*Measure #12 (NQF 0086): Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma who have an optic nerve head evaluation during one or more office visits within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with primary open-angle glaucoma (in either one or both eyes) will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-9-CM): 365.10, 365.11, 365.12, 365.15
Diagnosis for primary open-angle glaucoma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1510, H40.1511, H40.1512, H40.1513, H40.1514, H40.1520, H40.1521, H40.1522, H40.1523, H40.1524, H40.1530, H40.1531, H40.1532, H40.1533, H40.1534, H40.1590, H40.1591, H40.1592, H40.1593, H40.1594
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

CPT only copyright 2012 American Medical Association. All rights reserved.

NUMERATOR:
Patients who have an optic nerve head evaluation during one or more office visits within 12 months

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Optic Nerve Head Evaluation Performed
CPT II 2027F: Optic nerve head evaluation performed

OR

Optic Nerve Head Evaluation not Performed for Medical Reasons
Append a modifier (1P) to CPT Category II code 2027F to report documented circumstances that appropriately exclude patients from the denominator.
2027F *with* 1P: Documentation of medical reason(s) for not performing an optic nerve head evaluation

OR

Optic Nerve Head Evaluation not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2027F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2027F *with* 8P: Optic nerve head evaluation was not performed, reason not otherwise specified

RATIONALE:
Changes in the optic nerve are one of two characteristics which currently define progression and thus worsening of glaucoma disease status (the other characteristic is visual field). There is a significant gap in documentation patterns of the optic nerve for both initial and follow-up care (Fremont, 2003), even among specialists. (Lee, 2006) Examination of the optic nerve head and retinal nerve fiber layer provides valuable structural information about glaucomatous optic nerve damage. Visible structural alterations of the optic nerve head or retinal nerve fiber layer and development of peripapillary choroidal atrophy frequently occur before visual field defects can be detected. Careful study of the optic disc neural rim for small hemorrhages is important, since these hemorrhages can precede visual field loss and further optic nerve damage.

CLINICAL RECOMMENDATION STATEMENTS:
Ophthalmic Evaluation
In completing the elements in the comprehensive adult medical eye evaluation, the ophthalmic evaluation specifically focuses on the following elements:

- History [A:III]
- Visual acuity measurement [A:III]
- Pupil examination [B:II]
- Anterior segment examination [A:III]
- Intraocular pressure measurement [A:I]
- Gonioscopy [A:III]
- Optic nerve head and retinal nerve fiber layer examination [A:III]
- Fundus examination [A:III)

(AAO, 2010)

CPT only copyright 2012 American Medical Association. All rights reserved.

*Measure #14 (NQF 0087): Age-Related Macular Degeneration (AMD): Dilated Macular Examination

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of AMD who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with age-related macular degeneration (in either one or both eyes) will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 50 years and older with a diagnosis of age-related macular degeneration

> Denominator Criteria (Eligible Cases):
> Patients aged ≥ 50 years on date of encounter
> AND
> Diagnosis for age-related macular degeneration (ICD-9-CM): 362.50, 362.51, 362.52
> Diagnosis for age-related macular degeneration (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H35.30, H35.31, H35.32
> AND
> Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

CPT only copyright 2012 American Medical Association. All rights reserved.

NUMERATOR:
Patients who had a dilated macular examination performed which included documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity during one or more office visits within 12 months

Definitions:
Macular Thickening – Acceptable synonyms for "macular thickening" include: intraretinal thickening, serous detachment of the retina, pigment epithelial detachment.
Severity of Macular Degeneration – Mild, moderate, or severe.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dilated Macular Examination Performed
CPT II 2019F: Dilated macular exam performed, including documentation of the presence or absence of macular thickening or hemorrhage AND the level of macular degeneration severity

OR

Dilated Macular Examination not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 2019F to report documented circumstances that appropriately exclude patients from the denominator.
2019F *with* 1P: Documentation of medical reason(s) for not performing a dilated macular examination
2019F *with* 2P: Documentation of patient reason(s) for not performing a dilated macular examination

OR

Dilated Macular Examination not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2019F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2019F *with* 8P: Dilated macular exam was not performed, reason not otherwise specified

RATIONALE:
A documented complete macular examination is a necessary prerequisite to determine the presence and severity of AMD, so that a decision can be made as to the benefits of prescribing antioxidant vitamins. Further, periodic assessment is necessary to determine whether there is progression of the disease and to plan the on-going treatment of the disease, since several therapies exist that reduce vision loss once the advanced "wet" form of AMD occurs. While no data exist on the frequency or absence of regular examinations of the macula for patients with AMD, parallel data for key structural assessments for glaucoma, cataract and diabetic retinopathy suggest that significant gaps are likely.

CLINICAL RECOMMENDATION STATEMENTS:
According to the American Academy of Ophthalmology, a stereo biomicroscopic examination of the macula should be completed. Binocular slit-lamp biomicroscopy of the ocular fundus is often necessary to detect subtle clinical clues of CNV. These include small areas of hemorrhage, hard exudates, subretinal fluid, or pigment epithelial elevation. (Level A: III Recommendation) (AAO, 2005)

CPT only copyright 2012 American Medical Association. All rights reserved.

*Measure #18 (NQF 0088): Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetic retinopathy

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Diagnosis for diabetic retinopathy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
AND

CPT only copyright 2012 American Medical Association. All rights reserved.

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy AND the presence or absence of macular edema during one or more office visits within 12 months

Definitions:
Documentation – The medical record must include: documentation of the level of severity of retinopathy (e.g., background diabetic retinopathy, proliferative diabetic retinopathy, non-proliferative diabetic retinopathy) AND documentation of whether macular edema was present or absent.
Macular Edema – Acceptable synonyms for macular edema include: intraretinal thickening, serous detachment of the retina, or pigment epithelial detachment.
Severity of Retinopathy – mild nonproliferative, preproliferative, very severe nonproliferative.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Macular or Fundus Exam Performed
CPT II 2021F: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Macular or Fundus Exam not Performed for Medical or Patient Reasons
Append a modifier (1P or 2P) to CPT Category II code 2021F to report documented circumstances that appropriately exclude patients from the denominator.
2021F *with* 1P: Documentation of medical reason(s) for not performing a dilated macular or fundus examination
2021F *with* 2P: Documentation of patient reason(s) for not performing a dilated macular or fundus examination

OR

Macular or Fundus Exam not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 2021F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
2021F *with* 8P: Dilated macular or fundus exam was not performed, reason not otherwise specified

RATIONALE:
Several level 1 RCT studies demonstrate the ability of timely treatment to reduce the rate and severity of vision loss from diabetes (Diabetic Retinopathy Study – DRS, Early Treatment Diabetic Retinopathy Study – ETDRS). Necessary examination prerequisites to applying the study results are that the presence and severity of both peripheral diabetic retinopathy and macular edema be accurately documented. In the RAND chronic disease quality project, while administrative data indicated that roughly half of the patients had an eye exam in the recommended time period, chart review data indicated that only 19% had documented evidence of a dilated examination. (McGlynn, 2003). Thus, ensuring timely treatment that could prevent 95% of the blindness due to diabetes requires the performance and documentation of key examination parameters. The documented level of severity of retinopathy and the documented presence or absence of macular edema assists with the on-going plan of care for the patient with diabetic retinopathy.

CLINICAL RECOMMENDATION STATEMENTS:
Because treatment is effective in reducing the risk of visual loss, detailed examination is indicated to assess for the following features that often lead to visual impairment:

- Presence of macular edema
- Optic nerve head neovascularization and/or neovascularization elsewhere

CPT only copyright 2012 American Medical Association. All rights reserved.

