



2009 PQRI Measures Most Applicable to Nephrology Practice

The table below includes measures directly relevant to nephrology providers and are intended only for claims-based reporting options. Two ESRD PQRI measures, hemodialysis adequacy plan of care (measure #81) and peritoneal dialysis adequacy plan of care (measure #82) may only be reported through qualified registries. [Click here](#) for information about PQRI registry information.

CHRONIC KIDNEY DISEASE (CKD) MEASURES

[CKD Measures Group Description](#)
[CKD Measures Group Data Collection Sheet](#)

Measure 121: Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)

[Measure Description](#)
[Data Collection Sheet](#)
[Coding Specifications](#)

Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving renal replacement therapy (RRT), who had the following laboratory testing ordered at least once during the 12-month reporting period: serum levels of calcium, phosphorus, and intact PTH, and lipid profile</p> <p>ICD-9 Codes: 585.4, 585.5 AND CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245</p>	<p>Serum levels of calcium, phosphorus, intact parathyroid hormone (iPTH) and lipid profile ordered CPT II 3278F: Serum levels of calcium, phosphorus, intact parathyroid hormone (iPTH) and lipid profile ordered</p>	<p>At least once during the reporting period</p>	<p>Claims, Registry, OR Measures Group</p>	<p>Review clinical data (within the last 12 months of this encounter) regarding the presence or absence of order(s) for or results of laboratory tests at an encounter during the reporting period (January 1 through December 31, 2009). Select and submit the appropriate CPT Category II code corresponding to the measure.</p> <p>Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting and performance rates.</p> <p>Failure to report an applicable CPT Category II code in an eligible case will result in both a</p>
	<p>Serum levels of calcium, phosphorus, intact parathyroid hormone (iPTH) and lipid profile NOT ordered for medical reasons CPT II 3278F-1P: Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact parathyroid hormone (iPTH) and lipid profile ordered</p>			
	<p>Serum levels of calcium, phosphorus, intact parathyroid hormone (iPTH) and lipid profile NOT ordered for patient reasons CPT II 3278F-2P: Documentation of medical reason(s) for not ordering serum levels of calcium, phosphorus, intact parathyroid hormone (iPTH) and lipid profile ordered</p>			

	<p>Serum levels of calcium, phosphorus, intact parathyroid hormone (iPTH) and lipid profile NOT ordered, reason not specified</p> <p>CPT II 3278F-8P: Serum levels of calcium, phosphorus, intact parathyroid hormone (iPTH) and lipid profile not ordered, reason unspecified</p>			reporting and performance failure.
<p>Measure 122: Chronic Kidney Disease (CKD): Blood Pressure Management</p> <p>Measure Description Data Collection Sheet Coding Specifications</p>				
Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving renal replacement therapy (RRT), with a blood pressure < 130/80 mmHg OR blood pressure ≥ 130/80 mmHg with a documented plan of care</p> <p>ICD-9 Codes: 585.4, 585.5 AND CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245</p>	<p>Most recent blood pressure has a systolic measurement of < 130 mmHG and a diastolic measurement of < 80 mmHg</p> <p>G8476: Most recent blood pressure has a systolic measurement of < 130 mmHG and a diastolic measurement of < 80 mmHg</p>	Each visit	Claims, Registry, OR Measures Group	<p>Review clinical data regarding blood pressure measurement and plan of care if needed at each visit occurring during the reporting period (January 1 through December 31, 2008). Select and submit the appropriate CPT Category II code and/or G-code corresponding to the measure.</p> <p>A documented plan of care should include one or more of the following: recheck blood pressure at specified future date; initiate or alter pharmacologic therapy; initiate or alter non-pharmacologic therapy; documented review of patient's home blood pressure log which indicates that patient's blood pressure is or is not well controlled.</p> <p>Each eligible patient encounter during the reporting period will be counted when calculating the eligible professional's reporting and performance rates.</p> <p>The correct combination of codes must be reported on the claim form in order to properly report this measure. This may require the submission of multiple codes.</p> <p>Whenever G 8477 is used, you</p>
	<p>Most recent blood pressure has a systolic measurement of ≥ 130 mmHG and/or a diastolic measurement of ≥ 80 mmHg</p> <p>G8477: Most recent blood pressure has a systolic measurement of ≥ 130 mmHG and/or a diastolic measurement of ≥ 80 mmHg AND Whether plan of care is documented from list below:</p>			
	<ul style="list-style-type: none"> Elevated blood pressure plan of care documented CPT II 0513F: Documentation of elevated blood pressure plan of care 			
	<ul style="list-style-type: none"> Elevated blood pressure plan of care not documented CPT II 0513F-8P: No documentation of elevated blood pressure plan of care, reason not otherwise specified 			
	<p>Blood pressure measurement not performed or documented, reason not specified</p> <p>G8478: Blood pressure measurement not performed or documented, reason not specified</p>			

