentially-declared disaster area.
 - CMS has announced an internet-based enrollment system (PECOS) that will speed up the enrollment and re-enrollment process. They estimate that, once fully operational, MACs will be able to complete the enrollment process in 30-45 days rather than the 60-90 days they take currently. Phase I (for solo practices) should be fully operational by January 2009. Phase II (for organizations and clinics) should be fully operational by June 2009. Phase III (for DME suppliers) will be implemented in 2010. To access PECOS, you will use the user ID and password obtained when you applied for NPI. **Note:** Physicians and NPPs choosing to use billing agents, clearinghouses, academic medical institutions, etc. will be required to submit a paper enrollment application to enroll or make a change in their Medicare enrollment record.
 - Medicare will deny enrollment applications for additional Medicare billing privileges if a physician, NPP, physician or NPP organization has an existing payment suspension or has an existing overpayment that has not been repaid.
 - Physicians, NPPs or organizations must notify its Medicare contractor of a change of ownership, change in practice location or any final adverse action (felony, license suspensions, OIG exclusion, etc.) within 30 days of the reportable event. Failure to do so could result in revocation of Medicare billing privileges and or other penalties.
 - Effective 1/1/2009, providers and suppliers are required to maintain ordering and referring documentation, including the NPI, received from a physician or eligible NPP. This information must be retained for 7 years from the date of service. Failure to comply with these requirements is a reason for revocation of Medicare billing privileges.
- n. MIPPA rules provide payment incentives for practices that e-prescribe via systems that meet certain standards. Currently, only 5-18% of providers do so. The incentive payments are 2% of the practice's

allowed charges for 2009 & 2010; 1.0% for 2011 & 2012; 0.5% for 2013. Beginning in 2012, practices that don't use e-prescribing will find their payments reduced by 1%, with an additional 0.5% reduction in 2013 and a 2% reduction each year after that. They will retain the full exemption for computer-generated faxes of prescriptions for now, but will eliminate that exemption when the penalty phase begins in 2012. Use PQRI measure #125 to report electronic prescriptions. To obtain the bonus, practices must successfully report on this measure on at least 50% of cases billed with the following CPT[®] codes: 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, and G Codes: G0101, G0108 and G0109. There is no diagnosis code requirement. We should also point out that the bonus will be paid only if the total amounts allowed for the above codes constitute at least 10% of the practice's total Part B allowed charges. There are three G-codes: one = All Rx's in connection with the visit were e-prescribed; second = No Rx's were generated at the visit; third = Some or all Rx's were written or phoned due to pt request, State law or other reasons. You get credit for using the G-code – even if you didn't e-prescribe. CMS will post your eligibility and compliance results on their web site.