- Signs of severe NPDR (extensive retinal hemorrhages/microaneurysms, venous beading, and IRMA)
- Vitreous or preretinal hemorrhage

(Level A:III Recommendation) (AAO, 2008)

CPT only copyright 2012 American Medical Association. All rights reserved.

*Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for all patients with diabetic retinopathy seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for diabetic retinopathy (ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Diagnosis for diabetic retinopathy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
AND

CPT only copyright 2012 American Medical Association. All rights reserved.

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:
Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Definitions:
Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.
Findings – Includes level of severity of retinopathy AND the presence or absence of macular edema.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Dilated Macular or Fundus Exam Findings Communicated
(One CPT II code & one G-code [5010F & G8397] are required on the claim form to submit this numerator option)
CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons or Patient Reasons
(One CPT II code & one G-code [5010F-xP & G8397] are required on the claim form to submit this numerator option)
Append a modifier (1P or 2P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.
5010F *with* 1P: Documentation of medical reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the on going care of the patient with diabetes
5010F *with* 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the on going care of the patient with diabetes
AND
G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:
(One G-code [G8398] is required on the claim form to submit this numerator option)
G8398: Dilated macular or fundus exam not performed

CPT only copyright 2012 American Medical Association. All rights reserved.

OR

Dilated Macular or Fundus Exam Findings not Communicated, Reason not Otherwise Specified
*(One CPT II code & one G-code [*5010F-8P & G8397*] are required on the claim form to submit this numerator option)*
Append a reporting modifier (8P) to CPT Category II code 5010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
5010F *with* 8P: Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

RATIONALE:
The physician that manages the ongoing care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the ongoing diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS)

CLINICAL RECOMMENDATION STATEMENTS:
While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician. (Level A: III Recommendation) (AAO, 2003)

Although the ophthalmologist will perform most of the examination and all surgery, certain aspects of data collection may be conducted by other trained individuals under the ophthalmologist's supervision and review. Because of the complexities of the diagnosis and surgery for PDR, the ophthalmologist caring for patients with this condition should be familiar with the specific recommendations of the DRS, ETDRS, UKPDS, and DCCT/EDIC (see Appendices 3 and 5). The ophthalmologist should also have training in and experience with the management of this particular condition. (AAO, 2008)

CPT only copyright 2012 American Medical Association. All rights reserved.

♦ Measure #117 (NQF 0055): Diabetes Mellitus: Dilated Eye Exam

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam

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

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT or HCPCS codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 through 75 years with a diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND
Diagnosis for diabetes (ICD-9-CM): 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

Diagnosis for diabetes (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329,

CPT only copyright 2012 American Medical Association. All rights reserved.

E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.65, E11.69, E11.8, E11.9, E11.649, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

AND

Patient encounter during the reporting period (CPT or HCPCS): 92002, 92004, 92012, 92014, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271, G0402

NUMERATOR:

Patients who had a dilated eye exam for diabetic retinal disease at least once within 12 months

Numerator Instructions: This measure includes patients with diabetes who had one of the following: a retinal or dilated eye exam by an eye care professional (optometrist or ophthalmologist) during the reporting period, or a negative retinal exam (no evidence of retinopathy) by an eye care professional in the year prior to the reporting period. For dilated eye exams performed 12 months prior to the reporting period, an automated result must be available.

Definition:

Automated Result – Electronic system-based data that includes results generated from test or procedures. For administrative data collection automated/electronic results are necessary in order to show that the exam during the 12 months prior was negative for retinopathy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Eye Exam Performed by an Eye Care Professional

CPT II 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed

OR

CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed

OR

CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed

OR

CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)

OR

Dilated Eye Exam not Performed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code 2022F or 2024F or 2026F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

CPT II 2022F or 2024F or 2026F *with* 8P: Dilated eye exam was not performed, reason not otherwise specified

RATIONALE:

Examination of the eyes is the first step in the treatment of any existing or developing conditions related to retinopathy and the first step in the prevention of blindness.

CPT only copyright 2012 American Medical Association. All rights reserved.

CLINICAL RECOMMENDATION STATEMENTS:

American Diabetes Association (ADA): Patients with type 1 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist within 3-5 years after the onset of diabetes. In general evaluation for diabetic eye disease is not necessary before 10 years of age. However, some evidence suggests that the prepubertal duration of diabetes may be important in the development of microvascular complications; therefore, clinical judgment should be used when applying these recommendations to individual patients. (Level of Evidence: B)

Patients with type 2 diabetes should have an initial dilated and comprehensive eye examination by an ophthalmologist or optometrist shortly after diabetes diagnosis. (Level of Evidence: B)

Subsequent examinations for type 1 and type 2 diabetic patients should be repeated annually by an ophthalmologist or optometrist who is knowledgeable and experienced in diagnosing the presence of diabetic retinopathy and is aware of its management. Examination will be required more frequently if retinopathy is progressing. This follow-up interval is recommended recognizing that there are limited data addressing this issue. (Level of Evidence: B)

The older adult who has new-onset diabetes mellitus should have an initial screening dilated-eye examination performed by an eye-care specialist with funduscopy training (AGS, 2003).

CPT only copyright 2012 American Medical Association. All rights reserved.

*Measure #140 (NQF 0566): Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of AMD

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for AMD patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with AMD will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 50 years and older with a diagnosis of age-related macular degeneration

Denominator Criteria (Eligible Cases):
Patients aged ≥ 50 years on date of encounter
AND
Diagnosis for AMD (ICD-9-CM): 362.50, 362.51, 362.52
Diagnosis for AMD (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H35.30, H35.31, H35.32
AND
Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

CPT only copyright 2012 American Medical Association. All rights reserved.

NUMERATOR:
Patients with AMD or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD

Definition:
Counseling – Documentation in the medical record should include a discussion of risk or benefits of the AREDS formulation. Counseling can be discussed with all patients with AMD, even those who do not meet the criteria for the AREDS formulation, patients who are smokers (beta-carotene can increase the risk for cancer in these patients) or other reasons why the patient would not meet criteria for AREDS formulation as outlined in the AREDS. The ophthalmologist or optometrist can explain why these supplements are not appropriate for their particular situation. Also, given the purported risks associated with antioxidant use, patients would be informed of the risks and benefits and make their choice based on valuation of vision loss vs. other risks. As such, the measure seeks to educate patients about overuse as well as appropriate use.

NUMERATOR NOTE: If patient is already receiving AREDS formulation, the assumption is that counseling about AREDS has already been performed.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
AREDS Counseling Performed
CPT II 4177F: Counseling about the benefits and/or risks of the Age-Related Eye Disease Study (AREDS) formulation for preventing progression of age-related macular degeneration (AMD) provided to patient and/or caregiver(s)

OR

AREDS Counseling not Performed, Reason not Otherwise Specified
Append a reporting modifier (8P) to CPT Category II code 4177F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
4177F *with* 8P: AREDS counseling not performed, reason not otherwise specified

RATIONALE:
1. Scientific basis for counseling regarding use of AREDS formulation for patients with AMD

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

At the same time, published meta-analyses have raised an issue as to the presence of an elevated mortality risk among patients taking elements similar to parts of the AREDS formulation (and elevated risk among smokers). As such, patients need to know of their individualized risk profile for taking the AREDS formula AND the potential benefits, so that they can make their OWN individual decision as to whether or not to take the AREDS formulation.

