PQRI Changes Take Effect January 1. Be Ready

Susan Nedza, MD, MBA
Kendra Hanley, MS
Samantha Tierney, MPH

Discussion of....
- The history of the PQRI program, incentive payments and eligible professionals
- Changes to the PQRI program for 2009
- Measures applicable to your practice
- Key elements of PQRI 2009 performance measures and specifications
- New implementation tools developed by the AMA for PQRI 2009

Physician Quality Reporting Initiative
- Began in July, 2007
- Pay for Reporting Program
- PQRI reporting focused attention on measuring quality of care
- Foundation is evidence-based measures developed by professionals
- Reporting data for quality measurement is rewarded with financial incentive
- Measurement enables improvements in care
- Reporting is the first step toward pay for performance
PQRI Introduction: Eligible Professionals

- Physicians
  - MD/DO
  - Podiatrist
  - Optometrist
  - Oral Surgeon
  - Dentist
  - Chiropractor
- Therapists
  - Physical Therapist
  - Occupational Therapist
  - Qualified Speech-Language Pathologist
- Practitioners
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Registered Nurse Anesthetist
  - Certified Nurse Midwife
  - Clinical Social Worker
  - Clinical Psychologist
  - Registered Dietician
  - Nutrition Professional
  - Audiologists (as of 1/1/2009)

PQRI Introduction: The Bonus Payment

- Professionals that report successfully are eligible for a 2 percent bonus payment.

- Potential bonus payment is calculated using total allowed charges for covered professional services furnished during the reporting period and paid under the Physician Fee Schedule.

Understanding the Measures: Scope

- The measures address various aspects of quality care
  - Prevention
  - Chronic Care Management
  - Acute Episode of Care Management
  - Procedural Related Care
  - Resource Utilization
  - Care Coordination
Understanding the Measures:
Construct

Clinical action required for reporting and performance

Eligible cases for a measure (the eligible patient population associated with the numerator)

Understanding the Measures:
Construct

CPT II Code
or
Temporary G Code

ICD-9-CM
and
CPT Category I Codes
Or
HCPCS

PQRI Reporting:
Understanding the Modifiers

- Performance Measure Exclusion Modifiers indicate that an action specified in the measure was not provided due to medical, patient or systems reason(s) documented in the medical record:
  - 1P - Performance Measure Exclusion Modifier due to Medical Reasons
  - 2P - Performance Measure Exclusion Modifier used due to Patient Reason
  - 3P - Performance Measure Exclusion Modifier used due to System Reason
- One or more exclusions may be applicable for a given measure. Certain measures have no applicable exclusion modifiers. Refer to the measure specifications to determine the appropriate exclusion modifiers.
PQRI Reporting: Understanding the Modifiers

• Performance Measure Reporting Modifier facilitates reporting a case when the patient is eligible but the action described in a measure is not performed and the reason is not specified or documented
• 8P- Performance Measure Reporting Modifier- action not performed, reason not otherwise specified

Changes in PQRI 2009

• 153 measures in 2009 PQRI
• Reporting Mechanisms
  • Claims OR Registries
  • ★★Some measures designated only claims or only registries; some measures both claims and registries
• Reporting Criteria
  • Individual Measures OR
  • Measure Groups (some measures only reportable through a measures group)

2009 Options for Claims Reporting

• Reporting Criteria for Claims
  • Individual measures
    • At least 3 PQRI measures for 80% of applicable patients (Medicare FFS) (unless fewer than 3 measures apply in which case 1 or 2 acceptable)
  • Measures Groups
    • One measures group for 30 consecutive Medicare Part B FFS patients (Jan 1-Dec 31, 2009)
    • One measures group for 80% of applicable Part B FFS; minimum of 30 patients (Jan 1-Dec 31, 2009)
    • One measures group for 80% of applicable Part B FFS; minimum of 15 patients (July 1-Dec 31, 2009)
2009 Options for Registry Reporting

Individual Measures
- At least 3 PQRI measures for 80% of applicable patients (Medicare FFS) (Jan 1-Dec 31, 2009)
- At least 3 PQRI measures for 80% of applicable patients (Medicare FFS) (July 1-Dec 31, 2009)
- *If < 3 measures apply to a provider, can’t report on individual measures through registry

