MEASURE INFORMATION FORM

SEPTEMBER 2015

2014 MEASURE INFORMATION ABOUT THE ACUTE AND CHRONIC AMBULATORY CARE–SENSITIVE CONDITION COMPOSITE MEASURES, CALCULATED FOR THE VALUE-BASED PAYMENT MODIFIER PROGRAM

A. Measure Name

Ambulatory Care-Sensitive Condition (ACSC) Composite measures:

CMS-1: Acute Conditions Composite

CMS-2: Chronic Conditions Composite

B. Measure Description

The Acute Conditions Composite and Chronic Conditions Composite measures are the risk-adjusted rates at which Medicare beneficiaries are hospitalized for an established set of acute and chronic ACSCs, respectively, that are potentially preventable given appropriate primary and preventive care. The measures apply to solo practitioners and groups of practitioners, as identified by their Taxpayer Identification Number (TIN).

The measures are adapted from the area-level Prevention Quality Indicators (PQIs), which were developed by the Agency for Healthcare Research and Quality (AHRQ) and include measures of potentially avoidable hospitalizations.

C. Rationale

High rates of hospitalization for these ACSCs in a defined population of beneficiaries could indicate that the beneficiaries are not receiving high-quality ambulatory care. Therefore, measuring these outcomes can provide clear, actionable information on how TINs could improve the care they provide to their beneficiaries.

A TIN's performance on the ACSC Composite measures would improve if its attributed beneficiaries were hospitalized less frequently for ACSCs. A lower measure performance rate may signify that the TIN is providing better primary and preventive care and coordinating more effectively with other TINs in the continuum of care. Information on TINs' performance on these measures is included in the Mid-Year and Annual Quality and Resource Use Reports (QRURs) and used in the calculation of the Value Modifier.

D. Acute ACSC Composite

1. Measure Outcome (Numerator)

The outcome[1] of the Acute Conditions Composite is a hospitalization during the performance period with a primary diagnosis of one or more of the following conditions, as identified by the ICD-9 codes associated with the relevant PQI (see Table 1):

- Bacterial Pneumonia (PQI #11)
- Urinary Tract Infection (PQI #12)
- Dehydration (PQI #10)

2. Population Measured (Denominator)

After applying the exclusions outlined in the next section, all beneficiaries attributed to a TIN during the performance period are included in the calculation of the TIN's Acute Conditions Composite. Beneficiary attribution follows a two-step process (described in section G) that assigns a beneficiary to the TIN if the TIN's physicians or certain non-physician practitioners provided more primary care services to the beneficiary than any other TIN.

Patterns of utilization in Medicare claims in either the performance year or prior year identify beneficiaries with one of the four chronic conditions.[2] Section H contains links to more information on the population included in each measure and the algorithm for identifying chronic conditions.

3. Exclusions

- Beneficiaries are excluded from the population measured if they:
- were under the age of 18
- were enrolled in Medicare managed care (a Medicare Advantage plan) for any month during the performance period
- were enrolled in Medicare Part A only or Medicare Part B only for any month during the performance period
- resided outside of the United States, its territories, and its possessions for any month during the performance period
- Hospitalizations are excluded from the measure outcome if:

[1] This measure does not have a traditional numerator and denominator like a process of care measure; see risk adjustment and other resources below for more detail on measure construction.
[2] The algorithm used is based on the most current claims-based guidance for identifying these conditions developed by CMS' Chronic Conditions Warehouse (CCW).

- the hospital admission is a transfer from a hospital, skilled nursing facility, intermediate care facility, or other health care facility
- the hospitalization is missing a principal diagnosis
- the discharge had any diagnosis code for sickle-cell anemia or HB-S disease, or any diagnosis or procedure code for immunocompromised state (bacterial pneumonia component measure only)
- the discharge had any diagnosis code for kidney/urinary tract disorder or any diagnosis or procedure code for immunocompromised state (urinary tract infection component measure only)
- the discharge had any diagnosis code for chronic renal failure (dehydration component measure only)

4. Acute ACSC Composite Construction

Calculation of the Acute Conditions Composite measure begins by computing the simple (equally weighted) average of the three component measures: hospitalizations associated with bacterial pneumonia, urinary tract infection, and dehydration. The number of eligible cases for each component measure is all beneficiaries attributed to the TIN after applying exclusions. The composite average hospitalization rate is then risk adjusted separately for each component measure to create the Acute Conditions Composite (see section G, Methodological Information, for more information on risk adjustment).