This indicator thus seeks to directly enhance the provider-patient relationship to apply the results of level 1 randomized controlled trials (RCTs) in a manner that accommodates the needs of each individual patient in a patient-centered manner, rather than a paternalistic approach of either recommending or withholding treatment.

2. Evidence of gap in care.

Antioxidant vitamins and mineral supplements help to reduce the rate of progression to advanced AMD for those patients with intermediate or advanced AMD in one eye. From the same AREDS study, there is no evidence that the use of antioxidant vitamin and mineral supplements for patients with mild AMD alters the natural history of mild AMD.

CPT only copyright 2012 American Medical Association. All rights reserved.

CLINICAL RECOMMENDATION STATEMENTS:

Patients with intermediate AMD or advanced AMD in one eye should be counseled on the use of antioxidant vitamin and mineral supplements as recommended in the Age-related Eye Disease Study (AREDS) reports. (Level A:I Recommendation) (AAO)

TABLE 1
Antioxidant Vitamin and Mineral Supplements Used in the AREDS

Supplement	Daily Dose (See note below)
Vitamin C	500 mg
Vitamin E	400 IU
Beta-carotene	15 mg (25,000 IU)
Zinc oxide	80 mg
Cupric oxide	2 mg

Note: These doses are not those listed on the commercially available vitamin/mineral supplements because of a change in labeling rules by the U.S. Food and Drug Administration that specifies that the doses must reflect the amounts available at the end of the shelf life.

CPT only copyright 2012 American Medical Association. All rights reserved.

*Measure #141 (NQF 0563): Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level, a plan of care was documented within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for glaucoma patients seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with POAG will submit this measure.

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

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

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older with a diagnosis of primary open-angle glaucoma

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Diagnosis for primary open-angle glaucoma (ICD-9-CM): 365.10, 365.11, 365.12, 365.15
Diagnosis for primary open-angle glaucoma (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1510, H40.1511, H40.1512, H40.1513, H40.1514, H40.1520, H40.1521, H40.1522, H40.1523, H40.1524, H40.1530, H40.1531, H40.1532, H40.1533, H40.1534, H40.1590, H40.1591, H40.1592, H40.1593, H40.1594

CPT only copyright 2012 American Medical Association. All rights reserved.

AND

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

NUMERATOR:

Patients whose glaucoma treatment has not failed (the most recent IOP was reduced by at least 15% from the pre-intervention level) OR if the most recent IOP was not reduced by at least 15% from the pre-intervention level a plan of care was documented within 12 months

Definitions:

Plan of Care – May include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or health system reasons, and/or referral to a specialist.

Plan to Recheck – In the event certain factors do not allow for the IOP to be measured (e.g., patient has an eye infection) but the physician has a plan to measure the IOP at the next visit; the plan of care code should be reported.

Glaucoma Treatment Not Failed – The most recent IOP was reduced by at least 15% in the affected eye or if both eyes were affected, the reduction of at least 15% occurred in both eyes.

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

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Intraocular Pressure (IOP) Reduced Greater than or Equal to 15% Pre-Intervention Level

*(One CPT II code [*3284F*] is required on the claim form to submit this numerator option)*

CPT II 3284F: Intraocular pressure (IOP) reduced by a value of greater than or equal to 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Reduced Less than 15% Pre-Intervention Level with Plan of Care

*(Two CPT II codes [*0517F & 3285F*] are required on the claim form to submit this numerator option)*

CPT II 0517F: Glaucoma plan of care documented

AND

CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Glaucoma Plan of Care not Documented, Reason not Otherwise Specified

*(Two CPT II codes [*0517F-8P & 3285F*] are required on the claim form to submit this numerator option)*

Append a reporting modifier (8P) to CPT Category II code 0517F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

0517F *with* 8P: Glaucoma plan of care not documented, reason not otherwise specified

AND

CPT II 3285F: Intraocular pressure (IOP) reduced by a value less than 15% from the pre-intervention level

OR

Intraocular Pressure (IOP) Measurement not Documented, Reason not Otherwise Specified

*(One CPT II code [*3284F-8P*] is required on the claim form to submit this numerator option)*

CPT only copyright 2012 American Medical Association. All rights reserved.

Append a reporting modifier (8P) to CPT Category II code 3284F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3284F *with* 8P: IOP measurement not documented, reason not otherwise specified

RATIONALE:
1. Scientific basis for intraocular pressure (IOP) control as outcomes measure (intermediate)
Analyses of results of several randomized clinical trials all demonstrate that reduction of IOP of at least 18% (EMGT, CIGTS, AGIS, CNTGS) reduces the rate of worsening of visual fields by at least 40%. The various studies, however, achieved different levels of mean IOP lowering in realizing their benefit in patient outcomes, ranging from 18% in the "normal pressure" subpopulation of EMGT to 42% in the CIGTS study. (Level I studies) As such, an appropriate "failure" indicator is to NOT achieve at least a 15% IOP reduction. The rationales for a failure indicator are that 1) the results of different studies can lead experienced clinicians to believe that different levels of IOP reduction are appropriate; 2) to minimize the impact of adverse selection for those patients whose IOPs are more difficult to control; and 3) because each patient's clinical course may require IOP reduction that may vary from 18 to 40+%.

In addition, "…[s]several population based studies have demonstrated that the prevalence of POAG as well as the incidence of POAG, increases as the level of IOP increases. These studies provide strong evidence that IOP plays an important role in the neuropathy of POAG. Furthermore, studies have demonstrated that reduction in the level of IOP lessens the risk of visual field progression in open-angle glaucoma. In addition, treated eyes that have a greater IOP fluctuation are at increased risk of progression.

Intraocular pressure is the intermediate outcome of therapy used by the FDA for approval of new drugs and devices and, as noted above, has been shown to be directly related to ultimate patient outcomes of vision loss. As such, failure to achieve minimal pressure lowering, absent an appropriate plan of care to address the situation, would constitute performance whose improvement would directly benefit patients with POAG.

2. Evidence for gap in care
Based on studies in the literature reviewing documentation of IOP achieved under care, the gap could be as great as 50% or more in the community of ophthalmologists and optometrists treating patients with primary open-angle glaucoma. Based on loose criteria for control, IOP was controlled in 66% of follow-up visits for patients with mild glaucoma and 52% of visits for patients with moderate to severe glaucoma. Another study of a single comprehensive insurance plan suggested that a large proportion of individuals felt to require treatment for glaucoma or suspect glaucoma are falling out of care and are being monitored at rates lower than expected from recommendations of published guidelines.

CLINICAL RECOMMENDATION STATEMENTS:
The initial target pressure selected should be at least 20% lower than the pretreatment IOP, depending upon the clinical findings. Further reduction of the target IOP is often also justified by the severity of existing optic nerve damage, the level of the measured pretreatment IOP, the rapidity with which the damage occurred, and other risk factors. In general, the more advanced the damage, the lower the initial pressure should be (Level A: III Recommendation).

Please note that the American Optometric Association's (AOA) 2002 guideline on Open-angle Glaucoma was not reviewed during the development of this measure prior to the public comment period and therefore is not presented here verbatim. Review of the AOA guideline subsequent to initial measure development indicates that the recommendations in the AOA guideline are consistent with the intent of the measure. This also applies to the 2010 guidelines. As such, the intent of this measure is to have this indicator apply to both optometrists and ophthalmologists (and any other physician who provides glaucoma care); the use of "ophthalmologists" only in the preceding verbatim section reflects the wording in the American Academy of Ophthalmology Preferred Practice pattern.

CPT only copyright 2012 American Medical Association. All rights reserved.