				must also use either CPT II 0513F or CPT II 0513F-8P to successfully report this measure
Measure 123: Chronic Kidney Disease (CKD): Plan of Care – Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA) Measure Description Data Collection Sheet Coding Specifications				
Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving renal replacement therapy (RRT), receiving ESA therapy, have a hemoglobin < 13 g/dL OR patients whos hemoglobin is ≥ 13 g/dL and have a documented plan of care</p> <p>ICD-9 Codes: 585.4, 585.5 AND CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245</p>	<p>Patient not receiving ESA therapy CPT II 4172F: Patient not receiving ESA therapy</p>	Once per calendar month	Claims, Registry, OR Measures Group	<p>At a minimum of one encounter per month in which the patient is seen during the reporting period (January 1 through December 31, 2009), review clinical data regarding the hemoglobin level and whether or not the patient is receiving ESA therapy. For patients with hemoglobin greater than or equal to 13 g/dL and receiving ESA therapy, there should be a documented plan of care for elevated hemoglobin. Select and submit the appropriate CPT Category II code(s) corresponding to the measure.</p> <p>Each eligible calendar month that the patient is seen during the reporting period will be counted when calculating the eligible professional's reporting and performance rates. The measure may be reported again at a subsequent visit during the eligible month. If the measure is reported more than once for an eligible patient during the month, the single instance of reporting most advantageous to performance will be used when calculating the eligible professional's performance rate for this measure.</p> <p>The correct combination of codes must be reported on the claim</p>
	<p>Patient receiving ESA therapy CPT II 4171F: Patient receiving ESA therapy AND Appropriate hemoglobin level from list below</p>			
	<ul style="list-style-type: none"> Hemoglobin level is 11 g/dL to 12.9 g/dL CPT II 3280F: Hemoglobin is between 11 – 12.9 g/dL 			
	<ul style="list-style-type: none"> Hemoglobin level is less than 11 g/dL CPT II 3281F: Hemoglobin is less than 11 g/dL 			
	<ul style="list-style-type: none"> Hemoglobin level measurement not documented, reason not otherwise specified CPT II 3281F-8P: No documented hemoglobin level measurement, reason not otherwise specified 			
	<ul style="list-style-type: none"> Hemoglobin is greater than or equal to 13 g/dL CPT II 3279F: Hemoglobin is ≥ 13 g/dL AND Whether plan of care is documented from list below: <ul style="list-style-type: none"> Plan of care for elevated hemoglobin level CPT II 0514F: Plan of care for elevated hemoglobin level for patient receiving ESA therapy No documented plan of care for elevated hemoglobin level CPT II 0514F-8P: No documented plan of care for elevated hemoglobin level for patient receiving ESA therapy 			