E. Chronic ACSC Composite

1. Measure Outcome (Numerator)

The outcome[3] of the Chronic Conditions Composite is a hospitalization during the performance period with a primary diagnosis[4] of one or more of the following conditions, among attributed beneficiaries with the associated chronic condition:

- Short-Term Complications from Diabetes (PQI #1)[5]
- Long-Term Complications from Diabetes (PQI #3)
- Uncontrolled Diabetes (PQI #14)
- Lower Extremity Amputation among Patients with Diabetes (PQI #16)

[3] This measure does not have a traditional numerator and denominator like a process of care measure; see risk adjustment and other resources below for more detail on measure construction.

[4] The exception to this rule is diabetes. In addition to the principal diagnosis, hospital stays with a lower extremity amputation (evidenced by a procedure code) and a principal or secondary diabetes diagnosis qualify as a potentially avoidable hospitalization.

[5] PQIs 01, 03, 14, and 16 are all elements of a diabetes composite measure.

- Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults (PQI #5)
- Heart Failure (PQI #8)

The ICD-9 codes that identify these conditions are in Table 1 (section I).

2. Population Measured (Denominator)

After applying the exclusions outlined in the next section, all beneficiaries who are attributed to a TIN during the performance period and have one or more of the four associated chronic conditions that are included in the calculation of the TIN's Chronic Conditions Composite. Beneficiary attribution for the Chronic Conditions Composite follows the same two-step process used for the Acute Conditions Composite.

3. Exclusions

Beneficiaries are excluded from the population measured if they:

- were under the age of 40 for the COPD/asthma component measure or under the age of 18 for any of the other five component measures
- were enrolled in Medicare Part A only or Medicare Part B only for any month during the performance period
- were enrolled in Medicare managed care (for example, a Medicare Advantage plan) for any month during the performance period
- resided outside of the United States, its territories, and its possessions for any month during the performance period

Hospitalizations are excluded from the measure outcome if:

- the admission is a transfer from a hospital, skilled nursing facility, intermediate care facility, or other health care facility
- the admission was for cystic fibrosis and anomalies of the respiratory system (COPD/asthma component measure only)
- there was either a diagnosis of traumatic amputation of the lower extremity and/or a toe amputation procedure; or the hospitalization was associated with a pregnancy, childbirth, or puerperium period, as identified by Major Disease Category 14 (lower extremity amputation with diabetes component measure only)
- the discharge was for a hospitalization during which a cardiac procedure was performed (heart failure component measure only)

4. Chronic Conditions Composite Construction

Construction of the Chronic Conditions Composite begins with computing a combined rate of hospitalizations for diabetes from the four diabetes component measures as the number of hospitalizations associated with short-term complications from diabetes, long-term complications, uncontrolled diabetes, or lower extremity amputation per 1,000

attributed beneficiaries with diabetes. Next, the case-weighted average of the combined diabetes rate, the rate of COPD/asthma hospitalizations per 1,000 beneficiaries with COPD or asthma, and the rate of heart failure hospitalizations per 1,000 beneficiaries with heart failure is calculated, where the case weight is the number of attributed beneficiaries (that were not excluded from the measure population) with the condition associated with each condition-specific rate. The composite case-weighted average is then risk adjusted separately for each component measure to create the Chronic Conditions Composite (see section G, Methodological Information, for more information on risk adjustment).

F. Data Collection Approach and Measure Collection

The Chronic Conditions Composite and Acute Conditions Composite measures are calculated from Fee-for-Service Medicare claims and Medicare beneficiary enrollment data; no additional data submission by the TIN is required. The measures use one year of inpatient claims to calculate the hospitalization rates. In line with Chronic Condition Warehouse (CCW) guidance, two years of data are used to determine which beneficiaries qualify for the heart failure and diabetes measures, but only one year of data is used to determine which beneficiaries qualify for the COPD measure. When one year of data is used to identify chronic conditions, that year is the performance period. When two years of data are used to identify chronic conditions, those years are the performance period and the twelve months prior to the start of the performance period. The measure uses Medicare Part A and Part B claims from the performance period to attribute beneficiaries to TINs as described in section G (Methodological Information).

