



The
2007
Physician Quality
Reporting Initiative
(PQRI)



DISCLAIMER

This booklet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This booklet is a general summary that explains certain aspects of the Medicare Program; however, this is not a legal document and does not grant rights or impose obligations. The Centers for Medicare & Medicaid Services (CMS) will not bear any responsibility or liability for the results or consequences of using this summary guide. This document was current as of the date of publication; nevertheless, we encourage readers to review the specific laws, regulations and rulings for up-to-date detailed information. Providers are responsible for the correct submission of claims and response to any remittance advice in accordance with current laws, regulations and standards.

The Medicare Learning Network® (MLN)

The Medicare Learning Network® (MLN), a registered trademark of CMS, is the brand name for official CMS educational products and information for Medicare Fee-For-Service Providers. For additional information visit the MLN's web page at <http://www.cms.gov/MLNGenInfo> on the CMS website.

CPT Notice and Disclaimer

CPT only copyright 2006 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association. Applicable FARS\DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

ICD-9 Notice

The International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) is published by the United States Government. A CD-ROM, which may be purchased through the Government Printing Office, is the only official Federal government version of the ICD-9-CM. ICD-9-CM is an official Health Insurance Portability and Accountability Act standard.

TABLE OF CONTENTS

What is the Physician Quality Reporting Initiative (PQRI)?	4
Who Can Participate in PQRI?	4
Who is an Eligible Professional?	4
What is the 2007 PQRI Reporting Incentive?	5
How do Eligible Professionals Get Started With the 2007 PQRI?	6
What are the 2007 PQRI Quality Measures and Codes?	6
PQRI Quality-Data Codes (QDCs).....	7
CPT II Modifiers	7
How is the PQRI Quality Data Reported?	8
What are the 2007 PQRI Reporting Options?	8
Statute and Overview.....	8
Reporting Options	9
Reporting Period	10
How do Eligible Professionals Satisfactorily Report 2007 PQRI Measures?	10
Measure Denominators and Numerators.....	10
Reporting Frequency and Performance Timeframes.....	10
What are Some Tips for 2007 Successful Participation?	11
Ensuring Success	12
Appendix 1	13
2007 Physician Quality Reporting Initiative Measures.....	13

This booklet is a compilation of the Centers for Medicare & Medicaid Services' (CMS') various educational resources relevant to the 2007 Physician Quality Reporting Initiative (PQRI). On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorized the establishment of a physician quality reporting system by CMS. CMS titled this program the Physician Quality Reporting Initiative (PQRI).

What is the Physician Quality Reporting Initiative (PQRI)?

PQRI establishes a financial incentive for eligible professionals to participate in a **voluntary quality reporting program**. Eligible professionals who successfully report a designated set of quality measures on claims for dates of service from **July 1 to December 31, 2007, may earn a bonus payment, subject to a cap, of 1.5 percent of total allowed charges for covered Medicare Physician Fee Schedule (PFS) services.**

CMS is developing and implementing pay for performance to encourage the provision of high quality, cost-effective health care for Medicare beneficiaries. To view the legislative language and see a detailed list of eligible professionals, visit <http://www.cms.gov/PQRI> on the CMS website.

Who Can Participate in PQRI?

Who is an Eligible Professional?

The following professionals are eligible to participate in PQRI:

1. Medicare physicians as defined in Social Security Act (SSA) section 1861(r):

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- Chiropractor

2. Practitioners described in SSA section 1842(b)(18)(C):

- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician
- Nutrition Professional

3. Therapists:

- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Pathologist

All Medicare-enrolled professionals in these categories are eligible to participate in the 2007 PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

What is the 2007 PQRI Reporting Incentive?