1)

***Measure #191 (NQF 0565): Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery**

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery

INSTRUCTIONS:
This measure is to be calculated each time a procedure for uncomplicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated cataract surgery.

Note: This is an outcomes measure and can be calculated solely using registry data.

- *For patients who receive the cataract surgical procedures specified in the denominator coding, it should be reported whether or not the patient had best-corrected visual acuity of 20/40 or better achieved within 90 days following cataract surgery.*
- *Patients who have any of the listed comorbid conditions in the exclusion criteria should be removed from the denominator; these patients have existing ocular conditions that could impact the outcome of surgery and are not included in the measure calculation for those patients who have best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.*
- *Include only procedures performed through September 30 of the reporting period. This will allow the post operative period to occur within the reporting year.*

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to determine patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the visual outcome of surgery

Denominator Instructions: Clinicians who indicate modifier 56, preoperative management only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

CPT only copyright 2012 American Medical Association. All rights reserved.

AND NOT
Any of the following comorbid conditions that impact the visual outcome of surgery

(Patients with documentation of any of the following comorbid conditions that impact the visual outcome of surgery prior to date of cataract surgery are excluded from the measure calculation)

Comorbid Condition	Corresponding ICD-9-CM Codes
Acute and Subacute Iridocyclitis	364.00, 364.01, 364.02, 364.03, 364.04, 364.05
Amblyopia	368.01, 368.02, 368.03
Burn Confined to Eye and Adnexa	940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9
Cataract Secondary to Ocular Disorders	366.32, 366.33
Central Corneal Ulcer	370.03
Certain Types of Iridocyclitis	364.21, 364.22, 364.23, 364.24, 364.3
Choroidal Degenerations	363.43
Choroidal Detachment	363.72
Choroidal Hemorrhage and Rupture	363.61, 363.62, 363.63
Chorioretinal Scars	363.30, 363.31, 363.32, 363.33, 363.35
Chronic Iridocyclitis	364.10, 364.11
Cloudy Cornea	371.01, 371.02, 371.03, 371.04
Corneal Opacity and Other Disorders of Cornea	371.00, 371.03, 371.04
Corneal Edema	371.20, 371.21, 371.22, 371.23, 371.43, 371.44
Degeneration of Macula and Posterior Pole	362.50, 362.51, 362.52, 362.53, 362.54, 362.55, 362.56, 362.57
Degenerative Disorders of Globe	360.20, 360.21, 360.23, 360.24, 360.29
Diabetic Macular Edema	362.07
Diabetic Retinopathy	362.01, 362.02, 362.03, 362.04, 362.05, 362.06
Disorders of Optic Chiasm	377.51, 377.52, 377.53, 377.54
Disorders of Visual Cortex	377.75
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	363.10, 363.11, 363.12, 363.13, 363.14, 363.15
Focal Chorioretinitis and Focal Retinochoroiditis	363.00, 363.01, 363.03, 363.04, 363.05, 363.06, 363.07, 363.08
Glaucoma	365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89
Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes	365.41, 365.42, 365.43, 365.44, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89, 365.9
Hereditary Corneal Dystrophies	371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58
Hereditary Choroidal Dystrophies	363.50, 363.51, 363.52, 363.53, 363.54, 363.55, 363.56, 363.57
Hereditary Retinal Dystrophies	362.70, 362.71, 362.72, 362.73, 362.74, 362.75, 362.76
Injury to Optic Nerve and Pathways	950.0, 950.1, 950.2, 950.3, 950.9

CPT only copyright 2012 American Medical Association. All rights reserved.

Comorbid Condition	Corresponding ICD-9-CM Codes
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	369.10, 369.11, 369.12, 369.13, 369.14, 369.15, 369.16, 369.17, 369.18
Nystagmus and Other Irregular Eye Movements	379.51
Open Wound of Eyeball	871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3
Optic Atrophy	377.10, 377.11, 377.12, 377.13, 377.14, 377.15, 377.16
Optic Neuritis	377.30, 377.31, 377.32, 377.33, 377.34, 377.39
Other Background Retinopathy and Retinal Vascular Changes	362.12, 362.16, 362.18
Other Corneal Deformities	371.70, 371.71, 371.72, 371.73
Other Disorders of Optic Nerve	377.41
Other Disorders of Sclera	379.11, 379.12
Other Endophthalmitis	360.11, 360.12, 360.13, 360.14, 360.19
Other Proliferative Retinopathy	362.20, 362.21, 362.22, 362.23, 362.24, 362.25, 362.26, 362.27
Other Retinal Disorders	362.81, 362.82, 362.83, 362.84, 362.85, 362.89
Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis	363.20, 363.21, 363.22
Pathologic Myopia	360.20, 360.21
Prior Penetrating Keratoplasty	371.60, 371.61, 371.62
Profound Impairment, Both Eyes	369.00, 369.01, 369.02, 369.03, 369.04, 369.05, 369.06, 369.07, 369.08
Purulent Endophthalmitis	360.00, 360.01, 360.02, 360.03, 360.04
Retinal Detachment with Retinal Defect	361.00, 361.01, 361.02, 361.03, 361.04, 361.05, 361.06, 361.07
Retinal Vascular Occlusion	362.31, 362.32, 362.35, 362.36
Scleritis and Episcleritis	379.04, 379.05, 379.06, 379.07, 379.09
Separation of Retinal Layers	362.41, 362.42, 362.43
Uveitis	360.11, 360.12
Visual Field Defects	368.41

Comorbid Condition	Corresponding ICD-10-CM Codes
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.019, H20.021, H20.022, H20.023, H20.029, H20.031, H20.032, H20.033, H20.039, H20.041, H20.042, H20.043, H20.049, H20.051, H20.052, H20.053, H20.059
Amblyopia	H53.011, H53.012, H53.013, H53.019, H53.021, H53.022, H53.023, H53.029, H53.031, H53.032, H53.033, H53.039
Burn Confined to Eye and Adnexa	T26.00XA, T26.01XA, T26.02XA, T26.10XA, T26.11XA, T26.12XA, T26.20XA, T26.21XA, T26.22XA, T26.30XA, T26.31XA, T26.32XA, T26.40XA, T26.41XA, T26.42XA, T26.50XA, T26.51XA, T26.52XA, T26.60XA, T26.61XA, T26.62XA, T26.70XA, T26.71XA, T26.72XA, T26.80XA, T26.81XA, T26.82XA, T26.90XA, T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.219, H26.221, H26.222, H26.223, H26.229

CPT only copyright 2012 American Medical Association. All rights reserved.

