

2007 PQRI Measures for Consideration by Oncology Providers

The table below includes measures directly relevant to oncology providers. There may be other measures that are pertinent to an individual provider; see http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage for a listing of all 74 PQRI measures and complete specifications.

Measure #67: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow Description for Measure #67 Data Collection Sheet for Measure #67 Coding Specifications for Measure #67			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia ICD-9 diagnosis codes: 204.00, 205.00, 206.00, 207.00, 207.20, 208.00, 238.72-238.75 AND CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245	Baseline Cytogenetic Testing Performed CPT II 3155F: Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment	Once per reporting period	
	Baseline Cytogenetic Testing not Performed for medical reasons CPT II 3155F 1P: Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., no liquid bone marrow or fibrotic marrow)		
	Baseline Cytogenetic Testing not Performed for patient reasons CPT II 3155F 2P: Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., at time of diagnosis receiving palliative care or not receiving treatment as defined above)		
	Baseline Cytogenetic Testing not Performed for system reasons CPT II 3155F 3P: Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., patient previously treated by another physician at the time cytogenetic testing performed)		
	Baseline Cytogenetic Testing not Performed, Reason Not Specified CPT II 3155F 8P: Cytogenetic testing not performed on bone marrow at time of diagnosis or prior to initiating treatment, reason not otherwise specified		

Measure #68: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy Description for Measure #68 Data Collection Sheet for Measure #68 Coding Specifications for Measure #68			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy ICD-9 diagnosis codes: 238.72-238.75 AND CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245	Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy Performed CPT II 3160F: Documentation of iron stores prior to initiating erythropoietin therapy AND CPT II 4090F: Patient receiving erythropoietin therapy	Once per reporting period	For several of the measure codes, 2 CPT II codes must be reported together. If oncologists choose to report on this measure, a measure code must be submitted on claims for patients with MDS (ICD-9 codes 238.72-238.75) that include the listed E&M codes, even if the patient is not receiving erythropoietin therapy. If the patient otherwise meets the eligibility criteria but is not receiving erythropoietin, use the CPT II 4095F code. Submission of any code counts as an instance of reporting. Documentation of iron stores may have occurred at any time before initiating therapy.
	Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy not Performed for System Reasons CPT II 3160F 3P: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy AND CPT II 4090F: Patient receiving erythropoietin therapy		
	Patient Not Receiving Erythropoietin Therapy CPT II 4095F: Patient not receiving erythropoietin therapy		
	Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy not Performed, Reason Not Specified CPT II 3160F 8P: Iron stores prior to initiating erythropoietin therapy not documented, reason not otherwise specified AND CPT II 4090F: Patient receiving erythropoietin therapy		
Measure #69: Multiple Myeloma: Treatment with Bisphosphonates Description for Measure #69 Data Collection Sheet for Measure #69 Coding Specifications for Measure #69			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission ICD-9 diagnosis code: 203.00 AND CPT E/M service codes: 99201-99205, 99212-99215,	Intravenous Bisphosphonate Therapy Prescribed or Received CPT II 4100F: Bisphosphonate therapy, intravenous, ordered or received	Once per reporting period	Bisphosphonate therapy includes pamidronate and zoledronate.
	Intravenous Bisphosphonate Therapy not Prescribed or Received for Medical Reasons CPT II 4100F 1P: Documentation of medical reason(s) for not prescribing bisphosphonates		

99241-99245	Intravenous Bisphosphonate Therapy not Prescribed or Received for Patient Reasons CPT II 4100F 2P: Documentation of patient reason(s) for not prescribing bisphosphonates		
	Intravenous Bisphosphonate Therapy not Prescribed, Reason Not Specified CPT II 4100F 8P: Bisphosphonate therapy, intravenous, not ordered or received, reason not otherwise specified		
Measure #70: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry Description for Measure #70 Data Collection Sheet for Measure #70 Coding Specifications for Measure #70			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All patients aged 18 years and older with a diagnosis of CLL ICD-9 diagnosis code: 204.10 AND CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245	Baseline Flow Cytometry Studies Performed CPT II 3170F: Flow cytometry studies performed at time of diagnosis or prior to initiating treatment <hr/> Baseline Flow Cytometry Studies not Performed for Medical Reasons CPT II 3170F 1P: Documentation of medical reason(s) for not performing baseline flow cytometry studies <hr/> Baseline Flow Cytometry Studies not Performed for Patient Reasons CPT II 3170F 2P: Documentation of patient reason(s) for not performing baseline flow cytometry studies <hr/> Baseline Flow Cytometry Studies not Performed for System Reasons CPT II 3170F 3P: Documentation of system reason(s) for not performing baseline flow cytometry studies <hr/> Baseline Flow Cytometry Studies not Performed, Reason Not Specified CPT II 3170F 8P: Flow cytometry studies not performed at time of diagnosis or prior to initiating treatment, reason not otherwise specified	Once per reporting period	Baseline flow cytometry may have been performed at any time.