Participating eligible professionals who successfully report may earn a 1.5 percent bonus, subject to capitation. The potential 1.5 percent bonus will be based on allowed charges for covered professional services: (1) furnished during the reporting period of July 1 through December 31, 2007; (2) received into the CMS National Claims History (NCH) file by February 29, 2008; and (3) paid under the Medicare PFS. Because claims processing times may vary by time of the year and Medicare Carrier/Medicare Administrative Contractor (MAC), participating eligible professionals should submit claims from the end of 2007 promptly, so that those claims will reach the NCH file by February 29, 2008. Bonuses will be paid as a lump sum in mid-2008.

The bonus will apply to allowed charges for all covered professional services, not just those charges associated with reported quality measures. The term “allowed charges” refers to total charges, including the beneficiary deductible and copayment, not just the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is the secondary payer. Note that the amounts billed above the PFS amounts for assigned and non-assigned claims will not apply to the bonus. The statute defines PQRI-covered services as those paid under the PFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services, though based on a unique methodology. Other Part B services and items that may be billed by eligible professionals but are not paid under the PFS, such as clinical laboratory services, pharmaceuticals billed by physicians, and Rural Health Center/Federally Qualified Health Center services, do not apply to the bonus.

A payment cap that would reduce the potential bonus below 1.5 percent of allowed charges may apply in situations where an eligible professional reports relatively few instances of quality measure data. Eligible professionals’ caps are calculated by multiplying: (1) their total instances of reporting quality data for all measures (not limited only to measures meeting the 80 percent threshold), by (2) a constant of 300 percent, and by (3) the national average per measure payment amount.

The national average per measure payment amount is one value for all measures and all participants that is calculated by dividing: (1) the total amount of allowed charges under the PFS for all covered professional services furnished during the reporting period on claims for which quality measures were reported by all participants in the program by (2) the total number of instances for which data were reported by all participants in the

program for all measures during the reporting period. (Note that the national average per measure payment amount calculation only takes into account the charges on claims for which quality measures were reported, whereas the individual bonus calculation takes into account charges for all services furnished during the reporting period.) Thus, while the purpose of the cap is clear, it is not possible to determine the impact of the cap until the national average per measure payment amount can be calculated after the end of the reporting period.

How do Eligible Professionals Get Started With the 2007 PQRI?

Successful reporting is dependent upon the integration of PQRI into the eligible professionals' care delivery processes and includes the following:

1. Select Measures

Eligible professionals should select measures that address the services they provide to patients. When selecting measures, consider:

- Conditions treated;
- Types of care provided (e.g., preventive, chronic, acute);
- Settings of care (e.g., office, emergency department [ED], surgical suite); and
- Individual quality improvement goals for 2007.

2. Define Team Roles

Discuss measures and plan an approach to capture quality data for reporting with team.

3. Modify Workflows and Billing Systems

Walk through the care process and determine what systems changes will be required to capture quality-data codes (QDCs).

- Consider using worksheets or other tools for data capture;
- Discuss systems capabilities with practice management software vendors and third-party billing vendors and clearinghouses; and
- Test systems.

What are the 2007 PQRI Quality Measures and Codes?

The CMS 2007 Physician Quality Reporting Initiative Specifications document (the Specifications document) can be viewed by clicking 2007 PQRI Quality Measures under the 2007 PQRI Program section at www.cms.gov/PQRI/Downloads/2007PQRIQualityMeasures.zip on the CMS website. This document includes detailed specifications for each of the 74 unique measures associated with clinical conditions that are routinely represented on Medicare FFS claims through the use of diagnosis codes from the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology (CPT) Category I codes and from the Healthcare Common Procedure Coding System (HCPCS) Category II codes.

The Specifications document describes specific measures and associated codes that address various aspects of care such as: prevention, management of chronic conditions, care coordination, acute episode of care management, procedure-related care, and

resource utilization. The Specifications document contains descriptions for each PQRI quality measure, and includes instructions on how to code each measure's numerator and denominator.

Each measure has a **reporting frequency** requirement for each eligible patient seen during the reporting period (e.g., report one time only; once for each procedure performed; once for each acute episode, per each eligible patient).