Measures Groups
- One measures group for 30 consecutive Medicare Part B FFS patients (Jan 1-Dec 31, 2009)
- One measures group for 80% of applicable Part B FFS; minimum of 30 patients (Jan 1-Dec 31, 2009)
- One measures group for 80% of applicable Part B FFS; minimum of 15 patients (July 1-Dec 31, 2009)

Options for Participation—Claims or Registries

Claims Registries *

Individual Measures
At least 3 measures for 80% of applicable patients (unless < 3 apply)

Measure Groups

Jan-Dec ‘09
One measure group for 30 consecutive patients at any time during reporting period

July-Dec ‘09
One measure group for 80% of applicable patients (minimum 30 patients)
One measure group for 80% of applicable patients (minimum 15 patients)

What is a Measures Group?
- “A subset of PQRI measures that have a particular clinical condition or focus in common” (From MPFS Final Rule)
- Some measures groups reportable only through registry (eg, CABG)
What measure groups are available for 2009 PQRI reporting?

- Diabetes (6 measures)
- Chronic Kidney Disease (5 measures)
- Preventive Care (9 measures)
- CABG (10 measures)
- Rheumatoid Arthritis (6 measures)
- Perioperative Care (4 measures)
- Back Pain (4 measures)

Measures Retired Effective with PQRI 2009 Program

- 4. Screening for Future Fall Risk
- 73. Plan for Chemotherapy Documented Before Chemotherapy Administered
- 74. Radiation Therapy Recommended for Invasive Breast Cancer Patients who Have undergone Breast Conserving Surgery
- 75. Prevention of Ventilator-Associated Pneumonia – Head Elevation
- 77. Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD
- 78. Vascular Access for Patients Undergoing Hemodialysis
- 80. End Stage Renal Disease (ESRD): Plan of Care for ESRD Patients with Anemia
- 88. Hepatitis C: Hepatitis A and B Vaccination in Patients with HCV (Now separate measures – #183, 184)

Measures Retired Effective with PQRI 2009 Program (continued)

- 96. OME: Antihistamines or Decongestants – Avoidance of Inappropriate Use
- 97. OME: Systemic Antimicrobials – Avoidance of Inappropriate Use
- 98. OME: Systemic Corticosteroids – Avoidance of Inappropriate Use
- 101. Appropriate Initial Evaluation of Patients with Prostate Cancer
- 103. Prostate Cancer: Review of Treatment Options in Patients with Clinically Localized Prostate Cancer
- 120. Chronic Kidney Disease (CKD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
- 125. Health Information Technology (HIT): Adoption/Use of Medication Electronic Prescribing (e-Prescribing)
- 129. Universal Influenza Vaccine Screening and Counseling
- 132. Patient Co-Development of Treatment Plan/Plan of Care
- 133. Screening for Cognitive Impairment
New Measures (135-186) Available in the Following Topic Areas:

- Back Pain
- Cancer
- Chiropractic Care
- Chronic Wound Care
- CKD
- Coronary Artery Disease
- Endoscopy/Polyp Surveillance
- Eye Care
- Geriatric care – Falls, Elder Maltreatment Screen
- Hepatitis C
- HIV/AIDS
- Melanoma
- Nuclear Medicine
- Osteoarthritis
- Pediatric ESRD
- Preventive Care and Screening
- Radiology
- Rheumatoid Arthritis
- Surgical Care – Vascular, Thoracic (incl. CABG)

PQRI Basics

- Measure specifications have been updated for 2009 program
- Be sure to download and review 2009 specifications
- PQRI Specifications from prior years are not valid for reporting in 2009!!

