MEASURE OF THE MONTH:
STROKE AND STROKE REHABILITATION

By Lisa Kirkland, FACP

In accordance with a law passed by Congress in late 2006, physicians and other eligible professionals can receive bonus payments equal to a percentage (increased to 2%) of their total allowed Medicare charges, subject to a cap, by submitting information for defined quality measures. Many of these measures were developed by the AMA-convened Physician Consortium for Performance Improvement®, in collaboration with the National Committee for Quality Assurance and/or a medical specialty society.

In July 2008, CMS reported $36 million in bonus payments to many of the more than 56,700 health professionals who correctly reported quality information to Medicare under the 2007 Physician Quality Reporting Initiative (PQRI). The average incentive amount for individual professionals was over $600 and average incentive payment for a physician group practice was over $4,700, with the largest payment to a physician group practice totaling over $205,700.

Hospitalists have the following quality measures available to them for the 2009 PQRI and can choose up to three measures per reporting period:

- ACE inhibitor, ARB in heart failure,
- antiplatelets in CAD,
- beta-blocker in CAD with prior MI,
- DVT prophylaxis in stroke,
- antiplatelets in stroke,
- anticoagulant in stroke with atrial fibrillation,
- tPA considered in stroke,
- dysphagia screen in stroke,
- rehab considered in stroke,
- advance care plan,
- VAP prevention (head elevation), and
- CRBSI prevention (CVC insertion protocol).

For a specific measure, the eligible (“denominator”) patient population is identified by both ICD-9 diagnosis codes and CPT evaluation/management (E/M) service codes. If a patient falls into that denominator population, the appropriate CPT-II code(s) and modifiers for the individual patient (“numerator”) are required for submission. A modifier is required if a patient is in the eligible population but does not receive the measure; the explanation must be documented in the chart as a medical, patient, system, or unspecified reason.

Measure #36. Stroke and stroke rehabilitation: Consideration of rehabilitation services

This measure quantifies the percentage of patients 18 years of age and over with either ischemic stroke or intracranial hemorrhage for whom rehabilitation services were ordered or documented as “not indicated.”

The frequency of this measure is a minimum of once during each hospital stay during the reporting period.

The denominator is the ICD-9 code for ischemic stroke (433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91) or intracerebral hemorrhage (431)* AND CPT/EM service code 99238-9 or 99251-55.

<table>
<thead>
<tr>
<th>Numerator</th>
<th>CPT II</th>
<th>Modifier</th>
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<tbody>
<tr>
<td>Rehabilitation services ordered</td>
<td>4079F</td>
<td>None</td>
</tr>
<tr>
<td>Rehabilitation services documented as not indicated</td>
<td>4079F</td>
<td>8P</td>
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</tbody>
</table>

*Intracerebral hemorrhage code 431 is defined as intraparenchymal or intraventricular hemorrhage, not subarachnoid hemorrhage or epidural or subdural hematomas.

Dr. Kirkland is a hospitalist at the Mayo Clinic in Rochester, Minn., and a critical care specialist at Abbott Northwestern Hospital in Minneapolis. She is a member of ACP Hospitalist’s editorial advisory board.