Some measures include specific **performance timeframes** related to the clinical action in the numerator that may be distinct from the measure's reporting frequency requirement. For example, performance timeframes may be stated as "within 12 months" or "most recent."

PQRI Quality-Data Codes (QDCs)

There are specific PQRI QDCs associated with each of the 2007 PQRI measures. PQRI QDCs are CPT Category II codes, though temporary G-codes are used on an exception basis where CPT Category II codes have not yet been developed. PQRI QDCs translate clinical actions so they can be captured via the administrative claims process. For example, PQRI QDCs can relay that:

- The measure requirement was met;
- The measure requirement was not met due to documented allowable performance exclusions (i.e., using performance exclusion modifiers); or
- The measure requirement was not met and the reason is not documented in the medical record (i.e., using the 8P reporting modifier).

CPT II Modifiers

Individual PQRI QDCs can be associated with more than one measure or can require a specific modifier. PQRI measures may require an eligible professional to append a modifier to a CPT Category II code. CPT II modifiers may only be reported with CPT Category II codes and cannot be used with G-codes. Coding instructions included in the Specifications document indicate when a modifier may be applicable for a given measure. CPT Category II modifiers fall into two categories:

1. Performance Measure Exclusion Modifiers

There are three exclusion modifiers that indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. 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.

- **1P – Performance Measure Exclusion Modifier due to Medical Reasons:** Includes: Not Indicated (absence of organ/limb, already received/performed, other); Contraindicated (patient allergic history, potential adverse drug interaction, other)
- **2P – Performance Measure Exclusion Modifier due to Patient Reasons:** Includes: Patient declined; economic, social, or religious reasons; other patient reasons

CPT only copyright 2006 American Medical Association. All rights reserved.

- **3P – Performance Measure Exclusion Modifier due to System Reasons:** Includes: Resources to perform the services not available; insurance coverage/payor-related limitations; other reasons attributable to health care delivery system

2. Performance Measure Reporting Modifier

This modifier facilitates reporting a case when the patient is eligible, but an action described in a measure is not performed and the reason is not specified or documented.

- **8P – Action not performed, reason not otherwise specified**

How is the PQRI Quality Data Reported?

- The CPT Category II code, which supplies the numerator, must be reported on the same claim as the payment ICD-9-CM and CPT Category I codes, which supply the denominator of the measures.
- Multiple CPT Category II codes can be reported on the same claim, as long as the corresponding denominator codes are also on that claim.
- The individual National Provider Identifier (NPI) of the participating eligible professional must be properly used on the claim.
- Multiple eligible professionals with their NPIs may be reported on the same claim with each QDC line item corresponding to the services rendered by the professional for that encounter.
- Submitted charge field cannot be blank.
- Line item charge should be \$0.00; if the billing system does not allow \$0.00 line item charge, use a small amount like \$0.01.
- Entire claims with a zero charge will be rejected.
- Claims must reach the National Claims History (NCH) file by February 29, 2008, to be included in the analysis.
- QDC line items will be denied for payment but then passed through to the NCH file for PQRI analysis.
- Claims that are resubmitted only to add CPT Category II codes will not be included in the analysis.

What are the 2007 PQRI Reporting Options?

Statute and Overview

TRHCA section 101 allows CMS to specify the form and manner of reporting. For 2007, CMS will be building on the claims-based quality reporting system implemented for the 2006 Physician Voluntary Reporting Program (PVRP), which ended December 31, 2006. Participating eligible professionals whose Medicare patients fit the specifications of the 2007 PQRI quality measures will report the corresponding appropriate CPT Category II codes or G-codes (where CPT Category II codes are not yet available) on their claims. CPT Category II codes and G-codes are HCPCS codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS-1500 Claim form or (2) the

CPT only copyright 2006 American Medical Association. All rights reserved.

equivalent electronic transaction claim, the 837-P. There is no need to enroll or register to begin claims-based reporting for 2007 PQRI.