Available Tools and Resources

- 2009 PQRI Measures List
- Measure Specification Manuals
  - Individual Measures
  - Measures Groups
- Implementation Guide
- Participation Tools on AMA website
  - www.ama-assn.org/go/toolsMedicarePQRI
2009 PQRI Measures List

- Available on CMS Website
- Lists measures by number
- Measure Title and Description
- Measure Developer (e.g., AMA-PCPI, NCQA, QIP, APMA, STS)
- Reporting Options (Claims, Registry, Measures Groups)

<table>
<thead>
<tr>
<th>Measure Developer Information</th>
<th>Measure Title &amp; Description</th>
<th>Reporting Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>Adult and Pediatric Colorectal Cancer Screening for Patients with a History of Adenomatous Polyps - Enrolment in Inappropriate Plan</td>
<td>Claim, Registry, Measures Group</td>
</tr>
<tr>
<td>#2</td>
<td>Percentage of patients aged 75 years and older receiving a colonoscopy and a barium enema examination in a 3 year period</td>
<td>Claim, Registry, Measures Group</td>
</tr>
<tr>
<td>#3</td>
<td>Percentage of patients aged 75 years and older with a diagnosis of colon cancer and recommended adjuvant chemotherapy within the Cancer Tracking Period</td>
<td>Claim, Registry, Measures Group</td>
</tr>
</tbody>
</table>

PQRI Definitions

- Reporting Options
  - Claims, Registry or Measures Group
- Quality Data Codes or QDCs (Numerator)
  - CPT II codes or G-Codes used to report the numerator of the measures.
- NPI-National Provider Identifier
PQRI Definitions (cont’d)

- Reporting Frequency-per NPI
  - Once per reporting period for each patient
  - At each visit for each patient during the reporting period
  - Each time a certain procedure is performed
  - For each episode of care

- Eligible Cases (aka Denominator)
  - Population for whom the measure applies
  - Designated through Administrative Codesets (ICD-9-CM, CPT®, HCPCS)

  Example
  - 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
  - Diagnosis for primary open-angle glaucoma (line-item ICD-9-CM): 365.01, 365.10, 365.11, 365.12, 365.15
  - Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 92020, 92030, 92032, 92055, 92056, 92057, 92058, 92059, 92060, 92061, 92062, 92063, 92064, 92065, 92066, 92067, 92068, 92069, 92070, 92071, 92072, 92073, 92074, 92075, 92076, 92077, 92078, 92079, 92080, 92081, 92082, 92083, 92084, 92085, 92086, 92087, 92088, 92089, 92090, 92091, 92092, 92093, 92094, 92095, 92096, 92097, 92098, 92099, 92000, 92001, 92002, 92003, 92004, 92005, 92006, 92007, 92008, 92009, 92010, 92011, 92012, 92013, 92014, 92015, 92016, 92017, 92018, 92019, 92020, 92021, 92022, 92023, 92024, 92025, 92026, 92027, 92028, 92029, 92030, 92031, 92032, 92033, 92034, 92035, 92036, 92037

How to Select Measures for your Practice

- Reporting through claims or registries?
- Reporting on individual measures or measures groups?
- Review list of measures to identify potential measures applicable to your practice
- Review measure specifications to confirm measures are applicable to your practice (denominator coding)
If you have previously reported on.....
You may consider selecting...

<table>
<thead>
<tr>
<th>Clinical Topic</th>
<th>Retired Measure</th>
<th>New measures that may apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falls</td>
<td>4</td>
<td>154, 155</td>
</tr>
<tr>
<td>Oncology</td>
<td>73, 74, 101, 103</td>
<td>143, 144</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>77 (GERD)</td>
<td>185 (Endoscopy)</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>83</td>
<td>183, 184</td>
</tr>
<tr>
<td>HIT/Adoption of e-Prescribing</td>
<td>125</td>
<td>CMS E-Prescribing Incentive program (not part of PQRI)</td>
</tr>
</tbody>
</table>

If you are currently reporting on....you might ALSO want to consider....

<table>
<thead>
<tr>
<th>Clinical Topic</th>
<th>Measures in 2008 and 2009</th>
<th>2009 measures that may also be relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiology/Imaging</td>
<td>10, 11</td>
<td>145, 146, 147</td>
</tr>
<tr>
<td>Eye Care</td>
<td>12, 14, 18, 19</td>
<td>129, 140, 141</td>
</tr>
<tr>
<td>CKD</td>
<td>121, 122, 123</td>
<td>135, 153</td>
</tr>
<tr>
<td>CABG</td>
<td>43, 44</td>
<td>164-171 (Registry only) 157</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>108</td>
<td>176-180</td>
</tr>
<tr>
<td>Geriatrics (&gt;=65)</td>
<td>39, 46, 47, 48, 49, 50</td>
<td>181</td>
</tr>
<tr>
<td>Hematology (Cancer)</td>
<td>67, 68, 69, 70</td>
<td>143, 144</td>
</tr>
<tr>
<td>Prostate Cancer——Radiation Oncology</td>
<td>102, 105</td>
<td>156</td>
</tr>
<tr>
<td>Osteoarthritis</td>
<td>109</td>
<td>142</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>110-115, 128, 130</td>
<td>173</td>
</tr>
</tbody>
</table>