G. Methodological Information

Attribution. Beneficiaries are attributed to TINs for the Per Capita Costs for All Attributed Beneficiaries measure using a two-step process. Only beneficiaries who received a primary care service from a physician are considered for attribution. First, a beneficiary is attributed to a TIN if the TIN's primary care physicians (PCPs)—defined as family practice, internal medicine, geriatric medicine, or general practice physicians[6]—accounted for a larger share (plurality) of allowed charges for primary care services (as shown in Table 2) than PCPs for any other TIN.[7] Second, beneficiaries who did not receive a primary care service from a PCP are assigned to a TIN if the non-PCP physicians, nurse practitioners, clinical nurse specialists, and physician assistants in the TIN accounted for a larger amount of total Medicare allowed charges for primary care services than any other TIN.

Risk adjustment. Risk adjustment accounts for beneficiary-level risk factors that can affect quality outcomes, regardless of the care provided. The Chronic Conditions Composite and the Acute Conditions Composite are both calculated from individual components that have been risk

[6] These specialties are defined using the following CMS specialty codes: general practice (01), family practice (08), internal medicine (11), and geriatric medicine (38).

[7] In the 2015 Physician Fee Schedule Final Rule, CMS finalized a change to the attribution methodology. Beginning with the Value Modifier that will be applied in 2017, CMS will include non-physician practitioners (nurse practitioners, clinical nurse specialists, and physician assistants) in the first step of attribution and will no longer require that a beneficiary receive primary care services from a physician to be attributed to a TIN.

adjusted for the age and sex of beneficiaries, by comparing the TIN's actual rate of potentially avoidable hospitalizations with the rate that would be expected based on the age and sex distribution of the TIN's attributed beneficiaries (or attributed beneficiaries with the relevant chronic condition for the Chronic Conditions Composite components).

The first step in the risk-adjustment process is to categorize every Medicare beneficiary into 14 mutually exclusive sex-by-age categories.[8] Then, for each of the six ACSCs, a beneficiary-level logistic regression model estimates the relationship between whether the beneficiary was hospitalized for the condition and the beneficiary's sex-by-age category, weighting beneficiaries by the number of months they had both Medicare Part A and Part B coverage during the performance period. The model's output is an estimated probability for each sex-by-age category that a beneficiary in that category will be hospitalized for the condition. For each category, the expected number of beneficiaries who will be hospitalized for the condition is the product of the category's estimated probability and the number of beneficiaries attributed to the TIN (and with the condition, for chronic ACSCs) in that category.[9] The expected number of hospitalizations for the TIN is the sum of these products across all sex-by-age categories.

A TIN's risk-adjusted rate for each component and composite measure is the ratio of the actual (observed) rate to the expected rate for the TIN, multiplied by the overall rate per 1,000 beneficiaries in the Medicare population (for acute ACSCs), or the rate per 1,000 beneficiaries with the specified condition (for chronic ACSCs). This average is the population condition-specific hospitalization rate per 1,000 Medicare beneficiaries (or per 1,000 beneficiaries with the condition) across all TINs with one or more eligible professional.

H. For Further Information

- Detailed measure specifications for each PQI measure and composite measures are located at http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx.
- More detailed information on how the Acute and Chronic ACSC Composite measures are used in calculations of the Value Modifier is located in the Detailed Methodology Document for the 2014 QRUR and 2016 Value Modifier available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/2014-QRUR.html.
- More information on identifying beneficiaries with the chronic conditions who are included in the Chronic Conditions Composite is available at https://www.ccwdata.org/cs/groups/public/documents/document/ccw_condition_categories.pdf.

[8] The model classifies beneficiaries into one of seven age categories (and separately by sex, for a total of 14 age-sex categories): 0–39, 40–64, 65–69, 70–74, 75–79, 80–84, and 85 or older

[9] In counting beneficiaries, those with fewer than 12 months of Part A and Part B coverage receive a weight equal to the number of months during the performance period for which they *did* have both Part A and Part B, divided by 12.