Comorbid Condition	Corresponding ICD-10-CM Codes
Central Corneal Ulcer	H16.011, H16.012, H16.013, H16.019
Certain Types of Iridocyclitis	H20.20, H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.819, H20.821, H20.822, H20.823, H20.829, H20.9, H40.40X0
Choroidal Degenerations	H35.33
Choroidal Detachment	H31.411, H31.412, H31.413, H31.419
Choroidal Hemorrhage and Rupture	H31.301, H31.302, H31.303, H31.309, H31.311, H31.312, H31.313, H31.319, H31.321, H31.322, H31.323, H31.329
Chorioretinal Scars	H31.001, H31.002, H31.003, H31.009, H31.011, H31.012, H31.013, H31.019, H31.021, H31.022, H31.023, H31.029, H31.091, H31.092, H31.093, H31.099
Chronic Iridocyclitis	A18.54, H20.10, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829
Corneal Opacity and Other Disorders of Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9
Corneal Edema	H18.10, H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.229, H18.231, H18.232, H18.233, H18.239, H18.421, H18.422, H18.423, H18.429, H18.43
Degeneration of Macula and Posterior Pole	H35.30, H35.31, H35.32, H35.341, H35.342, H35.343, H35.349, H35.351, H35.352, H35.353, H35.359, H35.361, H35.362, H35.363, H35.369, H35.371, H35.372, H35.373, H35.379, H35.381, H35.382, H35.383, H35.389
Degenerative Disorders of Globe	H44.20, H44.21, H44.22, H44.23, H44.321, H44.322, H44.323, H44.329, H44.311, H44.312, H44.313, H44.319, H44.391, H44.392, H44.393, H44.399
Diabetic Macular Edema	E08.311, E08.321, E08.331, E08.341, E08.351, E09.311, E09.321, E09.331, E09.341, E09.351, E10.311, E10.321, E10.331, E10.341, E10.351, E11.311, E11.321, E11.331, E11.341, E11.351, E13.311, E13.321, E13.331, E13.341, E13.351
Diabetic Retinopathy	E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359
Disorders of Optic Chiasm	H47.41, H47.42, H47.43, H47.49
Disorders of Visual Cortex	H47.611, H47.612, H47.619
Disseminated Chorioretinitis and Disseminated Retinochoroiditis	A18.53, H30.101, H30.102, H30.103, H30.109, H30.111, H30.112, H30.113, H30.119, H30.121, H30.122, H30.123, H30.129, H30.131, H30.132, H30.133, H30.139, H30.141, H30.142, H30.143, H30.149

CPT only copyright 2012 American Medical Association. All rights reserved.

Comorbid Condition	Corresponding ICD-10-CM Codes
Focal Chorioretinitis and Focal Retinochoroiditis	H30.001, H30.002, H30.003, H30.009, H30.011, H30.012, H30.013, H30.019, H30.021, H30.022, H30.023, H30.029, H30.031, H30.032, H30.033, H30.039, H30.041, H30.042, H30.043, H30.049
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1390, H40.1391, H40.1392, H40.1393, H40.1394, H40.141, H40.142, H40.143, H40.149, H40.1510, H40.1511, H40.1512, H40.1513, H40.1514, H40.1520, H40.1521, H40.1522, H40.1523, H40.1524, H40.1530, H40.1531, H40.1532, H40.1533, H40.1534, H40.1590, H40.1591, H40.1592, H40.1593, H40.1594, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.219, H40.2210, H40.2211, H40.2212, H40.2213, H40.2214, H40.2220, H40.2221, H40.2222, H40.2223, H40.2224, H40.2230, H40.2231, H40.2232, H40.2233, H40.2234, H40.2290, H40.2291, H40.2292, H40.2293, H40.2294, H40.231, H40.232, H40.233, H40.239, H40.241, H40.242, H40.243, H40.249, H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.60X0, H40.60X1, H40.60X2, H40.60X3, H40.60X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, Q15.0

CPT only copyright 2012 American Medical Association. All rights reserved.

Comorbid Condition	Corresponding ICD-10-CM Codes
Glaucoma Associated with Congenital Anomalies, Dystrophies, and Systemic Syndromes	H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, H40.9, H42
Hereditary Corneal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59
Hereditary Choroidal Dystrophies	H31.20, H31.21, H31.22, H31.23, H31.29
Hereditary Retinal Dystrophies	H35.50, H35.51, H35.52, H35.53, H35.54, H36
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.019A, S04.02XA, S04.031A, S04.032A, S04.039A, S04.041A, S04.042A, S04.049A
Moderate or Severe Impairment, Better Eye, Profound Impairment Lesser Eye	H54.10, H54.11, H54.12
Nystagmus and Other Irregular Eye Movements	H55.01
Open Wound of Eyeball	S05.10XA, S05.11XA, S05.12XA, S05.20XA, S05.21XA, S05.22XA, S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52XA, S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.8X9A, S05.90XA, S05.91XA, S05.92XA
Optic Atrophy	H47.20, H47.211, H47.212, H47.213, H47.219, H47.22, H47.231, H47.232, H47.233, H47.239, H47.291, H47.292, H47.293, H47.299
Optic Neuritis	H46.00, H46.01, H46.02, H46.03, H46.10, H46.11, H46.12, H46.13, H46.2, H46.3, H46.8, H46.9
Other Background Retinopathy and Retinal Vascular Changes	H35.021, H35.022, H35.023, H35.029, H35.051, H35.052, H35.053, H35.059, H35.061, H35.062, H35.063, H35.069
Other Corneal Deformities	H18.70, H18.711, H18.712, H18.713, H18.719, H18.721, H18.722, H18.723, H18.729, H18.731, H18.732, H18.733, H18.739, H18.791, H18.792, H18.793, H18.799
Other Disorders of Optic Nerve	H47.011, H47.012, H47.013, H47.019
Other Disorders of Sclera	H15.831, H15.832, H15.833, H15.839, H15.841, H15.842, H15.843, H15.849
Other Endophthalmitis	H16.241, H16.242, H16.243, H16.249, H21.331, H21.332, H21.333, H21.339, H33.121, H33.122, H33.123, H33.129, H44.111, H44.112, H44.113, H44.119, H44.121, H44.122, H44.123, H44.129, H44.131, H44.132, H44.133, H44.139, H44.19

CPT only copyright 2012 American Medical Association. All rights reserved.

Comorbid Condition	Corresponding ICD-10-CM Codes
Other Proliferative Retinopathy	H35.101, H35.102, H35.103, H35.109, H35.111, H35.112, H35.113, H35.119, H35.121, H35.122, H35.123, H35.129, H35.131, H35.132, H35.133, H35.139, H35.141, H35.142, H35.143, H35.149, H35.151, H35.152, H35.153, H35.159, H35.161, H35.162, H35.163, H35.169, H35.171, H35.172, H35.173, H35.179
Other Retinal Disorders	H35.60, H35.61, H35.62, H35.63, H35.81, H35.89, H35.82
Other and Unspecified Forms of Chorioretinitis and Retinochoroiditis	H30.20, H30.21, H30.22, H30.23, H30.811, H30.812, H30.813, H30.819, H30.891, H30.892, H30.893, H30.899, H30.90, H30.91, H30.92, H30.93
Pathologic Myopia	H44.20, H44.21, H44.22, H44.23, H44.30
Prior Penetrating Keratoplasty	H18.601, H18.602, H18.603, H18.609, H18.611, H18.612, H18.613, H18.619, H18.621, H18.622, H18.623, H18.629
Profound Impairment, Both Eyes	H54.0, H54.10
Purulent Endophthalmitis	H44.001, H44.002, H44.003, H44.009, H44.011, H44.012, H44.013, H44.019, H44.021, H44.022, H44.023, H44.029
Retinal Detachment with Retinal Defect	H33.001, H33.002, H33.003, H33.009, H33.011, H33.012, H33.013, H33.019, H33.021, H33.022, H33.023, H33.029, H33.031, H33.032, H33.033, H33.039, H33.041, H33.042, H33.043, H33.049, H33.051, H33.052, H33.053, H33.059, H33.8
Retinal Vascular Occlusion	H34.10, H34.11, H34.12, H34.13, H34.231, H34.232, H34.233, H34.239, H34.811, H34.812, H34.813, H34.819, H34.831, H34.832, H34.833, H34.839
Scleritis and Episcleritis	A18.51, H15.021, H15.022, H15.023, H15.029, H15.031, H15.032, H15.033, H15.039, H15.041, H15.042, H15.043, H15.049, H15.051, H15.052, H15.053, H15.059, H15.091, H15.092, H15.093, H15.099
Separation of Retinal Layers	H35.711, H35.712, H35.713, H35.719, H35.721, H35.722, H35.723, H35.729, H35.731, H35.732, H35.733, H35.739
Uveitis	H44.111, H44.112, H44.113, H44.119, H44.131, H44.132, H44.133, H44.139
Visual Field Defects	H53.411, H53.412, H53.413, H53.419

NUMERATOR:
Patients who had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery

Numerator Options:
Best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following cataract surgery (4175F)

OR

Best-corrected visual acuity of 20/40 or better (distance or near) not achieved within 90 days following cataract surgery, reason not otherwise specified (4175F *with* 8P)

CPT only copyright 2012 American Medical Association. All rights reserved.