				<p>form in order to properly report this measure. This may require the submission of multiple codes.</p> <p>Whenever CPT II 4171F is used, you must also use either CPT II 3280F, CPT 3281F, or CPT II 3281F-8P to successfully report this measure.</p> <p>Also, whenever CPT II 3279F is used, you must also use either CPT II 0514F or CPT II 0514F-8P to successfully report this measure</p> <p>It is possible to report 3 PQRI codes for this one measure. For example, for a CKD patient receiving ESA therapy with a hemoglobin of 13.1 and has a documented plan of care, the claim should include the following PQRI codes: 4171F, CPT II 3279, and CPT II 0514F</p>
Measure 135: Chronic Kidney Disease (CKD): Plan of Care – Influenza Immunization Measure Description Data Collection Sheet Coding Specifications				
Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving renal replacement therapy (RRT), who received the influenza immunization during the flu season (September through February)</p> <p>ICD-9 Codes: 585.4, 585.5 AND CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245</p>	<p>Influenza immunization ordered or administered CPT II 4037F: Patient received influenza administration during the flu season (September through February)</p>	Once per reporting period	Claims, Registry, OR Measures Group	<p>Each eligible patient seen during the reporting period will be counted once when calculating the eligible professional's reporting rate for this measure.</p> <p>Review clinical data regarding influenza immunization ordered or administered at an encounter occurring during the reporting period (January 1 through December 31, 2009). Select and submit the appropriate CPT Category II code corresponding to the measure.</p>
	<p>Influenza immunization NOT ordered or administered for medical reasons CPT II 4037F-1P: Documentation of medical reason(s) for patient not receiving the influenza immunization</p>			
	<p>Influenza immunization NOT ordered or administered for patient reasons CPT II 4037F-2P: Documentation of patient reason(s) for patient not receiving the influenza immunization</p>			
	<p>Influenza immunization NOT ordered or administered for system reasons CPT II 4037F-3P: Documentation of system reason(s) for patient not receiving the influenza</p>			

	immunization			
	Influenza immunization NOT ordered or administered, reason not specified CPT II 4037F-8P: Patient did not receive influenza immunization during the flu season, reason not otherwise specified			
Measure 135: Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula Measure Description Data Collection Sheet Coding Specifications				
Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
All patients 18 years and older with a diagnosis of advanced CKD (stage 4 or 5, not receiving renal replacement therapy (RRT), who were referred for AV fistula at least once during the 12-month reporting period ICD-9 Codes: 585.4, 585.5 AND CPT Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245	AV fistula referred CPT II 4051F: Patient was referred for an AV fistula	Once per reporting period	Claims, Registry, OR Measures Group	
	AV fistula NOT referred for medical reasons CPT II 4051F-1P: Documentation of medical reason(s) for not referring for AV fistula			
	AV fistula NOT referred for patient reasons CPT II 4051F-2P: Documentation of patient reason(s) for not referring for AV fistula			
	AV Fistula NOT referred, reason not specified CPT II 4051F-8P: AV fistula NOT referred, reason not otherwise specified			
DIABETES MELLITUS Diabetes Measures Group Description Diabetes Measures Group Data Collection Sheet				
Measure 1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus Measure Description Data Collection Sheet Coding Specifications				
Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations

<p>All patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%</p> <p>ICD-9 Codes: 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, 250.80, 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</p> <p>AND</p> <p>CPT Codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271</p>	<p>Hemoglobin A1c level > 9.0% CPT II 3046F: Most recent hemoglobin A1c level is greater than 9.0%</p>	Once per reporting period	Claims, Registry, OR Measures Group	
	<p>Hemoglobin A1c level = 7.0% to 9.0% CPT II 3045F: Most recent hemoglobin A1c level is between 7.0% and 9.0%</p>			
	<p>Hemoglobin A1c level < 7.0% CPT II 3044F: Most recent hemoglobin A1c level is less than 7.0%</p>			
	<p>Hemoglobin A1c level was not performed CPT II 3046F-8P: Hemoglobin A1c level was not performed during the performance period (12 months), reason not otherwise specified</p>			