The applicable CPT Category II code or G-code quality data must be reported on the same claim as the patient diagnosis and service to which the QDC applies. The analysis algorithms that determine successful reporting match the QDCs to the diagnosis, service, and procedure codes on the claim. Thus, QDCs that are not submitted on the same claim as the applicable patient diagnosis, service, and procedure codes will not count toward successful reporting or for calculation of a potential bonus payment.

Reporting Options

As summarized in Table 1, in order to receive the incentive, an eligible professional must satisfactorily report one to three applicable unique quality measures. If 3 or fewer unique quality measures (out of the 74 measures available for 2007 PQRI) apply to the services furnished by the eligible professional, then each measure is to be reported for at least 80 percent of the cases in which the measure is reportable. If there are 4 or more quality measures applicable to the services furnished by the eligible professional, then at least 3 measures, selected by the eligible professional, are to be reported for at least 80 percent of the cases in which each measure is reportable.

Table 1: Criteria for Reporting Quality Measures

July 1, 2007 – December 31, 2007 Reporting Period	July 1, 2007 – December 31, 2007 Reporting Period
<p>1-3 Quality Measures Report each measure 80% of applicable Medicare cases in which each measure is reportable.</p> <p>Include appropriate quality-data code(s) (CPT II or G-code) on all applicable claims.</p>	<p>4 or more Quality Measures Report at least 3 measures 80% of applicable Medicare cases in which each measure is reportable.</p> <p>Include appropriate quality-data code(s) (CPT II or G-code) on all applicable claims.</p>

Reporting Period

TRHCA requires the 2007 PQRI program to begin on July 1, 2007, and that the quality data be submitted in a form and manner specified by the Secretary (by program instruction or otherwise), which could include claims-based submission. Because the statute requires that the PQRI program infrastructure be operational in less than seven months, submission via Medicare's existing claims processing system is the only feasible data collection/reporting mechanism that will allow CMS to meet the statutory requirement to collect quality data beginning July 1, 2007.

CMS will begin accepting data for the 2007 reporting period beginning July 1, 2007, and continue through December 31, 2007.

How do Eligible Professionals Satisfactorily Report 2007 PQRI Measures?

Eligible professionals select the quality measures that are applicable to their practices. If an eligible professional submits data for a quality measure, then that measure is presumed to be applicable for the purposes of determining satisfactory reporting. CMS recommends that eligible professionals report on every quality measure that is applicable to their patient populations to: (1) increase the likelihood that they will reach the 80 percent satisfactorily reporting requirement for the requisite number of measures and (2) increase the likelihood that they will not be affected by the bonus payment cap.

Measure Denominators and Numerators

Each PQRI measure consists of two major components:

1. A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator); and
2. A numerator that describes the clinical action required by the measure for reporting and performance.

Measure denominators and numerators are further specified by specific codes, usually ICD-9-CM and CPT Category I codes for denominators and CPT Category II codes or G-codes (where CPT Category II codes are not yet available) for numerators. Each measure is unique, so it is important to review and understand each measure's specifications, which provide definitions and specific instructions for coding and reporting measure components.

Reporting Frequency and Performance Timeframes

Each measure includes a reporting frequency requirement for each denominator-eligible patient seen during the reporting period. The reporting frequency is described in the instructions:

- Report one-time only;
- Report once for each procedure performed; and
- Report once for each acute episode.

A measure's performance timeframe is defined in the measure's description and is distinct from the reporting frequency requirement. The performance timeframe, unique to each measure, delineates the timeframe in which the clinical action described in the numerator may be accomplished.

Performance timeframes may be stated as "within 12 months," or "most recent." This means that:

1. The clinical action in the numerator needs to be performed only once during a 12-month period for each patient seen during the reporting period.
2. The quality code needs to be reported only one time for each patient by each eligible professional caring for the patient who has chosen to report that measure during the reporting period.