I. Tables

Table 1. Numerator and Exclusion ICD-9 Codes for Prevention Quality Indicators used to identify Acute and Chronic Ambulatory Care-Sensitive Conditions

Chronic Condition PQI		Numerator ICD-9 Codes	Exclusion ICD-9-Codes
PQI #1	25010	DMII KETO NT ST UNCNTRLD	
	25011	DMI KETO NT ST UNCNTRLD	
	25012	DMII KETOACD UNCONTROLD	
	25013	DMI KETOACD UNCONTROLD	
	25020	DMII HPRSM NT ST UNCNTRL	
	25021	DMI HPRSM NT ST UNCNTRLD	
	25022	DMII HPROSMLR UNCONTROLD	
	25023	DMI HPROSMLR UNCONTROLD	
	25030	DMII O CM NT ST UNCNTRLD	
	25031	DMI O CM NT ST UNCNTRLD	
	25032	DMII OTH COMA UNCONTROLD	
	25033	DMI OTH COMA UNCONTROLD	
PQI #3	25040	DMII RENL NT ST UNCNTRLD	
	25041	DMI RENL NT ST UNCNTRLD	
	25042	DMII RENAL UNCNTRLD	
	25043	DMI RENAL UNCNTRLD	
	25050	DMII OPHTH NT ST UNCNTRL	
	25051	DMI OPHTH NT ST UNCNTRLD	
	25052	DMII OPHTH UNCNTRLD	
	25053	DMI OPHTH UNCNTRLD	
	25060	DMII NEURO NT ST UNCNTRL	
	25061	DMI NEURO NT ST UNCNTRLD	
	25062	DMII NEURO UNCNTRLD	
	25063	DMI NEURO UNCNTRLD	
	25070	DMII CIRC NT ST UNCNTRLD	
	25071	DMI CIRC NT ST UNCNTRLD	
	25072	DMII CIRC UNCNTRLD	
	25073	DMI CIRC UNCNTRLD	
	25080	DMII OTH NT ST UNCNTRLD	
	25081	DMI OTH NT ST UNCNTRLD	
	25082	DMII OTH UNCNTRLD	
	25083	DMI OTH UNCNTRLD	
	25090	DMII UNSPF NT ST UNCNTRL	
	25091	DMI UNSPF NT ST UNCNTRLD	
	25092	DMII UNSPF UNCNTRLD	
	25093	DMI UNSPF UNCNTRLD	

Table 1 (continued)