- n. As a result of comments, CMS has finalized some provisions related to Comprehensive Outpatient Rehab Facilities (CORFs). These include revisions to the personnel qualifications for respiratory therapists and amends the duties of CORF physicians to include the oversight of non-physician personnel. In addition, they have created code G0409 to describe 15 minutes of face-to-face services by a CORF social worker or psychologist. They also clarified that that the alternate premises for provision of physical therapy, occupational therapy, and speech-language pathology services may be the patient's home. The definition of an "extension location" is also refined.
- o. Anti-Markup Rules – The "either/or" approach. CMS clarifies that they are not prohibiting reassignment of PCs, but are imposing restrictions on the reassignment of PCs. That is, a PC that is reassigned by the performing physician to the billing physician that ordered the PC may not be marked up by the billing physician, unless the performing physician shares a practice with the billing physician.
 - When a contracted physician who isn't part of the practice performs "substantially all" (greater than 75%) of his professional services for the same billing physician, then none of those services are subject to the anti-markup payment limitation. In this situation, the physicians are considered to be sharing space. CMS considers the other 25% work as 'locum tenens'. The "substantially all" requirement is satisfied if the billing physician or other supplier has a reasonable belief at the time it submits a claim that: (1) the performing physician has furnished substantially all of his professional services through the billing physician for the period of 12 months prior to and including the month in which the service was performed; or (2) the performing physician is expected to furnish substantially all of his professional services through the billing physician during the following 12 months (including the month the service is performed).
 - On the other hand, if the above standard doesn't apply, CMS will apply the "site-of-service" method wherein any PCs furnished in or TCs furnished in or supervised by the billing physician's office (in same suite or same building) will avoid anti-markup limits. Under this method, the performing physician must be an employee or independent contractor of the billing physician.
- p. MIPPA makes PQRI permanent and requires CMS to pay a 2% bonus to practices that successfully submit PQRI data during all of 2009. This is in addition to the bonus payable for e-prescribing. The bonus is calculated on *allowed* charges for services furnished in 2009 and submitted before March 1, 2010, and is available to physicians, NPPs, OT, PT, Speech Pathologists and Audiologists.
 - There are 153 PQRI measures for 2009; 52 of them are new. (See attached list)
 - To support the delivery of high-quality, efficient health care and enable consumers and providers to make more informed health care decisions, CMS plans to launch a web site hoping that the data will enhance the information found at www.medicare.gov/Physician/Home.asp?bhcp=1. This web site will include information about the quality of care and value for services provided by physicians to Medicare beneficiaries. At first, they plan to use information from the PQRI program and will publicly report the names of those practices that successfully reported on PQRI data and received an incentive payment. This information should be available to the public sometime in 2010. At a later date, the information will be expanded to include quality performance data and other information they deem pertinent and useful in guiding consumers to make informed decisions about healthcare options.
 - An eligible professional can meet the criteria for satisfactorily reporting quality data by reporting at least 3 measures for at least 80% of the cases in which they are reportable during 2009 or by reporting data for 30 consecutive Medicare Part B patients to which the measures are applicable.

- Practices can now report on groups of measures. CMS defines “measures groups” as a subset of PQRI measures that have a common clinical condition or a common focus. For 2009 there are 9 measures groups, which includes 3 groups from 2008 – Preventive Care, Diabetes and Chronic Kidney Disease. The new groups include: CABG Surgery, CAD, RA, HIV/AIDS, Back Pain and Perioperative Care. Some measures can be reported through claims-based or registry-based submission for 2009, although some measures and groups can be reported only via a registry. **Note:** Measures groups reported to Medicare via claims-based reporting will include just Medicare patients. However, PQRI data reported to registries can include some non-Medicare patients as long as some of the patients do have Medicare. Registry reporting often comes with a fee and/or limitations. Not all registries report all measures, and if you report through a registry, you must report on a minimum of 3 measures. Be sure you select a “qualified” registry approved by CMS.
- q. Technical changes were made to the regulations governing the qualifications of Nurse Practitioners. These changes add the DNP degree under the educational qualification requirements for NPs and CNSs, but will continue to monitor those programs to insure that graduates are qualified to furnish services to Medicare patients.
- r. Rules applicable to the training of radiographers have long been outdated and referenced training and certification organizations that no longer exist and specific duration of training that are no longer the community standard. Those rules have now been updated to reflect current requirements.
- s. CMS will not prohibit payment to the supplier of CPAPs when that supplier (or its affiliate) is directly or indirectly the provider of the sleep test that is used to diagnose a Medicare patient with Obstructive Sleep Apnea. The only exception is for attended facility-based polysomnography when the facility also supplies and provides patient support for CPAP.
- t. Ambulance companies will find it easier to obtain signatures authorizing their services. CMS makes it clear that the patient or authorized representative should sign the claim form (or a similar form authorizing them to file claims) whenever possible. When the patient is unable to sign, however, the ambulance company representative can sign on the patient’s behalf (for emergency and non-emergency transports) when the patient/representative is physically or mentally unable to sign. The company’s representative must have been present at the time of transport, document the patient’s inability to sign (and the reason for it) and indicate that no other authorized person is available or willing to sign. CMS also makes it clear that 1) the purpose of a signature is to verify that the services were in fact rendered as billed, 2) the person signing the form is not accepting financial liability for the bill and 3) the patient can be billed if they or their representative are capable but refuse to sign the claim form.
- u. In April 2008, CMS awarded a contract to a group to assist in the development of physician resource use measures and confidential feedback reports. This is the start of the Government’s Physician Resource Use Feedback (PRUF) program. When fully implemented, this program will help them find which individual physicians are responsible for the largest costs to Medicare in comparison to their outcomes. This is part of their Value Purchasing program. Some of the things they are testing in a couple of sites now include:
 - Which physicians bill the most E&M services that account for at least 10% of the total cost for a patient’s episode of care;
 - Who bills the most established patient E&M services for chronic conditions;
 - Who has the highest cost in proportion to billed visits? (for testing?)
- v. CMS is asking for public input on what it will add to the list of covered preventive services. Currently, there are 15 - 20 services (see www.preventiveservices.ahrq.gov) that are likely candidates for coverage.
- w. MIPPA re-defined the “Welcome to Medicare” or IPPE exam requirements. Beginning 1/1/2009, physicians are required to measure the patient’s body mass index as part of the exam, and, if the patient consents, you must include end-of-life planning in your IPPE services. It’s no longer mandatory to perform an EKG with your IPPE, though you must provide education and counseling about the service and provide referral services, if necessary. There’s more good news: patients now have a full year to get the service, instead of six months. Code G0402 should be used to bill for IPPEs done on or after 1/1/2009, and no deductible will apply, though patients will still be responsible for the 20% coinsurance. Screening EKGs performed as part of the evaluation should be billed G0403-G0405. The current G-codes will be deleted and can be used only for services prior to 1/1/2009. The RVUs for these services will remain the same.
- x. The cap on therapy has been increased. In 2009, the therapy cap will be \$1,840 for physical therapy and speech-language pathology (combined) and with a separate cap of \$1,840 for occupational therapy services.