Measure #71: Hormonal Therapy for Stage IC-III, ER/PR Positive Breast Cancer Description for Measure #71 Data Collection Sheet for Measure #71 Coding Specifications for Measure #71			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All female patients aged 18 years and older with breast cancer ICD-9 diagnosis codes: 174.0-174.6, 174.8, 174.9 AND CPT E/M service codes: 99201-99205, 99212-99215, 99218-99220, 99221-99223, 99231-99233, 99234-99236, 99241-99245, 99251-99255	Tamoxifen or Aromatase Inhibitor Documented or Prescribed G8381: For patients with ER or PR positive, Stage IC-III breast cancer, clinician documented or prescribed that the patient is receiving tamoxifen or aromatase inhibitor	Once per reporting period	The reporting clinician is not required to have written the initial prescription. If oncologists choose to report on this measure, a measure code must be submitted on claims for female patients with breast cancer (ICD-9 codes 174.0-174.6, 174.8, 174.9) that include the listed E&M codes, even if the patient is not stage IC to III or ER/PR positive. If the patient is not stage IC-III or is not ER/PR positive, use the second code, "Clinician documentation that breast cancer patient was not eligible for tamoxifen or aromatase inhibitor therapy measure." This code also should be used for patients who were not prescribed hormonal therapy due to documented contraindications or patient preference. Submission of any code counts as an instance of reporting.
	Tamoxifen or Aromatase Inhibitor not Documented or Prescribed for Documented Reasons G8376: Clinician documentation that breast cancer patient was not eligible for tamoxifen or aromatase inhibitor therapy <u>measure</u> <hr/> Tamoxifen or Aromatase Inhibitor not Documented or Prescribed G8380: For patients with ER or PR positive, Stage IC-III breast cancer, clinician did not document that the patient received or was prescribed tamoxifen or aromatase inhibitor		
Measure #72: Chemotherapy for Stage III Colon Cancer Patients Description for Measure #72 Data Collection Sheet for Measure #72 Coding Specifications for Measure #72			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All patients aged 18 to 80 years with colon cancer ICD-9 diagnosis codes: 153.0-153.9	Chemotherapy Documented as Received or Prescribed G8372: Chemotherapy documented as received or prescribed for Stage III colon cancer patients	Once per reporting period	The reporting clinician is not required to have written the initial prescription. If oncologists choose to report

AND CPT E/M service codes: 99201-99205, 99212-99215, 99218-99220, 99221-99223, 99231-99233, 99234-99236, 99241-99245, 99251-99255	Chemotherapy not Documented as Received or Prescribed for Documented Reasons G8377: Clinician documentation that colon cancer patient is not eligible for the chemotherapy measure		<p>on this measure, a measure code must be submitted on claims for patients with colorectal cancer (ICD-9 codes 153.0-153.9) that include the listed E&M codes, even if the patient is not stage III. If the patient is not stage III, use the second code, “Clinician documentation that colon cancer patient is not eligible for the chemotherapy measure.” This code also should be used for patients who were not prescribed chemotherapy due to documented contraindications or patient preference.</p> <p>CMS will exclude patients who are >80 years of age from the patient population when determining whether the reporting provider submitted measure codes for the minimum of 80% of eligible patients. Oncologists are not required to submit codes for colon cancer patients aged >80 years for this measure.</p> <p>Submission of any code counts as an instance of reporting.</p>
	Chemotherapy not Documented as Received or Prescribed G8371: Chemotherapy documented as not received or prescribed for Stage III colon cancer patients		
Measure #73: Plan for Chemotherapy Documented Before Chemotherapy Administered Description for Measure #73 Data Collection Sheet for Measure #73 Coding Specifications for Measure #73			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All cancer patients who were administered IV chemotherapy ICD-9 diagnosis codes: 140.0-239.9 (all cancer diagnoses)	Chemotherapy Plan Documented G8373: Chemotherapy plan documented prior to chemotherapy administration	Once per chemotherapy regimen received	A plan for the amount of chemotherapy to be given must include doses and time intervals.

<p>AND CPT procedure codes: 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415-96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521-96523, 96542, 96549 (chemotherapy administration) AND CPT E/M service codes: 99201-99205, 99212-99215, 99218-99220, 99221-99223, 99231-99233, 99234-99236, 99241-99245, 99251-99255</p>	<p>Chemotherapy Plan not Documented G8374: Chemotherapy plan not documented prior to chemotherapy administration</p>		
<p>Measure #74: Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have Undergone Breast Conserving Surgery Description for Measure #74 Data Collection Sheet for Measure #74 Coding Specifications for Measure #74</p>			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
<p>All female patients aged 18 to 70 years with invasive breast cancer ICD-9 diagnosis codes: 174.0-174.6, 174.8, 174.9 AND CPT E/M service codes: 99241-99245</p>	<p>Radiation Therapy Recommended G8379: Documentation of radiation therapy recommended within 12 months of first office visit</p>	<p>Once per reporting period</p>	<p>The full specification document implies that this measure should be reported by radiation oncology providers; however, the codes alone (presented here) could be relevant to other providers who care for breast cancer patients and document a recommendation for radiation post BCS.</p> <p>If providers choose to report on this measure, a measure code must be submitted on claims for patients with breast cancer (ICD-9 codes 174) that include the listed E&M codes, even if the breast cancer is not invasive or if the patient has not had BCS.</p>