Key Components of the Measure Specification Manuals
Measure Specifications Manuals

- Available on CMS website
- Separate manuals for Individual Measures and Measures Groups
  - General information about the specifications
  - List of measures in PQRI 2009
  - List of retired measures (effective 1/1/2009)
  - Measure developer information

PQRI Measure #
and Measure Developer Symbol

Measure Title

Reporting Options

Reporting Frequency

Changes to the 2009 Specifications for additional clarification

CPT codes, and patient demographics are used to identify patient eligibility and to make 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 with the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 3F- surgery reasons, 4R- reason not otherwise specified. All measure-specific coding should be reported on the SAME CLAIM.

Refers to #21 on CMS-1500 paper claim form

Denominator coding AND numerator coding (QDCs)
Claim Form Characteristics

- "Diagnosis" refers to Line-item Diagnosis
- All measure-specific codes must be reported on same claim in order to be counted
- Don’t forget to include the NPI in Field 24J
- Diagnosis pointer (field 24E) should "point" to corresponding line item diagnosis—only 1 reference per line

Sample CMS 1500 Claim Form

How do I know how many QDCs are required to report for a given measure?

Example: Measure #71

Numerator Quality-Data Coding Options for Successful Reporting:
Tamoxifen or Aromatase Inhibitor Prescribed
(These CPT II codes [CPT II 3315F & 3371F] are required on the claim form to submit this numerator option)
CPT II 3315F: Tamoxifen or aromatase inhibitor (AI) prescribed
AND
CPT II 3371F: AJCC Breast Cancer Stage I, TIC (tumor size < 1cm to 2cm), documented
OR
CPT II 3371F: AJCC Breast Cancer Stage II, documented
OR
CPT II 3371F: AJCC Breast Cancer Stage III, documented
AND
CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer
Exclusion reporting still requires the other eligibility codes be reported.

Example: Measure #71

Tamoxifen or aromatase inhibitor not prescribed for medical, patient, or system measure

If code 02511 is selected, codes 02512 or 02513 are required on the claim form to submit numerator option.

Append a modifier (99, P, or SP) in CPT Category II code 4179F to report documented circumstances that appropriately exclude patients from the denominator:
4179F with SP: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient is on medical leave, patient refusal, patient is pregnant, patient has contraindication).
4179F with SP: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient has progressed to metastatic).
4179F with SP: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient has received other chemotherapy).
4179F with SP: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient has recently completed a clinical trial).

CPT II 33709: AJCC Breast Cancer Stage I: T1C (tumor size > 1cm to 2cm), documented
CPT II 33709: AJCC Breast Cancer Stage II, documented
CPT II 33709: AJCC Breast Cancer Stage III, documented
CPT III 33019F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer.

If patient is not eligible for this measure because patient is not stage IC through IIC breast cancer, report:

Patient not Stage IC through IIC Breast Cancer

(One CPT II code 02512 or 02513 is required on the claim form to submit this numerator option).

Note: If reporting a code from the category below (33709 or 33707 or 33019F), it is not necessary to report the patient’s ER/PR status.

CPT II 33709: AJCC Breast Cancer Stage I, documented
CPT II 33709: AJCC Breast Cancer Stage II, documented
CPT II 33709: AJCC Breast Cancer Stage III, documented

Only one code required, because patient does not have the cancer stage that is the focus of the measure.

Example: Measure #71

If patient is not eligible for this measure because patient is estrogen receptor (ER) and progesterone receptor (PR) negative, report:

Patient is estrogen receptor (ER) and progesterone receptor (PR) negative.

(One CPT II code 02512 or 02513 is required on the claim form to submit this numerator option).

Note: If reporting code 33707, it is not necessary to report the patient’s AJCC Cancer Stage.