RATIONALE:

1. Scientific basis for measuring visual acuity outcomes after cataract surgery

The only reason to perform cataract surgery (other than for a limited set of medical indications) is to improve a patient's vision and associated functioning. The use of a 20/40 visual acuity threshold is based on several considerations. First, it is the level for unrestricted operation of a motor vehicle in the US. Second, it has been consistently used by the FDA in its assessment for approval of IOL and other vision devices. Third, it is the literature standard to denote success in cataract surgery. Fourth, work by West et al in the Salisbury Eye Study suggests that 20/40 is a useful threshold for 50th percentile functioning for several vision-related tasks.

Most patients achieve excellent visual acuity after cataract surgery (20/40 or better). This outcome is achieved consistently through careful attention through the accurate measurement of axial length and corneal power and the appropriate selection of an IOL power calculation formula. As such, it reflects the care and diligence with which the surgery is assessed, planned and executed. Failure to achieve this after surgery in eyes without comorbid ocular conditions that would impact the success of the surgery would reflect care that should be assessed for opportunities for improvement.

The exclusion of patients with other ocular and systemic conditions known to increase the risk of an adverse outcome reflects the findings of the two published prediction rule papers for cataract surgery outcomes, by Mangione et al and Steinberg et al. In both papers, the presence of comorbid glaucoma and macular degeneration negatively impacted the likelihood of successful outcomes of surgery. Further, as noted in the prior indicator, exclusion of eyes with ocular conditions that could impact the success of the surgery would NOT eliminate the large majority of eyes undergoing surgery while also minimizing the potential adverse selection that might otherwise occur relative to those patients with the most complex situations who might benefit the most from having surgery to maximize their remaining vision.

2. Evidence of a gap in care

This is an outcome of surgery indicator of direct relevance to patients and referring providers. The available evidence suggests that cataract surgery achieves this in between 86% and 98% of surgeries in eyes without comorbid ocular conditions (this indicator). While small, the volume of cataract surgery in the US of over 2.8 million surgeries suggests that the impact could affect more than 100,000 patients per year. Because of the exclusion of comorbid ocular conditions, one would expect performance on this indicator to be as high as possible, with significantly lower rates suggestive of opportunities for improvement.

The ASCRS National Cataract Database reported that at 3 months postoperatively, 85.5% of all patients had a 20/40 or better best-corrected visual acuity, 57.2% of patients had 20/25 or better postoperative best-corrected visual acuity, and 74.6% of patients were within ± 1.0 D of target spherical equivalent. Based on 5,788 responses, the mean visual function index score at 3 months postoperatively was 70.3% compared with 55.0% preoperatively. (The score is based on a scale of 0 to 100, with 0 indicating an inability to perform any of the activities.) The European Cataract Outcome Study reported for 1999 that 89% of patients achieved a postoperative visual acuity of 0.5 or more (20/40 or better), the average induced astigmatism was 0.59 D, and 86% of patients had an induced astigmatism within ± 1.0 D.

The AAO National Eyecare Outcomes Network (NEON) database also found similar rates of success, with an improvement in visual acuity in 92.2% of patients and improvement in VF-14 in over 90% of patients. Best-corrected visual acuity of 20/40 was achieved by 89% of all NEON patients and 96% of NEON patients without preoperative ocular comorbid conditions. Seventy-eight percent of patients were within ± 1.0 D of target spherical equivalent. Ninety-five percent of patients reported being satisfied with the results of their surgery. Patients who were dissatisfied with the results of their surgery were slightly older and more likely to have ocular comorbidity.
In studies of phacoemulsification cataract surgery performed by ophthalmology residents, the reported range of patients with postoperative BCVA of 20/40 or better is 80% to 91%. Eyes with ocular comorbidities are excluded, the reported range of patients with postoperative BCVA of 20/40 or better is 86% to 98%. (AAO)

CPT only copyright 2012 American Medical Association. All rights reserved.

CLINICAL RECOMMENDATION STATEMENTS:

This is an outcomes measure. As such, there are no statements in the guideline specific to this measurement topic.

CPT only copyright 2012 American Medical Association. All rights reserved.

*Measure #192 (NQF 0564): Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures

2013 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
REGISTRY ONLY

DESCRIPTION:
Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence

INSTRUCTIONS:
This measure is to be calculated each time a procedure for non-complicated cataracts is performed during the reporting period. This measure is intended to reflect the quality of services provided for the patients receiving uncomplicated cataract surgery.

Note: This is an outcomes measure and can be calculated solely using registry data.

- *For patients who receive the cataract surgical procedures specified in the denominator coding, claims should be reviewed to determine if any of the procedure codes listed in the numerator were performed within 30 days of the date of cataract surgery.*
- *Patients who have any of the listed comorbid conditions in the exclusion criteria should be removed from the denominator, and not considered as having a complication within 30 days following cataract surgery.*

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes and patient demographics are used to determine patients who are included in the measure's denominator. The listed numerator options are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

DENOMINATOR:
All patients aged 18 years and older who had cataract surgery and no significant pre-operative ocular conditions impacting the surgical complication rate

Denominator Instructions: Clinicians who indicate modifier 56, preoperative management only, will not qualify for this measure.

Denominator Criteria (Eligible Cases):
Patients aged ≥ 18 years on date of encounter
AND
Patient encounter during the reporting period (CPT): 66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984
AND NOT
Comorbid conditions that impact the visual outcome of surgery

CPT only copyright 2012 American Medical Association. All rights reserved.

(Patients with documentation of one or more of the following comorbid conditions prior to date of cataract surgery are excluded from the measure calculation)