- Beginning July 1, 2009, speech-language pathologists can enroll in Medicare and bill (and receive direct payment) for outpatient SLP services furnished in private practices. Private practice services can be furnished at a patient’s home, but not at an institution that is a hospital, CAH or SNF.
 - MIPPA gives SLP the same meaning as “physical therapy services” and will pay for them in the same manner. While the law clearly states that they are distinct and separate services from PT, it does not create a separate therapy cap for the SLP services. (See above)
 - SLP services cannot be provided “incident to” a physician’s services.
 - CMS has added SLP services to the list of services subject to Stark physician self-referral rules.
- y. MIPPA repeals the requirement that a supplier transfer title to oxygen equipment to the patient after the 36-month rental period. In its place, it establishes a 36-month rental cap and adds new payment rules for furnishing the oxygen and equipment after the 36 months has elapsed.
- The supplier is required to continue to furnish the equipment at any time of medical need for the reasonable useful lifetime of the equipment (no exceptions). Thus, if the patient relocates outside the area, the supplier must make arrangements for the patient to continue receiving the equipment at his new residence. This new responsibility does not transfer to the other supplier. In addition, the length of a break in medical need or the number of such breaks that occur after the 36 months has no effect.
 - CMS will pay for the oxygen used in this equipment if medically necessary. They will also reimburse for maintenance and servicing of the equipment.
- z. Other Fee Schedule Adjustments
- Payments under the Clinical Lab Fee Schedule are increased by 4.5% for 2009.
 - Payments for ground ambulance transports that originate in rural areas will be increased by 3%.
 - For ground ambulance transports that do not originate in rural areas, the fee schedule will be increased by 2%.
 - The ESRD composite rate is increased by 1.0% for dialysis services furnished in 2009.
- aa. Specific Coding Issues
- Cardiac MRIs: Codes that include blood flow/velocity quantification will continue to be denied as “not medically necessary” in accordance with the NCD on this issue.
 - Services that don’t require a face-to-face service (protime phone calls, patient questions via email, etc.) are still considered ‘bundled’ and are not payable. *CPT*[®] lists codes for these services, but they should be used for tracking activities, not for billing to Medicare.
 - *CPT*[®] revised the descriptors for treatment of pelvic fractures, but CMS disagrees with the AMA’s revised wording. For that reason, CMS has created 4 HCPCS codes to be used for these services. These new codes (G0412 thru G0415) will retain the 2008 definitions and RVUs previously assigned to codes 27215-27218, which should not be used for Medicare billing.
 - *CPT*[®] deleted code 61793 (stereotactic Radiosurgery) and created seven new codes to replace it. CMS disagrees with this decision and with the valuation of the RVUs associated with the new codes, but will use them on a temporary basis until they can be studied further.
 - *CPT*[®] created a new code 95992 for Canalith repositioning procedures (Epley maneuver, Semont maneuver) per day. Previously this was billed by physicians as part of an E&M service and by some practices as 97112. CMS feels the service should be “bundled” and has designated it as such.
- bb. CMS reaffirms its position that low vision aids are essentially eyeglasses and, as such, are not covered by Medicare. They have finally written rules to that affect.