CPT II 33707: Estrogen receptor (ER) and progesterone receptor (PR) negative breast cancer.

Example: Measure #71

Only one code required, because patient does not have the cancer stage that is the focus of the measure.
Reporting the Correct Number of Codes-Summary

- Read the specifications
- Be familiar with the construct of the measure
- Look for the instructions that indicate how many codes need to be reported
- Follow logic and order of questions on AMA participation tools

Paired Measures in PQRI 2009

- Four sets of “Paired Measures”
- Processes of care that should be performed together
- Measures should be reported together
  - #84, #85 (Hepatitis C)
  - #143, #144 (Pain Intensity Quantified/Plan of Care for Pain-Cancer)
  - #154, #155 (Falls-Risk Assmt and Plan of Care)
  - #183, #184 (Hepatitis C- Hep A & Hep B Vaccinations)

Example of Paired Measure
Oncology--Pain Intensity Quantified (143) and Plan of Care for Pain(144)

- Measure 143—Assess for presence or absence of pain
- Measure 144—If pain is present (in 143), there should be a plan of care to address pain
- Measures are linked together—should be reported together
- Numerator code (1125F-Pain severity quantified; pain present) acts as denominator for measure 144
Measures from 2008 Program with Significant (or Notable) Changes for 2009

Measures with Notable Changes
- Measure #71
- Measure #30
- Measures #99, #100

Complicated Measure
- Measure #118

Measure 71-Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
- CPT II coding was revised based on feedback from users of the measures
  - Staging codes now specific to the type of cancer
  - Removed the (A, B, C) level of granularity from the code, except where relevant to the measure
    - 3370F: AJCC Breast Cancer Stage 0, documented
    - 3372F: AJCC Breast Cancer Stage I: T1 mic, T1a or T1b (tumor size < 1cm), documented
    - 3374F: AJCC Breast Cancer Stage I: T1C (tumor size > 1cm to 2cm), documented
    - 3376F: AJCC Breast Cancer Stage II, documented
    - 3378F: AJCC Breast Cancer Stage III, documented
    - 3380F: AJCC Breast Cancer Stage IV, documented
Measure 30-Perioperative Care: Timing of Prophylactic Antibiotics – Administering Physician
- Measures timely administration of prophylactic antibiotics
- Denominator structure now more in alignment with anesthesia practice
- Have identified a set of anesthesia administration codes for which prophylactic antibiotics are commonly indicated
- Report 1 of four CPT II codes:
  - 4048F- Antibiotics given within appropriate timeframe
  - 4048F-1P-Antibiotics not given due to valid medical reason
  - 4047F-8P-Antibiotics not given—antibiotic not ordered
  - 4048F-8P-Antibiotics not given—reason not otherwise specified
- If anesthesiologist chooses to order and is administered within the appropriate timeframe, 4048F should be reported.

Measures 99,100-Breast and Colon Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade
- CPT II Code 3250F added as an option for reporting
  - 3250F-Specimen site other than anatomic location of primary tumor
- Example- Patient meets denominator inclusion of Diagnosis of Breast (or colon), and CPT Procedure code
  - Specimen could be a liver biopsy to check for metastatic disease

Measure 118-CAD: ACE or ARB Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
- Does patient have coronary artery disease?
- Does patient also have diabetes?
  - If yes—choose reporting criteria 2
  - If no—report patient’s ejection fraction, and, if <40% or moderately or severely depressed, whether or not ACE/ARB was prescribed.
- HINT for simpler reporting: If patient with CAD has Diabetes AND ejection fraction < 40%, choose criteria 2.
Participation Tools for PQRI 2009

- Purpose: To assist physicians and other eligible professionals who may elect to participate in the PQRI program
- Developed by the AMA
- Publicly available on the AMA Web site www.ama-assn.org/go/toolsMedicarePQRI

New Features for PQRI 2009

- Incorporated changes from measure specifications manual (ie, line item diagnosis, all measure-specific coding on the same claim)
- New tools for measures groups
- Targeted toward claims-based submission
  - 131 individual quality measures
  - 6 measures groups

Measure Description, Measure 173

Preventive Care and Screening

Unhealthy Alcohol Use — Screening

This measure is to be reported for all patients aged 18 years and older seen by the clinician — a minimum of once per reporting period.