Measure 2: Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus

[Measure Description](#)
[Data Collection Sheet](#)
[Coding Specifications](#)

Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)</p> <p>ICD-9 Codes: 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,</p>	<p>LDL-C < 100 mg/dL CPT II 3048F: Most recent LDL-C is less than 100 mg/dL</p>	Once per reporting period	Claims, Registry, OR Measures Group	
	<p>LDL-C = 100 – 129 mg/dL CPT II 3049F: Most recent LDL-C is between 100 and 129 mg/dL</p>			
	<p>LDL-C ≥ 130 mg/dL CPT II 3050F: Most recent LDL-C is greater than or equal to 130 mg/dL</p>			
	<p>LDL-C was not performed CPT II 3048F-8P: LDL-C was not performed during</p>			

<p>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, 250.80, 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</p> <p>AND</p> <p>CPT Codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271</p>	<p>the performance period (12 months), reason not otherwise specified</p>			
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Measure 3: Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus

[Measure Description](#)
[Data Collection Sheet](#)
[Coding Specifications](#)

Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)</p> <p>ICD-9 Codes: 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, 250.80, 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</p> <p>AND</p> <p>CPT Codes: 97802, 97803, 97804, 99201, 99202, 99203,</p>	<p>Systolic blood pressure < 130 mmHg CPT II 3074F: Most recent systolic blood pressure < 130 mmHg</p> <p>Systolic blood pressure = 130 to 139 mmHg CPT II 3075F: Most recent systolic blood pressure is between 130 and 139 mmHg</p> <p>Systolic blood pressure is ≥ 140 mmHg CPT II 3077F: Most recent systolic blood pressure is greater than or equal to 140 mmHg</p> <p>Diastolic blood pressure is less than 80 mmHg CPT II 3078F: Most recent diastolic blood pressure is less than 80 mmHg</p> <p>Diastolic blood pressure = 80 to 89 mmHg CPT II 3079F: Most recent diastolic blood pressure is between 80 and 89 mmHg</p> <p>Diastolic blood pressure is ≥ 90 mmHg CPT II 3080F: Most recent diastolic blood pressure is greater than or equal to 90 mmHg</p> <p>No documentation of blood pressure management CPT II 2000F-8P: No documentation of blood pressure management</p>	<p>Once per reporting period</p>	<p>Claims, Registry, OR Measures Group</p>	

<p>99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271</p>				
Measure 117: Dilated Eye Exam in Diabetic Patient Measure Description Data Collection Sheet Coding Specifications				
Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam</p> <p>ICD-9 Codes: 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, 250.80, 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</p> <p>AND</p> <p>CPT Codes: 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, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271</p>	<p>Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed CPT II 2022F: Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed</p> <p>Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed CPT II 2024F: Seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed</p> <p>Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed CPT II 2026F: Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results documented and reviewed</p> <p>Low risk for retinopathy CPT II 3072F: Low risk for retinopathy (no evidence of retinopathy in the prior year)</p> <p>Dilated eye exam was not performed CPT II 2022F-8P OR CPT II 2024F-8p OR CPT II 2026F-8P: Dilated eye exam was not performed, reason not otherwise specified</p>	<p>Once per reporting period</p>	<p>Claims, Registry, OR Measures Group</p>	
Measure 119: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients Measure Description				

[Data Collection Sheet](#)
[Coding Specifications](#)

Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients aged 18 through 75 years with a diagnosis of diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months</p> <p>ICD-9 Codes: 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, 250.80, 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</p> <p>AND</p> <p>CPT Codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271</p>	<p>Positive microalbuminuria test result documented and reviewed CPT II 3060F: Positive microalbuminuria test result documented and reviewed</p> <p>Negative microalbuminuria test result documented and reviewed CPT II 3061F: Negative microalbuminuria test result documented and reviewed</p> <p>Positive macroalbuminuria test result documented and reviewed CPT II 3062F: Positive macroalbuminuria test result documented and reviewed</p> <p>Documentation of treatment for nephropathy CPT II 3066F: Documented treatment for nephropathy (eg., patient receiving dialysis, patient being treated for ESRD< CRF, ARF, or renal insufficiency, any visit to a nephrologist)</p> <p>Patient receiving ACE inhibitor or ARB therapy G8506: Patient receiving angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) therapy</p> <p>Nephropathy screening was not performed CPT II 3060F-8P OR CPT II 3061F-8P OR 3062F-8P: Nephropathy screening was not performed, reason not otherwise specified</p>	<p>Once per reporting period</p>	<p>Claims, Registry, OR Measures Group</p>	

Measure 163: Diabetic Foot Exam

[Measure Description](#)
[Data Collection Sheet](#)
[Coding Specifications](#)

Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
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<p>All patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a foot examination</p> <p>ICD-9 Codes: 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, 250.80, 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</p> <p>AND</p> <p>CPT Codes: 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271</p>	<p>Foot examination performed CPT II 2028F: Foot examination performed</p> <hr/> <p>Foot examination NOT performed due to medical reason CPT II 2028F-1P: Documentation of medical reason for not performing foot examination</p> <hr/> <p>Foot examination NOT performed, reason not specified CPT II 2028F-8P: Foot exam was not performed, reason not otherwise specified</p>	<p>Once per reporting period</p>	<p>Claims, Registry, OR Measures Group</p>	<p>Foot exam includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when any of the three components are completed</p> <p>There may be times when it is not appropriate to perform a foot examination due to medical reasons (ie, patient with bilateral foot/leg amputation)</p>
<p>Measure 126: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation</p> <p style="text-align: center;"> Measure Description Data Collection Sheet Coding Specifications </p>				
Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months</p> <p>ICD-9 Codes: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21,</p>	<p>Lower extremity neurological exam preformed and documented G8404: Lower extremity neurological exam performed and documented</p>	<p>Once per reporting period</p>	<p>Claims OR Registry</p>	<p>There may be times when it is not appropriate to perform a lower extremity exam. In these cases, you will need to indicate that a documented reason applies, and specify the reason in the medical chart.</p>

<p>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, 250.80, 250.91, 250.92, 250.93</p> <p>AND CPT Codes: 11040, 11041, 11042, 11043, 11044, 11055, 11056, 11057, 11719, 11720, 11721, 11730, 11740, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350</p>	<p>Patient not eligible for lower extremity neurological exam measure G8406: clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure</p>			
	<p>Lower extremity neurological exam not performed G8405: Lower neurological exam not performed</p>			

Measure 127: Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear

[Measure Description](#)
[Data Collection Sheet](#)
[Coding Specifications](#)

Reporting Eligibility	Measure Coding	Reporting Frequency	Reporting Options	Considerations
<p>All patients aged 18 through 75 years with a diagnosis of diabetes mellitus who were evaluated for proper footwear and sizing</p> <p>ICD-9 Codes: 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, 250.80, 250.91, 250.92, 250.93</p> <p>AND CPT Codes: 11040, 11041, 11042, 11043, 11044, 11055,</p>	<p>Footwear evaluation performed and documented G8410: footwear evaluation performed and documented</p>	<p>Once per reporting period</p>	<p>Claims OR Registry</p>	<p>There may be times when it is not appropriate to evaluate a diabetic patient for proper footwear and sizing. In these cases, you will need to indicate that a documented reason applies, and specify the reason in the medical chart.</p>
	<p>Patient not eligible for footwear evaluation G8416: clinician documented that patient was not an eligible candidate for footwear evaluation measure</p>			

11056, 11057, 11719, 11720, 11721, 11730, 11740, 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	Footwear evaluation not performed G8415: Footwear evaluation not performed			
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