Hospital Ownership of Physician Practices

We will review the appropriateness of Medicare reimbursement to hospital-owned physician practices that have the provider-based designation. In October 2005, CMS revised Federal regulations at 42 CFR § 413.65 to delineate requirements for hospitals to obtain provider-based designation for purchased physician practices. These requirements address such issues as the physical location of the entity, the patient population served, and the types of controls and governance exhibited by the hospital over the physician practice. Under the Hospital Outpatient Prospective Payment System (OPPS), hospitals may receive Medicare reimbursement for outpatient services in provider-based practices at amounts greater than CMS's Medicare Physician Fee Schedule (MPFS). We will determine whether hospitals have met the Federal requirements to obtain the provider-based designation and assess the impact of the increased cost to Medicare as a result of reimbursement under the OPPS for physician services in provider-based practices. We will also determine the extent to which hospital-owned physician practices without provider-based designation improperly received reimbursement under the OPPS.

Physician Billing for Medicare Hospice Beneficiaries

We will review the extent of Part B billing for physician services provided to Medicare hospice beneficiaries. The regulations at 42 CFR § 418.304 list the physician services that are already covered by Medicare under the hospice benefit. The regulation provides that, for physicians employed by or in an arrangement with the hospice, payments for certain services are reimbursed to the hospice as part of the hospice payment, while other services are paid to the hospice under the Part B MPFS. Physicians may receive reimbursement for hospice services under Medicare Part A or Part B. This study is a follow-up to recent OIG studies on hospice care. We will determine the frequency of and total expenditures for physician services under Part A and Part B for hospice beneficiaries. We will identify whether physicians double-billed hospice services to Part A and Part B.

Place of Service Errors

We will review physician coding of place of service on Medicare Part B claims for services performed in ambulatory surgical centers (ASC) and hospital outpatient departments. Federal regulations at 42 CFR § 414.22(b)(5)(i)(B) provide for different levels of payments to physicians depending on where the services are performed. Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC. We will determine whether physicians properly coded the places of service on claims for services provided in ASCs and hospital outpatient departments.

Evaluation and Management Services During Global Surgery Periods

We will review industry practices related to the number of evaluation and management (E&M) services provided by physicians and reimbursed as part of the global surgery fee. CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 12, § 40, contains the criteria for the global surgery policy. Under the global surgery fee concept, physicians bill a single fee for all of their services usually associated with a surgical procedure and related E&M services provided during the global surgery period. We will determine whether industry practices related to the number of E&M services provided during the global surgery period have changed since the global surgery fee concept was developed in 1992.

Outpatient Physical Therapy Services Provided by Independent Therapists

We will review outpatient physical therapy services provided by independent therapists to determine if they are in compliance with Medicare reimbursement regulations. The Social Security Act, § 1862(a)(1)(A), provides that Medicare will not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member."

CMS’s “Medicare Benefit Policy Manual,” Pub. No. 100-02, ch. 15, § 220.3, contains documentation requirements for therapy services. Previous OIG work has identified claims for therapy services provided by independent physical therapists that were not reasonable, medically necessary, or properly documented. Focusing on independent therapists who have a high utilization rate for outpatient physical therapy services, we will determine whether the services that they billed to Medicare were in accordance with Federal requirements.