Measure description
Percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic, screening method within 24 months.

What if the process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to screen for unhealthy alcohol use. Due to:
- Patient refusing, harmed by experience,
- In these cases, you will need to indicate the reason on the worksheet and in the medical chart. The official chart will then report a code with a modifier that represents these valid reasons (also coded elsewhere).

Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include daily use, problem drinking, hard use, and alcohol abuse, and the use can also include women's alcoholics and alcohol dependence. Risk use is defined as:
- Under 5 times per occasion for women and persons 65 years of age or older.
- 5 or more standard drinks per week in men or 4 drinks per occasion for men 45 years of age or older.

Date reviewed 2008
Web:www.ama-assn.org/go/toolsMedicarePQRI

17
### Data Collection Sheet, Measure 173

**Preventive Care and Screening**

**Unhealthy Alcohol Use — Screening**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Name</td>
<td>Required</td>
</tr>
<tr>
<td>Provider Name</td>
<td>Required</td>
</tr>
<tr>
<td>Date of Exam</td>
<td>Required</td>
</tr>
<tr>
<td>Patient's Health History</td>
<td>Required</td>
</tr>
<tr>
<td>Patient's Medical Record Number (MRN)</td>
<td>Required</td>
</tr>
<tr>
<td>Provider's Name</td>
<td>Required</td>
</tr>
<tr>
<td>Office Visit Number</td>
<td>Required</td>
</tr>
<tr>
<td>Code of Service</td>
<td>Required</td>
</tr>
</tbody>
</table>

#### Coding Specifications, Measure 173

**Preventive Care and Screening**

**Unhealthy Alcohol Use — Screening**

<table>
<thead>
<tr>
<th>Coding Specifications</th>
<th>Quality code for this measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 codes for alcohol misuse or dependence</td>
<td>CPT/ICD-10 codes for alcohol misuse or dependence</td>
</tr>
</tbody>
</table>

#### Data Collection Sheet, Measure 118

**Critical Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes/No</td>
<td>Code Required on Claim Form</td>
</tr>
<tr>
<td>Patient is aged 65 years or older on date of encounter</td>
<td>Required</td>
</tr>
<tr>
<td>Patient has a history of any of the following conditions</td>
<td>Required</td>
</tr>
<tr>
<td>Yes/No</td>
<td>Code to be reported on UIC Form 2400 if documented on claim form</td>
</tr>
</tbody>
</table>

#### Coding Specifications, Measure 118

**Preventive Care and Screening**

**Unhealthy Alcohol Use — Screening**

<table>
<thead>
<tr>
<th>Coding Specifications</th>
<th>Quality code for this measure:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10 codes for alcohol misuse or dependence</td>
<td>CPT/ICD-10 codes for alcohol misuse or dependence</td>
</tr>
</tbody>
</table>

---

**Note:** The information provided is a simplified representation of the content and may not capture all details present in the original document.
Individual Measures Tools on the Web

Quality Measure for 2009 POR

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Gastrointestinal</td>
<td>[Link]</td>
</tr>
<tr>
<td>Acute Hypertensive</td>
<td>[Link]</td>
</tr>
<tr>
<td>Acute Ethics: Ethics</td>
<td>[Link]</td>
</tr>
<tr>
<td>Acute Ethics: Ethics</td>
<td>[Link]</td>
</tr>
<tr>
<td>Acute Ethics: Ethics</td>
<td>[Link]</td>
</tr>
<tr>
<td>Acute Ethics: Ethics</td>
<td>[Link]</td>
</tr>
<tr>
<td>Acute Ethics: Ethics</td>
<td>[Link]</td>
</tr>
</tbody>
</table>

Measure Description, Diabetes Measures Group

Diabetes Mellitus: Measures Group

The following 2009 POR measures are included in the Diabetes Mellitus Measures Group:

1. Prevalence of diabetes in the United States
2. Prevalence of diabetes in the United States
3. Prevalence of diabetes in the United States
4. Prevalence of diabetes in the United States
5. Prevalence of diabetes in the United States
6. Prevalence of diabetes in the United States
7. Prevalence of diabetes in the United States
8. Prevalence of diabetes in the United States
9. Prevalence of diabetes in the United States
10. Prevalence of diabetes in the United States