Chronic Condition PQI	Numerator ICD-9 Codes		Exclusion ICD-9-Codes	
PQI#5	494	BRONCHIECTASIS	7483	LARYNGOTRACH ANOMALY NEC
	496	CHR AIRWAY OBSTRUCT NEC	7484	CONGENITAL CYSTIC LUNG
	4910	SIMPLE CHR BRONCHITIS	7485	AGENESIS OF LUNG
	4911	MUCOPURUL CHR BRONCHITIS	7488	RESPIRATORY ANOMALY NEC
	4918	CHRONIC BRONCHITIS NEC	7489	RESPIRATORY ANOMALY NOS
	4919	CHRONIC BRONCHITIS NOS	7503	CONG ESOPH FISTULA/ATRES
	4920	EMPHYSEMATOUS BLEB	7593	SITUS INVERSUS
	4928	EMPHYSEMA NEC	7707	PERINATAL CHR RESP DIS
	4940	BRONCHIECTAS W/O AC EXAC	27700	CYSTIC FIBROS W/O ILEUS
	4941	BRONCHIECTASIS W AC EXAC	27701	CYSTIC FIBROS W ILEUS
	49120	OBST CHR BRONC W/O EXAC	27702	CYSTIC FIBROS W PUL MAN
	49121	OBS CHR BRONC W(AC) EXAC	27703	CYSTIC FIBROSIS W GI MAN
	49300	EXTRINSIC ASTHMA NOS	27709	CYSTIC FIBROSIS NEC
	49301	EXT ASTHMA W STATUS ASTH	51661	NEUROEND CELL HYPRPL INF
	49302	EXT ASTHMA W(ACUTE) EXAC	51662	PULM INTERSTITL GLYCOGEN
	49310	INTRINSIC ASTHMA NOS	51663	SURFACTANT MUTATION LUNG
	49311	INT ASTHMA W STATUS ASTH	51664	ALV CAP DYSP W VN MISALN
	49312	INT ASTHMA W (AC) EXAC	51669	OTH INTRST LUNG DIS CHLD
	49320	CHRONIC OBST ASTHMA NOS	74721	ANOMALIES OF AORTIC ARCH
	49321	CH OB ASTHMA W STAT ASTH	74860	LUNG ANOMALY NOS
	49322	CH OBST ASTH W (AC) EXAC	74861	CONGEN BRONCHIECTASIS
	49381	EXERCSE IND BRONCHOSPASM	74869	LUNG ANOMALY NEC
	49382	COUGH VARIANT ASTHMA		
	49390	ASTHMA NOS		
	49391	ASTHMA W STATUS ASTHMAT		
	49392	ASTHMA NOS W (AC) EXAC		
	4660	ACUTE BRONCHITIS		
	490	BRONCHITIS NOS		
PQI #8	4280	CHF NOS		
	4281	LEFT HEART FAILURE		
	39891	RHEUMATIC HEART FAILURE		
	42820	SYSTOLIC HRT FAILURE NOS		
	42821	AC SYSTOLIC HRT FAILURE		
	42822	CHR SYSTOLIC HRT FAILURE		
	42823	AC ON CHR SYST HRT FAIL		
	42830	DIASTOLC HRT FAILURE NOS		
	42831	AC DIASTOLIC HRT FAILURE		
	42832	CHR DIASTOLIC HRT FAIL		
	42833	AC ON CHR DIAST HRT FAIL		
	42840	SYST/DIAST HRT FAIL		
	42841	AC SYST/DIASTOL HRT FAIL		
	42842	CHR SYST/DIASTL HRT FAIL		
	42843	AC/CHR SYST/DIA HRT FAIL		
	4289	HEART FAILURE NOS		
PQI #14	25002	DMII WO CMP UNCNTRLD		
	25003	DMI WO CMP UNCNTRLD		
PQI #16	8410	LOWER LIMB AMPUTAT NOS	8950	AMPUTATION TOE
		TOE AMPUTATION	8951	AMPUTATION TOE-COMPLICAT
	8412	AMPUTATION THROUGH FOOT	8960	AMPUTATION FOOT, UNILAT
	8413	DISARTICULATION OF ANKLE	8961	AMPUT FOOT, UNILAT-COMPL
	8414	AMPUTAT THROUGH MALLEOLI	8962	AMPUTATION FOOT, BILAT
	8415	BELOW KNEE AMPUTAT NEC	8963	AMPUTAT FOOT, BILAT-COMP
	8416	DISARTICULATION OF KNEE	8970	AMPUT BELOW KNEE, UNILAT
	8417	ABOVE KNEE AMPUTATION	8971	AMPUTAT BK, UNILAT-COMPL
	8418	DISARTICULATION OF HIP	8972	AMPUT ABOVE KNEE, UNILAT
	8419	HINDQUARTER AMPUTATION	8973	AMPUT ABV KN, UNIL-COMPL
	25000	DMII WO CMP NT ST UNCNTR	8974	AMPUTAT LEG, UNILAT NOS
	25001	DMI WO CMP NT ST UNCNTRL	8975	AMPUT LEG, UNIL NOS-COMP

Table 1 (continued)