Medicare Payments for Colonoscopy Services

We will review the appropriateness of Medicare payments to physicians for colonoscopy services. A colonoscopy is a complex procedure for examining the entire colon and may include, for example, biopsy to remove polyps, tumors, or other lesions or related services that the physician may deem necessary, such as medical consultations and office visits. A colonoscopy generally requires that the patient be placed under sedation in an outpatient hospital setting. The Social Security Act, § 1833(e), precludes payment to any service provider unless the provider has furnished the information necessary to determine the amounts due such provider. We will determine whether Medicare payments for colonoscopy services were properly supported, billed, and paid in accordance with Medicare requirements.

Physicians’ Medicare Services Performed by Nonphysicians

We will review services physicians bill to Medicare but do not perform personally. Such services, called **“incident to,”** are typically performed by nonphysician staff members in physicians’ offices. The Social Security Act, § 18610(s)(2)(A), provides for Medicare coverage of services and supplies performed “incident to” the professional services of a physician. However, these services may be vulnerable to overutilization or put beneficiaries at risk of receiving services that do not meet professionally recognized standards of care. We will examine the qualifications of nonphysician staff that perform “incident to” services and assess whether these qualifications are consistent with professionally recognized standards of care.

Long-Distance Physician Claims Requiring a Face-to-Face Visit

We will review the appropriateness of Medicare claims for long-distance evaluation and management services. Pursuant to the CMS “Medicare Benefits Policy Manual,” Pub. No. 100-02, ch. 15, § 30, a service may be considered a physician’s service if the physician either examines the patient in person or is able to visualize some aspect of the patient’s condition without a third person’s judgment. Although services provided by means of a telephone call between the physician and the beneficiary may be covered under Medicare, there are certain services that require a face-to-face visit. Previous OIG work indentified instances of physicians billing for services that would normally require a face-to-face examination for beneficiaries who lived a significant distance from the physician. We will also examine factors that contribute to the submission of long-distance physician claims.

Patterns Related to High Utilization of Ultrasound Services

We will review services and billing patterns in geographic areas with high utilization of ultrasound services paid under the MPFS. The Social Security Act, § 1848(a)(1), establishes the MPFS as the basis for Medicare reimbursement for all physician services, including ultrasound services, and section 1862(a)(1)(A) provides that Medicare will pay for services only if they are medically necessary. In areas of high utilization of ultrasound services, we will examine service profiles, provider profiles, and beneficiary profiles.

Laboratory Test Unbundling by Clinical Laboratories

We will review the extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments. Pursuant to the “Medicare Claims Processing Manual,” Pub. No. 100-04, ch. 16, § 90, to ensure the accuracy of payments, Medicare contractors must group together individual laboratory tests that clinical laboratories can perform at the same time on the same equipment and then consider the price of related profile tests. Payment for individual tests must not exceed the lower of the profile

price or the total price of all the individual tests. We will determine whether clinical laboratories have unbundled profile or panel tests by submitting claims for multiple dates of service or by drawing specimens on sequential days. We will also determine the extent to which the Medicare carriers have controls in place to detect and prevent inappropriate payments for laboratory tests.

Medicare Billings With Modifier GY

We will review the appropriateness of providers' use of modifier GY on claims for services that are not covered by Medicare. CMS's "Medicare Carriers Manual," Pub. No. 14-3, pt. 3, § 4508.1, states that modifier GY is to be used for coding services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable, either personally or through other insurance, for all charges associated with the provision of these services. Pursuant to CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 1, § 60.1.1, providers are not required to provide beneficiaries with advance notice of charges for services that are excluded from Medicare by statute. As a result, beneficiaries may unknowingly acquire large medical bills that they are responsible for paying. In FY 2006, Medicare received over 53 million claims with a modifier GY and denied claims totaling over \$400 million. We will examine patterns and trends for physicians' and suppliers' use of modifier GY.

Medical Identity Theft in Medicare

We will review CMS's activities designed to deter medical identity theft in Medicare. The Social Security Act, § 1893(a), established the Medicare Integrity Program in an effort to combat fraud, waste, and abuse in the Medicare program. In 2007, the Department of Justice (DOJ) and the Federal Trade Commission reported identity theft as one of the fastest growing crimes, with data showing annual monetary losses in the billions of dollars. Early detection and notification of medical identity theft could deter or limit the impact of Medicare fraud. We will review CMS's medical identity theft deterrence measures, including its outreach to beneficiaries.