If the measure calls for a clinical test result, the most recent test result needs to be obtained, assessed, and reported only one time per reporting period. A test does not need to have been performed within the reporting period, nor does it need to have been performed by the same eligible professional.

Performance timeframes may also be tied to a specific clinical event that requires reporting each time the event occurs within the reporting period. The following are examples of measures reported each time the clinical action described by the measure numerator is taken:

- Procedure-related measures require reporting each time the procedure is performed and have distinct performance timeframes tied to them. The date of service is the date that is used to report the measure. Examples are perioperative care or imaging measures.
- Chronic care measures, such as those that call for prescribing a medication, require the eligible professional to verify whether the medication is current and being taken by the patient. A new prescription is not required to meet the measure requirement unless it is clinically indicated.
- Acute care measures are tied to specific episodes of acute care and require reporting each time an acute event occurs. Examples are measures related to hospitalizations, fractures and osteoporosis management, or stroke measures.

What are Some Tips for 2007 Successful Participation?

Successful participation in PQRI is dependent on accurate submission of all information required for selected PQRI measures on Medicare claims for services provided to Medicare FFS beneficiaries. The following tips are offered to assist eligible professionals' accuracy of reporting:

- For measures that have been selected, review all ICD-9-CM and Evaluation and Management (E/M) codes that will qualify claims for inclusion in calculations and be sure that each claim includes an appropriate QDC or QDC with an allowable modifier

and correct NPI. [Appendix 1](#) lists the 2007 PQRI measures.

- For measures that require that clinical values be captured for coding, make sure that these clinical values are available to those who are doing the coding.
- For measures that only require reporting once per patient per reporting period, report early to ensure that the claim counts toward successful reporting.
- For measures that involve timeframes, ensure that all members of the team understand and capture this information in the clinical record to facilitate coding.
- For measures that require more than one CPT Category II or G-code, ensure that all codes are captured on the claim.
- When submitting codes for Measure #3 - High Blood Pressure Control in Type I and Type II Diabetes Mellitus, be sure to include codes for both the systolic and diastolic blood pressure.
- When applicable, utilize the 8P modifier when the action is not performed and the reason is not specified, so that the claim will count toward successful reporting.
- Pay attention to demographics. Remember that some measures specify an age or sex requirement for successful reporting.
- Some measures apply broadly to all Medicare patients and do not specify an ICD-9-CM diagnosis code in the denominator. Eligible cases for reporting Measure #4 - Screening for Future Fall Risk, #46 - Medication Reconciliation, or #47 - Advance Care Plan are pulled into the denominator through the CPT E/M office visit codes for one time submission per reporting period.
- Perioperative care measures are sequential measures that specify reporting for ordering a prophylactic antibiotic (Measure #20), which is different from administering the antibiotic (Measure #30).

Ensuring Success

- Take advantage of the educational resources available to you on the PQRI website. These include a 2007 PQRI tool kit designed to help eligible professionals be successful.
- Start reporting July 1, 2007, to increase the probability of achieving the 80 percent rate of reporting during the reporting period.
- Report on as many measures as possible to increase the likelihood of achieving successful reporting.
- Report on as many eligible patients as you can to decrease the probability of being subject to the bonus cap.
- Ensure that quality codes are reported on the same claim as the diagnosis and CPT Category I codes.

For additional educational resources or information on the PQRI for 2007, the CMS PQRI website contains all publicly available information at http://www.cms.gov/PQRI/33_2007_PQRI_Program.asp on the CMS website.

CPT only copyright 2006 American Medical Association. All rights reserved.