Comorbid Condition	Corresponding ICD-9-CM Codes
Acute and Subacute Iridocyclitis	364.00, 364.01, 364.02, 364.03, 364.04, 364.05
Adhesions and Disruptions of Iris and Ciliary Body	364.70, 364.71, 364.72, 364.73, 364.74, 364.75, 364.76, 364.77, 364.81, 364.82, 364.89
Anomalies of Puillary Function	379.42
Aphakia and Other Disorders of Lens	379.32, 379.33, 379.34
Burn Confined to Eye and Adnexa	940.0, 940.1, 940.2, 940.3, 940.4, 940.5, 940.9
Cataract Secondary to Ocular Disorders	366.32, 366.33
Cataract, Congenital	743.30
Cataract, Mature or Hypermature	366.9
Cataract, Posterior Polar	743.31
Central Corneal Ulcer	370.03
Certain Types of Iridocyclitis	364.21, 364.22, 364.23, 364.24, 364.3
Chronic Iridocyclitis	364.10, 364.11
Cloudy Cornea	371.01, 371.02, 371.03, 371.04
Corneal Opacity and Other Disorders of Cornea	371.00, 371.03, 371.04
Corneal Edema	371.20, 371.21, 371.22, 371.23, 371.43, 371.44
Cysts of Iris, Ciliary Body, and Anterior Chamber	364.60, 364.61, 364.62, 364.63, 364.64
Enophthalmos	376.50, 376.51, 376.52
Glaucoma	365.10, 365.11, 365.12, 365.13, 365.14, 365.15, 365.20, 365.21, 365.22, 365.23, 365.24, 365.31, 365.32, 365.51, 365.52, 365.59, 365.60, 365.61, 365.62, 365.63, 365.64, 365.65, 365.81, 365.82, 365.83, 365.89
Hereditary Corneal Dystrophies	371.50, 371.51, 371.52, 371.53, 371.54, 371.55, 371.56, 371.57, 371.58
High Hyperopia	367.0
High Myopia	360.21
Hypotony of Eye	360.30, 360.31, 360.32, 360.33, 360.34
Injury to Optic Nerve and Pathways	950.0, 950.1, 950.2, 950.3, 950.9
Open Wound of Eyeball	871.0, 871.1, 871.2, 871.3, 871.4, 871.5, 871.6, 871.7, 871.9, 921.3
Pathologic Myopia	360.20, 360.21
Posterior Lenticonus	743.36
Prior Pars Plana Vitrectomy	67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure)
Pseudoexfoliation Syndrome	365.52
Retrolental Fibroplasias	362.21
Senile Cataract	366.11
Traumatic Cataract	366.20, 366.21, 366.22, 366.23

CPT only copyright 2012 American Medical Association. All rights reserved.

Comorbid Condition	Corresponding ICD-9-CM Codes
Use of Systemic Sympathetic Alpha-1a Antagonist Medication for Treatment of Prostatic Hypertrophy	Patient taking tamsulosin hydrochloride
Uveitis	360.11, 360.12
Vascular Disorders of Iris and Ciliary Body	364.42

Comorbid Condition	Corresponding ICD-10-CM Codes
Acute and Subacute Iridocyclitis	H20.00, H20.011, H20.012, H20.013, H20.019, H20.021, H20.022, H20.023, H20.029, H20.031, H20.032, H20.033, H20.039, H20.041, H20.042, H20.043, H20.049, H20.051, H20.052, H20.053, H20.059
Adhesions and Disruptions of Iris and Ciliary Body	H21.40, H21.41, H21.42, H21.43, H21.501, H21.502, H21.503, H21.509, H21.511, H21.512, H21.513, H21.519, H21.521, H21.522, H21.523, H21.529, H21.531, H21.532, H21.533, H21.539, H21.541, H21.542, H21.543, H21.549, H21.551, H21.552, H21.553, H21.559, H21.561, H21.562, H21.563, H21.569, H21.81, H21.82, H21.89, H22
Anomalies of Puillary Function	H57.03
Aphakia and Other Disorders of Lens	H27.10, H27.111, H27.112, H27.113, H27.119, H27.121, H27.122, H27.123, H27.129, H27.131, H27.132, H27.133, H27.139
Burn Confined to Eye and Adnexa	T26.00XA, T26.01XA, T26.02XA, T26.10XA, T26.11XA, T26.12XA, T26.20XA, T26.21XA, T26.22XA, T26.30XA, T26.31XA, T26.32XA, T26.40XA, T26.41XA, T26.42XA, T26.50XA, T26.51XA, T26.52XA, T26.60XA, T26.61XA, T26.62XA, T26.70XA, T26.71XA, T26.72XA, T26.80XA, T26.81XA, T26.82XA, T26.90XA, T26.91XA, T26.92XA
Cataract Secondary to Ocular Disorders	H26.211, H26.212, H26.213, H26.219, H26.221, H26.222, H26.223, H26.229
Cataract, Congenital	Q12.0
Cataract, Mature or Hypermature	H26.9
Cataract, Posterior Polar	Q12.0
Central Corneal Ulcer	H16.011, H16.012, H16.013, H16.019
Certain Types of Iridocyclitis	H20.20, H20.21, H20.22, H20.23, H20.811, H20.812, H20.813, H20.819, H20.821, H20.822, H20.823, H20.829, H20.9, H40.40X0
Chronic Iridocyclitis	A18.54, H20.10, H20.11, H20.12, H20.13, H20.9
Cloudy Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.811, H17.812, H17.813, H17.819, H17.821, H17.822, H17.823, H17.829
Corneal Opacity and Other Disorders of Cornea	H17.00, H17.01, H17.02, H17.03, H17.10, H17.11, H17.12, H17.13, H17.89, H17.9
Corneal Edema	H18.10, H18.11, H18.12, H18.13, H18.20, H18.221, H18.222, H18.223, H18.229, H18.231, H18.232, H18.233, H18.239, H18.421, H18.422, H18.423, H18.429, H18.43

CPT only copyright 2012 American Medical Association. All rights reserved.

Comorbid Condition	Corresponding ICD-10-CM Codes
Cysts of Iris, Ciliary Body, and Anterior Chamber	H21.301, H21.302, H21.303, H21.309, H21.311, H21.312, H21.313, H21.319, H21.321, H21.322, H21.323, H21.329, H21.341, H21.342, H21.343, H21.349, H21.351, H21.352, H21.353, H21.359
Enophthalmos	H05.401, H05.402, H05.403, H05.409, H05.411, H05.412, H05.413, H05.419, H05.421, H05.422, H05.423, H05.429
Glaucoma	H40.10X0, H40.10X1, H40.10X2, H40.10X3, H40.10X4, H40.11X0, H40.11X1, H40.11X2, H40.11X3, H40.11X4, H40.1210, H40.1211, H40.1212, H40.1213, H40.1214, H40.1220, H40.1221, H40.1222, H40.1223, H40.1224, H40.1230, H40.1231, H40.1232, H40.1233, H40.1234, H40.1290, H40.1291, H40.1292, H40.1293, H40.1294, H40.1310, H40.1311, H40.1312, H40.1313, H40.1314, H40.1320, H40.1321, H40.1322, H40.1323, H40.1324, H40.1330, H40.1331, H40.1332, H40.1333, H40.1334, H40.1390, H40.1391, H40.1392, H40.1393, H40.1394, H40.141, H40.142, H40.143, H40.149, H40.1510, H40.1511, H40.1512, H40.1513, H40.1514, H40.1520, H40.1521, H40.1522, H40.1523, H40.1524, H40.1530, H40.1531, H40.1532, H40.1533, H40.1534, H40.1590, H40.1591, H40.1592, H40.1593, H40.1594, H40.20X0, H40.20X1, H40.20X2, H40.20X3, H40.20X4, H40.211, H40.212, H40.213, H40.219, H40.2210, H40.2211, H40.2212, H40.2213, H40.2214, H40.2220, H40.2221, H40.2222, H40.2223, H40.2224, H40.2230, H40.2231, H40.2232, H40.2233, H40.2234, H40.2290, H40.2291, H40.2292, H40.2293, H40.2294, H40.231, H40.232, H40.233, H40.239, H40.241, H40.242, H40.243, H40.249, H40.30X0, H40.30X1, H40.30X2, H40.30X3, H40.30X4, H40.31X0, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X0, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X0, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.40X0, H40.40X1, H40.40X2, H40.40X3, H40.40X4, H40.41X0, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X0, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X0, H40.43X1, H40.43X2, H40.43X3, H40.43X4, H40.50X0, H40.50X1, H40.50X2, H40.50X3, H40.50X4, H40.51X0, H40.51X1, H40.51X2, H40.51X3, H40.51X4, H40.52X0, H40.52X1, H40.52X2, H40.52X3, H40.52X4, H40.53X0, H40.53X1, H40.53X2, H40.53X3, H40.53X4, H40.60X0, H40.60X1, H40.60X2, H40.60X3, H40.60X4, H40.61X0, H40.61X1, H40.61X2, H40.61X3, H40.61X4, H40.62X0, H40.62X1, H40.62X2, H40.62X3, H40.62X4, H40.63X0, H40.63X1, H40.63X2, H40.63X3, H40.63X4, H40.811, H40.812, H40.813, H40.819, H40.821, H40.822, H40.823, H40.829, H40.831, H40.832, H40.833, H40.839, H40.89, Q15.0

CPT only copyright 2012 American Medical Association. All rights reserved.