Early and Periodic Screening, Diagnostic, and Treatment Services

We will review the extent to which Medicaid-eligible children receive appropriate EPSDT services. The Social Security Act, §§ 1905(a)(4) and 1905(r), provides for periodic screening, vision, dental, hearing, and other necessary health services to Medicaid-eligible individuals under the age of 21. The EPSDT program is designed to screen at periodic intervals and diagnose and treat medical conditions that might otherwise go undetected or untreated. This study will also examine CMS's oversight of State reporting of EPSDT services in accordance with Federal requirements.

Providers Billing More Time Than Is Feasible in a Day

We will review services provided by physicians to determine whether claims are submitted for more time than is feasible in a day. Prior partnership audits in one State identified significant improper claims submission and service upcoding by physicians. We will analyze provider claims to identify providers with potential billing problems.

Medicare/Medicaid Credit Balances

We will review providers, including independent laboratories and hospitals, to determine whether there are Medicare/Medicaid overpayments in patient accounts with credit balances. For Medicare, the Social Security Act, § 1862(b), and 42 CFR pt. 411 require participating providers to furnish information about payments made to them and to refund any monies incorrectly paid. For Medicaid, the Social Security Act, § 1902(a)(25), regulations at 42 CFR pt. 433, subpart D, and various State laws require that Medicaid be the payer of last resort and that providers identify and refund overpayments received. Prior OIG work has identified Medicare/Medicaid overpayments in patients' accounts with credit balances.

2009 PQRI Measure Specifications

(2008 Measures that were retained for 2009)

Table of Contents (As of: 11/15/2008)

Measure Number and Title
1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus*
2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus*
3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus*
5. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*
6. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
7. Coronary Artery Disease Prior Myocardial Infarction (CAD): Beta-Blocker Therapy for CAD Patients with (MI)+,*
8. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
9. Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD
10. Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports
11. Stroke and Stroke Rehabilitation: Carotid Imaging Reports
12. Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
14. Age-Related Macular Degeneration (AMD): Dilated Macular Examination
18. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
19. Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
20. Perioperative Care: Timing of Antibiotic Prophylaxis - Ordering Physician
21. Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin
22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
24. Osteoporosis: Communication With the Physician Managing Ongoing Care Post-Fracture
28. Aspirin at Arrival for Acute Myocardial Infarction (AMI)
30. Perioperative Care: Timing of Prophylactic Antibiotics - Administering Physician
31. Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage
32. Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy
33. Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge+
34. Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered
35. Stroke and Stroke Rehabilitation: Screening for Dysphagia
36. Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services
39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
40. Osteoporosis: Management Following Fracture
41. Osteoporosis: Pharmacologic Therapy
43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Isolated CABG Surgery
44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
45. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)
46. Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility+
47. Advance Care Plan
48. Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 years and Older
49. Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older
50. Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
51. Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
52. Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy

53. Asthma: Pharmacologic Therapy
54. 12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain
55. 12-Lead Electrocardiogram (ECG) Performed for Syncope
56. Community-Acquired Pneumonia (CAP): Vital Signs
57. Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation
58. Community-Acquired Pneumonia (CAP): Assessment of Mental Status
59. Community-Acquired Pneumonia (CAP): Empiric Antibiotic
64. Asthma: Asthma Assessment
65. Treatment for Children with Upper Respiratory Infection (URI) - Avoidance of Inappropriate Use
66. Appropriate Testing for Children with Pharyngitis
67. Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
68. Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
69. Multiple Myeloma: Treatment With Bisphosphonates
70. Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
71. Breast Cancer: Hormonal Therapy for Stage IC-III Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
72. Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
76. Prevention of Catheter-Related Bloodstream Infections (CRBSI) - Central Venous Catheter Insertion Protocol
79. End-Stage Renal Disease (ESRD): Influenza Vaccination in Patients with ESRD
81. End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients+
82. End-Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis+
83. Hepatitis C: Testing for Chronic Hepatitis C - Confirmation of Hepatitis C Viremia
84. Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment
85. Hepatitis C: HCV Genotype Testing Prior to Therapy
86. Hepatitis C: Consideration for Antiviral Therapy in HCV Patients
87. Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment
89. Hepatitis C: Counseling Regarding Risk of Alcohol Consumption
90. Hepatitis C: Counseling of Patients Regarding Use of Contraception Prior to Starting Antiviral Therapy
91. Acute Otitis Externa (AOE): Topical Therapy
92. Acute Otitis Externa (AOE): Pain Assessment
93. Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use
94. Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility
95. Otitis Media with Effusion (OME): Hearing Testing
99. Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
100. Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
102. Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
104. Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients
105. Prostate Cancer: Three-Dimensional (3D) Radiotherapy
106. Major Depressive Disorder (MDD): Diagnostic Evaluation
107. Major Depressive Disorder (MDD): Suicide Risk Assessment
108. Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug Therapy
109. Osteoarthritis (OA): Function and Pain Assessment
110. Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Old*
111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older*
112. Preventive Care and Screening: Screening Mammography*
113. Preventive Care and Screening: Colorectal Cancer Screening*
114. Preventive Care and Screening: Inquiry Regarding Tobacco Use
115. Preventive Care and Screening: Advising Smokers to Quit
116. Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis - Avoidance of Inappropriate Use

117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
118. Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD)
119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention A84for Nephropathy in Diabetic Patients
121. Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
122. Chronic Kidney Disease (CKD): Blood Pressure Management
123. Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)
124. HIT: Adoption/Use of Electronic Health Records (EHR)*
126: Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation
127. Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear
128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
130. Documentation and Verification of Current Medications in the Medical Record
131. Pain Assessment Prior to Initiation of Patient Treatment
134. Screening for Clinical Depression

+ This measure is reportable only via registry-based reporting and is not reportable via claims-based reporting.

* This measure is 1 of 10 measures on which specifications are available for testing electronic submission via EHRs.

MIPPA authorized a new incentive program for successful electronic prescribers. As a result, PQRI quality measures shall not include electronic prescribing measures. Therefore, Measure # 125 HIT: Adoption/Use of Medication e-Prescribing is not included in the final set of 2009 PQRI quality measures. This measure will instead be used for the new e-prescribing incentive program authorized by MIPPA as discussed previously.

New PQRI Measures for 2009

Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications
Back Pain: Initial Visit
Back Pain: Physical Exam
Back Pain: Advice for Normal Activities
Back Pain: Advice Against Bed Rest
Diabetes Mellitus: Foot Exam
Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)+
Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate+
Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)+
Coronary Artery Bypass Graft (CABG): Post-operative Renal Insufficiency+
Coronary Artery Bypass Graft (CABG): Surgical Re-exploration+
Coronary Artery Bypass Graft (CABG): Anti-platelet Medications at Discharge
Coronary Artery Bypass Graft (CABG): Beta Blockade at Discharge+
Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling+
Hemodialysis Vascular Access Decision-making by Surgeons to Maximize Placement of Autogenous Arterial Venous Fistula
Chronic Kidney Disease (CKD): Influenza Immunization
Melanoma: Follow-Up Aspects of Care
Melanoma: Continuity of Care – Recall System
Melanoma: Coordination of Care
Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement
Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
Primary Open-Angle Glaucoma (POAG) : Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care
Oncology: Medical and Radiation – Plan of Care for Pain
Radiology: Exposure Time Reported for Procedures Using Fluoroscopy
Oncology: Medical and Radiation – Pain Quantified
Radiology: Inappropriate Use of “Probably Benign” Assessment Category in Mammography Screening
Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD
Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula
Falls: Plan of Care
Falls: Risk Assessment
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Hepatitis C: Hepatitis A Vaccination
Hepatitis C: Hepatitis B Vaccination
Oncology: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer
Nuclear Medicine: Correlation with Existing Imaging Studies for all
Patients Undergoing Bone Scintigraphy
Preventive Care and Screening: Unhealthy Alcohol Use -Screening & Brief Counseling
Pediatric ESRD: Adequacy of Hemodialysis+
Pediatric ESRD: Influenza Immunization
Rheumatoid Arthritis: Tuberculosis Screening
Rheumatoid Arthritis: Periodic Assessment of Disease Activity
Rheumatoid Arthritis: Functional Limitation Assessment
Rheumatoid Arthritis: Assessment and Classification of Disease Prognosis
Rheumatoid Arthritis: Glucocorticoid Management
Endoscopy & Polyp Surveillance: Surveillance Colonoscopy Interval in Patients With History of Adenomatous Polyps
Wound Care: Use of Compression System in Patients with Venous Ulcers
HIV/AIDS: CD4+ Cell Count or CD4+ Percentage+

HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis+
HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS who are Prescribed Potent Antiretroviral Therapy+
HIV/AIDS: HIV RNA Control After 6 Months of Potent Antiretroviral Therapy+
Elder Maltreatment Screen and Follow-up Plan
Functional Outcome Assessment in Chiropractic Care
Endarterectomy: Use of Patch During Conventional Endarterectomy

+ This measure is reportable only via registry-based reporting and is not reportable via claims-based reporting.

TABLE 19: 2009 Diabetes Mellitus Measures Group

- 1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
- 2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
- 3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
- 117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- 119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Pts
- Diabetes Mellitus: Foot Exam

TABLE 20: Final 2009 CKD Measures Group

- 121. Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile) AMA-PCPI
- 122. Chronic Kidney Disease (CKD): Blood Pressure Management AMA-PCPI
- 123. Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA) AMA-PCPI
- Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula AMA-PCPI
- Chronic Kidney Disease (CKD): Influenza Immunization AMA-PCPI

TABLE 21: 2009 Preventive Care Measures Group

- 39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older AMA-PCPI/NCQA
- 48. Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older AMA-PCPI/NCQA
- 110. Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old AMA-PCPI
- 111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older NCQA
- 112. Preventive Care and Screening: Screening Mammography NCQA
- 113. Preventive Care and Screening: Colorectal Cancer Screening NCQA
- 114. Preventive Care and Screening: Inquiry Regarding Tobacco Use AMA-PCPI
- 115. Preventive Care and Screening: Advising Smokers to Quit NCQA
- 128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up QIP/CMS

TABLE 22: 2009 CABG Measures Group

- 43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Isolated CABG Surgery STS
- 44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery STS
- Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)+ STS
- Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate+ STS
- Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)+ STS
- Coronary Artery Bypass Graft (CABG): Post-operative Renal Insufficiency+ STS
- Coronary Artery Bypass Graft (CABG): Surgical Re-exploration+ STS
- Coronary Artery Bypass Graft (CABG): Anti-platelet Medications at Discharge+ STS
- Coronary Artery Bypass Graft (CABG): Beta Blockers Administered at Discharge+ STS
- Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling+ STS

+ This measure is reportable only via registry-based reporting and is not reportable via claims-based reporting.

TABLE 23: 2009 Rheumatoid Arthritis Measures Group

108. Rheumatoid Arthritis: Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy NCQA
Rheumatoid Arthritis: Tuberculosis Screening AMA-PCPI/NCQA
Rheumatoid Arthritis: Periodic Assessment of Disease Activity AMA-PCPI/NCQA
Rheumatoid Arthritis: Functional Limitation Assessment AMA-PCPI/NCQA
Rheumatoid Arthritis: Assessment and Classification of Disease Prognosis AMA-PCPI/NCQA
Rheumatoid Arthritis: Glucocorticoid Management AMA-PCPI/NCQA

TABLE 24: 2009 Perioperative Care Measures Group

20. Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician AMA-PCPI/NCQA
21. Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin AMA-PCPI/NCQA
22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures) AMA-PCPI/NCQA
23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients) AMA-PCPI/NCQA

TABLE 25: 2009 Back Pain Measures Group

Back Pain: Initial Visit NCQA
Back Pain: Physical Exam NCQA
Back Pain: Advice for Normal Activities NCQA
Back Pain: Advice Against Bed Rest NCQA