Appendix 1

2007 Physician Quality Reporting Initiative Measures

2007 Physician Quality Reporting Initiative Measures

Measure Number	Measure Title and Description
1	<p>Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus</p> <p><u>Description</u> Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent hemoglobin A1c greater than 9.0%</p>
2	<p>Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus</p> <p><u>Description</u> Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent LDL-C level in control (less than 100 mg/dl)</p>
3	<p>High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus</p> <p><u>Description</u> Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent blood pressure in control (less than 140/80 mm Hg)</p>
4	<p>Screening for Future Fall Risk</p> <p><u>Description</u> Percentage of patients aged 65 years and older who were screened for future fall risk (patients are considered at risk for future falls if they have had 2 or more falls in the past year or any fall with injury in the past year) at least once within 12 months</p>
5	<p>Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of heart failure and left ventricular systolic dysfunction (LVSD) who were prescribed ACE inhibitor or ARB therapy</p>
6	<p>Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease who were prescribed oral antiplatelet therapy</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
7	<p>Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease and prior myocardial infarction (MI) who were prescribed beta-blocker therapy</p>
8	<p>Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have left ventricular systolic dysfunction (LVSD) and who were prescribed beta-blocker therapy</p>
9	<p>Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression</p> <p><u>Description</u> Percentage of patients aged 18 years and older diagnosed with new episode of major depressive disorder (MDD) and documented as treated with antidepressant medication during the entire 84-day (12-week) acute treatment phase</p>
10	<p>Stroke And Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports</p> <p><u>Description</u> Percentage of final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with the diagnosis of ischemic stroke or TIA or intracranial hemorrhage that include documentation of the presence or absence of each of the following: hemorrhage and mass lesion and acute infarction</p>
11	<p>Stroke and Stroke Rehabilitation: Carotid Imaging Reports</p> <p><u>Description</u> Percentage of final reports for carotid imaging studies (neck MR angiography [MRA], neck CT angiography [CTA], neck duplex ultrasound, carotid angiogram) performed for patients aged 18 years and older with the diagnosis of ischemic stroke or TIA that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
12	<p>Primary Open Angle Glaucoma: Optic Nerve Evaluation</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months</p>
13	<p>Age-Related Macular Degeneration: Age-Related Eye Disease study (AREDS) Prescribed/Recommended</p> <p><u>Description</u> Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration who had AREDS prescribed/recommended within 12 months</p>
14	<p>Age-Related Macular Degeneration: Dilated Macular Examination</p> <p><u>Description</u> Percentage of patients aged 50 years and older with a diagnosis of age-related macular degeneration 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</p>
15	<p>Cataracts: Assessment of Visual Functional Status</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of cataracts who were assessed for visual functional status during one or more office visits within 12 months</p>
16	<p>Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation</p> <p><u>Description</u> Percentage of patients aged 18 years and older who had cataract surgery who had the pre-surgical axial length, corneal power measurement and method of intraocular lens power calculation performed and documented within 6 months prior to the procedure</p>
17	<p>Cataracts: Pre-Surgical Dilated Fundus Evaluation</p> <p><u>Description</u> Percentage of patients aged 18 years and older who had cataract surgery who had a dilated fundus evaluation performed within six months prior to the procedure</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
18	<p>Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy</p> <p><u>Description</u> 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</p>
19	<p>Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care</p> <p><u>Description</u> 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 regarding the findings of the macular or fundus exam at least once within 12 months</p>
20	<p>Perioperative Care: Timing of Antibiotic Prophylaxis - Ordering Physician</p> <p><u>Description</u> Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics, who have an order for prophylactic antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)</p>
21	<p>Perioperative Care: Selection of Prophylactic Antibiotic - First OR Second Generation Cephalosporin</p> <p><u>Description</u> Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis</p>
22	<p>Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)</p> <p><u>Description</u> Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
23	<p>Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)</p> <p><u>Description</u> Percentage of patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time</p>
24	<p>Osteoporosis: Communication with the Physician Managing Ongoing Care Post Fracture</p> <p><u>Description</u> Percentage of patients aged 50 years and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient's ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis</p>
25	<p>Melanoma: Patient Medical History</p> <p><u>Description</u> Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months</p>
26	<p>Melanoma: Complete Physical Skin Examination</p> <p><u>Description</u> Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who had a complete physical skin exam performed at least once within 12 months</p>
27	<p>Melanoma: Counseling on Self-Examination</p> <p><u>Description</u> Percentage of patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma who were counseled at least once within 12 months to perform a self-examination for new or changing moles</p>
28	<p>Aspirin at Arrival for Acute Myocardial Infarction (AMI)</p> <p><u>Description</u> Percentage of patients with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
29	<p>Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)</p> <p><u>Description</u> Percentage of patients with a diagnosis of AMI who had documentation of receiving beta-blocker within 24 hours before or after hospital arrival</p>
30	<p>Perioperative Care: Timing of Prophylactic Antibiotic - Administering Physician</p> <p><u>Description</u> Percentage of surgical patients aged 18 years and older who have an order for a parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required) for whom administration of prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)</p>
31	<p>Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who received DVT prophylaxis by end of hospital day two</p>
32	<p>Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA who were prescribed antiplatelet therapy at discharge</p>