Chronic Condition PQI	Numerator ICD-9 Codes		Exclusion ICD-9-Codes	
PQI #16 (continued)	25002	DMII WO CMP UNCNTRLD	8976	AMPUTATION LEG, BILAT
	25003	DMI WO CMP UNCNTRLD	8977	AMPUTAT LEG, BILAT-COMPL
	25010	DMII KETO NT ST UNCNTRLD	8411	TOE AMPUTATION
	25011	DMI KETO NT ST UNCNTRLD		
	25012	DMII KETOACD UNCONTROLD		
	25013	DMI KETOACD UNCONTROLD		
	25020	DMII HPRSM NT ST UNCNTRL		
	25021	DMI HPRSM NT ST UNCNTRLD		
	25022	DMII HPROSMLR UNCONTROLD		
	25023	DMI HPROSMLR UNCONTROLD		
	25030	DMII O CM NT ST UNCNTRLD		
	25031	DMI O CM NT ST UNCNTRL		
	25032	DMII OTH COMA UNCONTROLD		
	25033	DMI OTH COMA UNCONTROLD		
	25040	DMII RENL NT ST UNCNTRLD		
	25041	DMI RENL NT ST UNCNTRLD		
	25042	DMII RENAL UNCNTRLD		
	25043	DMI RENAL UNCNTRLD		
	25050	DMII OPHTH NT ST UNCNTRL		
	25051	DMI OPHTH NT ST UNCNTRLD		
	25052	DMII OPHTH UNCNTRLD		
	25053	DMI OPHTH UNCNTRLD		
	25060	DMII NEURO NT ST UNCNTRL		
	25061	DMI NEURO NT ST UNCNTRLD		
	25062	DMII NEURO UNCNTRLD		
	25063	DMI NEURO UNCNTRLD		
	25070	DMII CIRC NT ST UNCNTRLD		
	25071	DMI CIRC NT ST UNCNTRLD		
	25072	DMII CIRC UNCNTRLD		
	25073	DMI CIRC UNCNTRLD		
	25080	DMII OTH NT ST UNCNTRLD		
	25081	DMI OTH NT ST UNCNTRLD		
	25082	DMII OTH UNCNTRLD		
	25083	DMI OTH UNCNTRLD		
	25090	DMII UNSPF NT ST UNCNTRL		
	25091	DMI UNSPF NT ST UNCNTRLD		
	25092	DMII UNSPF UNCNTRLD		
	25093	DMI UNSPF UNCNTRLD		
PQI #11	481	PNEUMOCOCCAL PNEUMONIA	28241	THLASEMA HB-S W/O CRISIS
	485	BRONCOPNEUMONIA ORG NOS	28242	THLASSEMIA HB-S W CRISIS
	486	PNEUMONIA, ORGANISM NOS	28260	SICKLE CELL DISEASE NOS
	4822	H.INFLUENZAE PNEUMONIA	28261	HB-SS DISEASE W/O CRISIS
	4829	BACTERIAL PNEUMONIA NOS	28262	HB-SS DISEASE W CRISIS
	4830	PNEU MYCPLSM PNEUMONIAE	28263	HB-SS/HB-C DIS W/O CRSIS
	4831	PNEUMONIA D/T CHLAMYDIA	28264	HB-S/HB-C DIS W CRISIS
	4838	PNEUMON OTH SPEC ORGNSM	28268	HB-S DIS W/O CRISIS NEC
	48230	STREPTOCOCCAL PNEUMN NOS	28269	HB-SS DIS NEC W CRISIS
	48231	PNEUMONIA STRPTOCOCCUS A		
	48232	PNEUMONIA STRPTOCOCCUS B		
	48239	PNEUMONIA OTH STREP		
	48241	METH SUS PNEUM D/T STAPH		
	48242	METH RES PNEU D/T STAPH		

Table 1 (continued)