This measure group is reported by one of the following entities, as applicable:

- American Hospital Association
- National Committee for Quality Assurance
- National Quality Forum
Data Collection Sheet, Diabetes Measures Group

Diabetes Mellitus Measures Group

FBG Baseline Collection Sheet* [ ] Male  [ ] Female

Height/Weight

BMI/Body Fat Percentage

Step 1: Eligibility requirements

You must meet the following requirements for inclusion in the Diabetes Mellitus Measures Group:

Step 2: Determine patient eligibility

(All determinations patient eligibility must be reported in the same state as the quality control validation in Step 3 below)

Patient is 18 years or older

[ ] Yes  [ ] No

Date of birth:

Patient has a history of diabetes mellitus

[ ] Yes  [ ] No

Date of diagnosis:

Note: if a patient is below 18 years of age, the patient cannot be eligible for reporting in the measures group.

Step 2: Complete individual measures

Table 1: Measures of FBG Management

<table>
<thead>
<tr>
<th>Measure</th>
<th>Code</th>
<th>Minimum cut-off value (FBG)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBG &lt; 80</td>
<td>0151M</td>
<td>0151M</td>
<td>FBG &gt; 110</td>
</tr>
<tr>
<td>FBG &lt; 80</td>
<td>0151M</td>
<td>0151M</td>
<td>FBG &gt; 110</td>
</tr>
</tbody>
</table>

Table 2: Measures of LDL Cholesterol Management

<table>
<thead>
<tr>
<th>Measure</th>
<th>Code</th>
<th>Minimum cut-off value (LDL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL &lt; 130</td>
<td>0201M</td>
<td>0201M</td>
</tr>
</tbody>
</table>

Table 3: Measures of HDL Cholesterol Management

<table>
<thead>
<tr>
<th>Measure</th>
<th>Code</th>
<th>Minimum cut-off value (HDL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDL &gt; 40</td>
<td>0201M</td>
<td>0201M</td>
</tr>
</tbody>
</table>

Data Collection Sheet (cont.), Diabetes Measures Group

Data Collection Sheet, Diabetes Measures Group (cont.)

Diabetes Mellitus Measures Group

FBG Baseline Collection Sheet* [ ] Male  [ ] Female

Height/Weight

BMI/Body Fat Percentage

Step 1: Eligibility requirements

You must meet the following requirements for inclusion in the Diabetes Mellitus Measures Group:

Step 2: Determine patient eligibility

(All determinations patient eligibility must be reported in the same state as the quality control validation in Step 3 below)

Patient is 18 years or older

[ ] Yes  [ ] No

Date of birth:

Patient has a history of diabetes mellitus

[ ] Yes  [ ] No

Date of diagnosis:

Note: if a patient is below 18 years of age, the patient cannot be eligible for reporting in the measures group.

Step 2: Complete individual measures

Table 1: Measures of FBG Management

<table>
<thead>
<tr>
<th>Measure</th>
<th>Code</th>
<th>Minimum cut-off value (FBG)</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>FBG &lt; 80</td>
<td>0151M</td>
<td>0151M</td>
<td>FBG &gt; 110</td>
</tr>
<tr>
<td>FBG &lt; 80</td>
<td>0151M</td>
<td>0151M</td>
<td>FBG &gt; 110</td>
</tr>
</tbody>
</table>

Table 2: Measures of LDL Cholesterol Management

<table>
<thead>
<tr>
<th>Measure</th>
<th>Code</th>
<th>Minimum cut-off value (LDL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL &lt; 130</td>
<td>0201M</td>
<td>0201M</td>
</tr>
</tbody>
</table>

Table 3: Measures of HDL Cholesterol Management

<table>
<thead>
<tr>
<th>Measure</th>
<th>Code</th>
<th>Minimum cut-off value (HDL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HDL &gt; 40</td>
<td>0201M</td>
<td>0201M</td>
</tr>
</tbody>
</table>

20
Conclusions

• Why participate in PQRI?
• How to select measures applicable to your practice?
• Where to find the appropriate tools for implementation?

Questions?

cpe@ama-assn.org