	<p>Radiation Therapy not Recommended for Documented Reasons G8378: Clinician documentation that patient was not an eligible candidate for radiation therapy measure</p> <hr/> <p>Radiation Therapy not Recommended G8383: No documentation of radiation therapy recommended within 12 months of first office visit</p>		<p>If the breast cancer is not invasive or the patient has not had BCS, use the second code, “Clinician documentation that patient was not an eligible candidate for radiation therapy measure.”</p> <p>CMS will exclude patients who are >70 years of age from the patient population when determining whether the reporting provider submitted measure codes for the minimum of 80% of eligible patients.</p> <p>Oncologists are not required to submit codes for breast cancer patients aged >70 years for this measure.</p>
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Measure #25: Melanoma: Patient Medical History
[Description for Measure #25](#)
[Data Collection Sheet for Measure #25](#)
[Coding Specifications for Measure #25](#)

ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
<p>All patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma ICD-9 diagnosis codes: V10.82, 172.0-172.9 AND CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245</p>	<p>Medical History with Review of New or Changing Moles Documented CPT II 1050F: History obtained regarding new or changing moles</p> <hr/> <p>Medical History with Review of New or Changing Moles not Completed for Medical Reasons CPT II 1050F 1P: Documentation of medical reason(s) for not asking about presence of new or changing moles</p> <hr/> <p>Medical History with Review of New or Changing Moles not Completed for Patient Reasons CPT II 1050F 2P: Documentation of patient reason(s) for not asking about presence of new or changing moles</p> <hr/> <p>Medical History with Review of New or Changing Moles not Completed for System Reasons CPT II 1050F 3P: Documentation of system reason(s) for not asking about presence of new or changing moles</p>	<p>Once per reporting period</p>	<p>The measure documentation notes, “It is anticipated that clinicians who provide services for the primary treatment or follow-up of cutaneous melanoma or primary management of patients with a history of cutaneous melanoma will submit this measure.”</p>

	Medical History with Review of New or Changing Moles not Completed, Reason Not Specified CPT II 1050F 8P: History was not obtained regarding new or changing moles, reason not otherwise specified		
Measure #26: Melanoma: Complete Physical Skin Examination Description for Measure #26 Data Collection Sheet for Measure #26 Coding Specifications for Measure #26			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma ICD-9 diagnosis codes: V10.82, 172.0-172.9 AND CPT E/M service codes: 99201-99205, 99212-99215, 99241-99245	Complete Physical Skin Exam Documented CPT II 2029F: Complete physical skin exam performed	Once per reporting period	The measure documentation notes, “It is anticipated that clinicians who provide primary treatment or follow-up for melanoma or primary management of patients with a history of cutaneous melanoma will submit this measure.”
	Complete Physical Skin Exam not Performed for Medical Reasons CPT II 2029F 1P: Documentation of medical reason(s) for not performing a complete physical skin exam		
	Complete Physical Skin Exam not Performed for Patient Reasons CPT II 2029F 2P: Documentation of patient reason(s) for not performing a complete physical skin exam		
	Complete Physical Skin Exam not Performed for System Reasons CPT II 2029F 3P: Documentation of system reason(s) for not performing a complete physical skin exam		
	Complete Physical Skin Exam not Performed, Reason Not Specified CPT II 2029F 8P: Complete physical skin exam was not performed, reason not otherwise specified		
Measure #27: Melanoma: Counseling on Self-Examination Description for Measure #27 Data Collection Sheet for Measure #27 Coding Specifications for Measure #27			
ELIGIBLE PATIENTS	MEASURE CODING	REPORTING FREQUENCY	NOTES
All patients with either a current diagnosis of cutaneous melanoma or a history of cutaneous melanoma ICD-9 diagnosis codes: V10.82, 172.0-172.9 AND CPT E/M service codes: 99201-99205, 99212-99215,	Patient Counseling to Perform Self-Examination Documented CPT II 5005F: Patient counseled on self-examination for new or changing moles	Once per reporting period	The measure documentation notes, “It is anticipated that clinicians who provide primary treatment or follow-up for melanoma or primary management of patients with a history of cutaneous melanoma will submit this measure.”
	Patient Counseling to Perform a Self-Examination not Performed for Medical Reasons CPT II 5005F 1P: Documentation of medical reason(s) for not counseling patient to perform self-examination for new or changing moles		

99241-99245	<p>Patient Counseling to Perform a Self-Examination not Performed for Patient Reasons CPT II 5005F 2P: Documentation of patient reason(s) for not counseling patient to perform self-examination for new or changing moles</p>		
	<p>Patient Counseling to Perform a Self-Examination not Performed for System Reasons CPT II 5005F 3P: Documentation of system reason(s) for not counseling patient to perform self-examination for new or changing moles</p>		
	<p>Patient Counseling to Perform a Self-Examination not Performed, Reason Not Specified CPT II 5005F 8P: Patient was not counseled on self-examination for new or changing moles, reason not otherwise specified</p>		