33	<p>Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or TIA with documented permanent, persistent, or paroxysmal atrial fibrillation who were prescribed an anticoagulant at discharge</p>
34	<p>Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke whose time from symptom onset to arrival is less than 3 hours who were considered for t-PA administration</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
35	<p>Stroke and Stroke Rehabilitation: Screening for Dysphagia</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage who underwent a dysphagia screening process before taking any foods, fluids, or medication by mouth</p>
36	<p>Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or intracranial hemorrhage for whom consideration of rehabilitation services is documented</p>
37	<p>Dialysis Dose in End Stage Renal Disease (ESRD) Patients</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis with a documented urea reduction ratio (URR) value greater than or equal to 65% (or a single-pool Kt/V greater than or equal to 1.2)</p>
38	<p>Hematocrit Level in End Stage Renal Disease (ESRD) Patients</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of end-stage renal disease undergoing hemodialysis with a documented hematocrit value greater than or equal to 33 (or a hemoglobin value greater than or equal to 11)</p>
39	<p>Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older</p> <p><u>Description</u> Percentage of female patients aged 65 years and older who have a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed at least once since age 60 or pharmacologic therapy prescribed within 12 months</p>
40	<p>Osteoporosis: Management Following Fracture</p> <p><u>Description</u> Percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius who had a central dual-energy X-ray absorptiometry (DXA) measurement ordered or performed or pharmacologic therapy prescribed</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
41	<p>Osteoporosis: Pharmacologic Therapy</p> <p><u>Description</u> Percentage of patients aged 50 years and older with a diagnosis of osteoporosis who were prescribed pharmacologic therapy within 12 months</p>
42	<p>Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise</p> <p><u>Description</u> Percentage of patients, regardless of age, with a diagnosis of osteoporosis who are either receiving both calcium and vitamin D or have been counseled regarding both calcium and vitamin D intake, and exercise at least once within 12 months</p>
43	<p>Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery</p> <p><u>Description</u> Percentage of patients undergoing coronary artery bypass graft (CABG) surgery using an internal mammary artery (IMA)</p>
44	<p>Pre-Operative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery</p> <p><u>Description</u> Percentage of patients undergoing coronary artery bypass graft (CABG) surgery who received a beta-blocker pre-operatively</p>
45	<p>Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)</p> <p><u>Description</u> Percentage of cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic antibiotics AND who received a prophylactic antibiotic, who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time</p>
46	<p>Medication Reconciliation</p> <p><u>Description</u> Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
47	<p>Advance Care Plan</p> <p>Description Percentage of patients aged 65 years and older with documentation of a surrogate decision-maker or advance care plan in the medical record</p>
48	<p>Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older</p> <p>Description Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months</p>
49	<p>Characterization of Urinary Incontinence in Women Aged 65 Years and Older</p> <p>Description Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence whose urinary incontinence was characterized at least once within 12 months</p>
50	<p>Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older</p> <p>Description Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months</p>
51	<p>Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation</p> <p>Description Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented</p>
52	<p>Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy</p> <p>Description Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator</p>
53	<p>Asthma: Pharmacologic Therapy</p> <p>Description Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
54	<p>Electrocardiogram Performed for Non-Traumatic Chest Pain</p> <p><u>Description</u> Percentage of patients aged 40 years and older with an emergency department discharge diagnosis of non-traumatic chest pain who had an electrocardiogram (ECG) performed</p>
55	<p>Electrocardiogram Performed for Syncope</p> <p><u>Description</u> Percentage of patients aged 60 years and older with an emergency department discharge diagnosis of syncope who had an ECG performed</p>
56	<p>Vital Signs for Community-Acquired Bacterial Pneumonia</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with vital signs documented and reviewed</p>
57	<p>Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with oxygen saturation documented and reviewed</p>
58	<p>Assessment of Mental Status for Community-Acquired Bacterial Pneumonia</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with mental status assessed</p>
59	<p>Empiric Antibiotic for Community-Acquired Bacterial Pneumonia</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of community-acquired bacterial pneumonia with an appropriate empiric antibiotic prescribed</p>
60	<p>Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, who were assessed for the presence or absence of the following alarm symptoms: involuntary weight loss, dysphagia, and GI bleeding</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
61	<p>Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, with at least one alarm symptom who were either referred for upper endoscopy or had an upper endoscopy performed</p>
62	<p>Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of GERD or heartburn whose upper endoscopy report indicates a suspicion of Barrett's esophagus who had a forceps esophageal biopsy performed</p>
63	<p>Gastroesophageal Reflux Disease (GERD): Barium Swallow - Inappropriate Use</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of GERD, seen for an initial evaluation, who did not have a Barium swallow test ordered</p>
64	<p>Asthma Assessment</p> <p><u>Description</u> Percentage of patients aged 5 to 40 years with a diagnosis of asthma who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms</p>
65	<p>Appropriate Treatment for Children with Upper Respiratory Infection (URI)</p> <p><u>Description</u> Percentage of children aged 3 months-18 years with a diagnosis of upper respiratory infection (URI) who were not dispensed an antibiotic prescription on or 3 days after the episode date</p>
66	<p>Appropriate Testing for Children with Pharyngitis</p> <p><u>Description</u> Percentage of children aged 2-18 years with a diagnosis of pharyngitis, who were prescribed an antibiotic and who received a group A streptococcus (strep) test for the episode</p>
67	<p>Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenetic testing performed on bone marrow</p>