Comorbid Condition	Corresponding ICD-10-CM Codes
Hereditary Corneal Dystrophies	H18.50, H18.51, H18.52, H18.53, H18.54, H18.55, H18.59
High Hyperopia	H52.00, H52.01, H52.02, H52.03
High Myopia	H44.20, H44.21, H44.22, H44.23
Hypotony of Eye	H44.40, H44.411, H44.412, H44.413, H44.419, H44.421, H44.422, H44.423, H44.429, H44.431, H44.432, H44.433, H44.439, H44.441, H44.442, H44.443, H44.449
Injury to Optic Nerve and Pathways	S04.011A, S04.012A, S04.019A, S04.02XA, S04.031A, S04.032A, S04.039A, S04.041A, S04.042A, S04.049A
Open Wound of Eyeball	S05.10XA, S05.11XA, S05.12XA, S05.20XA, S05.21XA, S05.22XA, S05.30XA, S05.31XA, S05.32XA, S05.50XA, S05.51XA, S05.52XA, S05.60XA, S05.61XA, S05.62XA, S05.70XA, S05.71XA, S05.72XA, S05.8X1A, S05.8X2A, S05.8X9A, S05.90XA, S05.91XA, S05.92XA
Pathologic Myopia	H44.20, H44.21, H44.22, H44.23, H44.30
Posterior Lenticonus	Q12.2, Q12.4, Q12.8
Prior Pars Plana Vitrectomy	67036, 67039, 67040, 67041, 67042, 67043 (patient with history of this procedure)
Pseudoexfoliation Syndrome	H40.141, H40.142, H40.143, H40.149
Retrolental Fibroplasias	H35.171, H35.172, H35.173, H35.179
Senile Cataract	H25.89
Traumatic Cataract	H26.101, H26.102, H26.103, H26.109, H26.111, H26.112, H26.113, H26.119, H26.121, H26.122, H26.123, H26.129, H26.131, H26.132, H26.133, H26.139
Use of Systemic Sympathetic Alpha-1a Antagonist Medication for Treatment of Prostatic Hypertrophy	Patient taking tamsulosin hydrochloride
Uveitis	H44.111, H44.112, H44.113, H44.119, H44.131, H44.132, H44.133, H44.139
Vascular Disorders of Iris and Ciliary Body	H21.1X1, H21.1X2, H21.1X3, H21.1X9

NUMERATOR:
Patients who had one or more specified operative procedures for any of the following major complications within 30 days following cataract surgery: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence

Numerator Instructions: Codes for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence): 65235, 65800, 65810, 65815, 65860, 65880, 65900, 65920, 65930, 66030, 66250, 66820, 66825, 66830, 66852, 66986, 67005, 67010, 67015, 67025, 67028, 67030, 67031, 67036, 67039, 67041, 67042, 67043, 67101, 67105, 67107, 67108, 67110, 67112, 67141, 67145, 67250, 67255

NUMERATOR NOTE: For performance, a lower rate indicates better performance.

CPT only copyright 2012 American Medical Association. All rights reserved.

Numerator Options:

Surgical procedure performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) (G8627)

OR

Surgical procedure not performed within 30 days following cataract surgery for major complications (e.g., retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment or wound dehiscence) (G8628)

RATIONALE:

1. Scientific basis for assessing short-term complications following cataract surgery.

Complications that may result in a permanent loss of vision following cataract surgery are uncommon. This short-term outcomes of surgery indicator seeks to identify those complications from surgery that can reasonably be attributed to the surgery and surgeon and which reflect situations which - if untreated - generally result in significant avoidable vision loss that would negatively impact patient functioning. Further, it seeks to reduce surgeon burden and enhance accuracy in reporting by focusing on those significant complications that can be assessed from administrative data alone and which can be captured by the care of another physician or the provision of additional, separately coded, post-operative services. Finally, it focuses on patient safety and monitoring for events that, while hopefully uncommon, can signify important issues in the care being provided. For example, the need to reposition or exchange an IOL reflects in part "wrong power" IOL placement, a major patient safety issue.

In order to achieve these ends, the indicator excludes patients with other known, pre-operative ocular conditions that could impact the likelihood of developing a complication. Based on the results of the Cataract Appropriateness Project at RAND, other published studies, and one analysis performed on a national MCO data base, the exclusion codes would preserve over 2/3 of all cataract surgery cases for analysis. Thus, this provides a "clean" indicator that captures care for the large majority of patients undergoing cataract surgery.

2. Evidence for gap in care.

The advances in technology and surgical skills over the last 30 years have made cataract surgery much safer and more effective. An analysis of a single company's database (commercial age MCO) demonstrated that the rate of complications found for this indicator was approximately 1 to 2%. Nevertheless, as noted above, the occurrence of one of these events is associated with a significant potential for vision loss that is otherwise avoidable. Furthermore, with an annual volume of 2.8 million cataract surgeries in the US, a 2% rate would mean that over 36,000 surgeries are accompanied by these complications (2/3 of 56,000 surgeries).

A synthesis of the literature published prior to 1992 found weighted mean complication rates among all patients undergoing cataract surgery of 0.13% for endophthalmitis, 0.3% for bullous keratopathy, 1.4% clinically detectable CME, 3.5% for angiographically demonstrated CME, 0.7% for retinal detachment, and 1.1% for IOL dislocation. Bullous keratopathy and CME are not included in this indicator because they are conditions that are almost always temporary and resolve without additional intervention through additional procedures and associated care in this population of patients without prior known ocular conditions.

Additional studies similarly demonstrate the low occurrence of complications, including many that are temporary in nature and without a significant impact on patient outcomes. A national survey of over 100 hospitals from 1997 to 1998 found the following results on 18,454 patients 50 years old or older. Seventy-seven percent of these patients had surgery performed by phacoemulsification. Rates for events that occurred during surgery were 4.4% for posterior capsule rupture and vitreous loss, 1.0% for incomplete cortical cleanup, 1.0% for anterior chamber hemorrhage and or collapse, and 0.77% for iris damage. Short-term (within 48 hours) perioperative complications included corneal edema (9.5%), increased IOP (7.9%), uveitis (5.6%), wound leak (1.2%), hyphema (1.1%), and retained lens material (1.1%).

CPT only copyright 2012 American Medical Association. All rights reserved.

A retrospective study from New Zealand of 1,793 consecutive patients undergoing phacoemulsification reported a rate of 1.8% for posterior capsule rupture and a rate of 1.2% for rhegmatogenous retinal detachment. (AAO)

CLINICAL RECOMMENDATION STATEMENTS:
This is an outcomes measure. As such, there are no statements in the guideline specific to this measurement topic.

CPT only copyright 2012 American Medical Association. All rights reserved.