Chronic Condition PQI	Numerator ICD-9 Codes		Exclusion ICD-9-Codes	
PQI #10	2765	HYPOVOLEMIA	585	CHRONIC RENAL FAILURE
	27650	VOLUME DEPLETION NOS	5855	CHRON KIDNEY DIS STAGE V
	27651	DEHYDRATION	5856	END STAGE RENAL DISEASE
	27652	HYPOVOLEMIA	40300	MAL HY KID W CR KID I-IV
	2760	HYPEROSMOLALITY	40301	MAL HYP KID W CR KID V
	88	VIRAL ENTERITIS NOS	40310	BEN HY KID W CR KID I-IV
	90	INFECTIOUS ENTERITIS NOS	40311	BEN HYP KID W CR KID V
	91	ENTERITIS OF INFECT ORIG	40390	HY KID NOS W CR KID I-IV
	92	INFECTIOUS DIARRHEA NOS	40391	HYP KID NOS W CR KID V
	93	DIARRHEA OF INFECT ORIG	40400	MAL HY HT/KD I-IV W/O HF
	861	INTES INFEC ROTAVIRUS	40401	MAL HYP HT/KD I-IV W HF
	862	INTES INFEC ADENOVIRUS	40402	MAL HY HT/KD ST V W/O HF
	863	INT INF NORWALK VIRUS	40403	MAL HYP HT/KD STG V W HF
	864	INT INF OTH SML RND VRUS	40410	BEN HY HT/KD I-IV W/O HF
	865	ENTERITIS D/T CALICIVIRS	40411	BEN HYP HT/KD I-IV W HF
	866	INTES INFEC ASTROVIRUS	40412	BEN HY HT/KD ST V W/O HF
	867	INT INF ENTEROVIRUS NEC	40413	BEN HYP HT/KD STG V W HF
	869	OTHER VIRAL INTES INFEC	40490	HY HT/KD NOS I-IV W/O HF
	5589	NONINF GASTROENTERIT NEC	40491	HYP HT/KD NOS I-IV W HF
	5845	AC KIDNY FAIL, TUBR NECR	40492	HY HT/KD NOS ST V W/O HF
	5846	AC KIDNY FAIL, CORT NECR	40493	HYP HT/KD NOS ST V W HF
	5847	AC KIDNY FAIL, MEDU NECR		
	5848	ACUTE KIDNEY FAILURE NEC		
	5849	ACUTE KIDNEY FAILURE, NOS		
	586	RENAL FAILURE NOS		
	9975	SURG COMPL-URINARY TRACT		
PQI #12	5902	RENAL/PERIRENAL ABSCESS	7530	RENAL AGENESIS
	5903	PYELOURETERITIS CYSTICA	7533	KIDNEY ANOMALY NEC
	5909	INFECTION OF KIDNEY NOS	7534	URETERAL ANOMALY NEC
	5950	ACUTE CYSTITIS	7535	BLADDER EXSTROPHY
	5959	CYSTITIS NOS	7536	CONGEN URETHRAL STENOSIS
	5990	URIN TRACT INFECTION NOS	7538	CYSTOURETHRAL ANOM NEC
	59010	AC PYELONEPHRITIS NOS	7539	URINARY ANOMALY NOS
	59011	AC PYELONEPHR W MED NECR	59000	CHR PYELONEPHRITIS NOS
	59080	PYELONEPHRITIS NOS	59001	CHR PYELONEPH W MED NECR
	59081	PYELONEPHRIT IN OTH DIS	59370	VESCOURETRL RFLUX UNSPCF
			59371	VSCURT RFLX NPHT UNILTRL
			59372	VSCOURTL RFLX NPHT BLTRL
			59373	VSCOURTL RFLX W NPHT NOS
			75310	CYSTIC KIDNEY DISEAS NOS
			75311	CONGENITAL RENAL CYST
			75312	POLYCYSTIC KIDNEY NOS
			75313	POLYCYST KID-AUTOSOM DOM
			75314	POLYCYST KID-AUTOSOM REC
			75315	RENAL DYSPLASIA
			75316	MEDULLARY CYSTIC KIDNEY
			75317	MEDULLARY SPONGE KIDNEY
			75319	CYSTIC KIDNEY DISEAS NEC
			75320	OBS DFCT REN PLV&URT NOS
			75321	CONGEN OBST URTROPLV JNC
			75322	CONG OBST URETEROVES JNC
			75323	CONGENITAL URETEROCELE
			75329	OBST DEF REN PLV&URT NEC

Table 2. Healthcare Common Procedure Coding System (HCPCS) primary care service codes

HCPCS codes	Brief description
99201–99205	New patient, office, or other outpatient visit
99211–99215	Established patient, office, or other outpatient visit
99304–99306	New patient, nursing facility care
99307–99310	Established patient, nursing facility care
99315–99316	Established patient, discharge day management service
99318	Established patient, other nursing facility service
99324–99328	New patient, domiciliary or rest home visit
99334–99337	Established patient, domiciliary or rest home visit
99339–99340	Established patient, physician supervision of patient (patient not present) in home, domiciliary, or rest home
99341–99345	New patient, home visit
99347–99350	Established patient, home visit
G0402	Initial Medicare visit
G0438	Annual wellness visit, initial
G0439	Annual wellness visit, subsequent

Note: Labels are approximate. For detailed definitions, see the American Medical Association's Current Procedural Terminology and the CMS website (http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html).