2007 Physician Quality Reporting Initiative Measures (continued)

Measure Number	Measure Title and Description
68	<p>Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy</p>
69	<p>Multiple Myeloma: Treatment With Bisphosphonates</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12 month reporting period</p>
70	<p>Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry</p> <p><u>Description</u> Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed</p>
71	<p>Hormonal Therapy for Stage IC-III, ER/PR Positive Breast Cancer</p> <p><u>Description</u> Percentage of stage IC-III, estrogen receptor (ER) or progesterone receptor (PR) positive, female breast cancer patients aged 18 years and older who are receiving tamoxifen or aromatase inhibitor (AI) at the time of the visit</p>
72	<p>Chemotherapy for Stage III Colon Cancer Patients</p> <p><u>Description</u> Percentage of stage III colon cancer patients aged 18 to 80 years who were prescribed chemotherapy</p>
73	<p>Plan for Chemotherapy Documented Before Chemotherapy Administered</p> <p><u>Description</u> Percentage of cancer patients for whom a plan for the amount of chemotherapy to be given was documented before the chemotherapy was administered</p>
74	<p>Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery</p> <p><u>Description</u> Percentage of invasive female breast cancer patients aged 18 to 70 years old who have undergone breast conserving surgery and who have received recommendation for radiation therapy within 12 months of the first office visit</p>

This page intentionally left blank



November 2010
ICN 905743