Iowa Foundation for Medical Care
6000 Westown Pky
West Des Moines, IA 50266
Phone 515-223-2900
Fax: 515-222-2407

IFMC / PQRI

PQRI 2008 Data and Analytic Processing

Product Requirements Document

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CHANGE HISTORY

Date	Changed By	Changes	Version
10/08/2007	Trevor Richards	Initial draft developed with the cooperation of miscellaneous resources.	0
02/09/2008	Trevor Richards	Comments received from Sheri Jandik, Janet Reynolds, Mike Sacca, Marian Brenton, Susie Joe and Kathy Kain.	.1
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6/02/2008	Rachel Merriam	Updated registry related requirements for RAV, data integration, and minor measure analytic changes. Added two open issues.	.7
6/03/2008	Rachel Merriam	Updated RAV requirements. Sent to CMS for approval.	1.0 (0.8)
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8/14/2008	Rachel Merriam	Included PQRI 2008 Measure Flows in Appendix F.	1.0 (0.12)
8/26/2008	Rachel Merriam	Included comments received from final CMS walk-through.	1.0 (0.13)

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Section 1 – Product Perspective

Executive Overview

Background

The overall goal of the PQRI program is to provide an incentive for physicians and other eligible professional to report quality measures on Medicare Physician Fee Schedule (MPFS) covered professional services furnished to Medicare beneficiaries; helping to ensure that high quality services are provided to Medicare beneficiaries.

On December 29, 2007, President Bush signed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). MMSEA included amendments to provisions and requirements established by the Tax Relief and Health Care Act of 2006 (TRHCA). TRHCA Division B, Part I, Section 101, authorizes a physician reporting system and a financial incentive for eligible professionals who voluntarily satisfy criteria for the satisfactory reporting of quality of care data on covered professional services furnished July 1 through December 31, 2007. MMSEA authorizes an incentive of 1.5% of Medicare Physician Fee Schedule (PFS) covered professional services total allowed charges for each professional who satisfies reporting criteria for reporting quality of care data on services furnished in calendar-year 2008. MMSEA also directs establishment of alternative reporting periods within 2008, and alternative criteria for satisfactory reporting, of quality measures data on services furnished within the reporting period. Alternative reporting criteria are applicable to the reporting of measures groups, whether submitted via claims- or registry-based submission, and to the reporting of at least 3 individual measures submitted through a registry. PQRI 2008 builds on and expands the options and features implemented in the 2007 PQRI.

Legislative Mandates

- Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)
- Tax Relief and Health Care Act of 2006 (TRHCA)

Contract(s) Supported

- Physician Performance Information Center (PPIC)
- Physician Quality Reporting Initiative (PQRI)

Stakeholders & Audience

- Centers for Medicare and Medicaid Services (CMS)
- Quality Improvement Organizations (QIOs)
- Physicians
- Non-Physicians (healthcare) Practitioners
- Practice Managers
- Medicare Beneficiaries

Measures

The overall PQRI 2008 program involves a combination of measures from multiple data sources such as Medicare Claims and Selected Physician Registries. The scope of this requirements document is limited to the 119 core claims-based measures for the 2008 PQRI program when reported individually, and 4 measures groups comprising topic-specific subsets of these measures. The below measures and data sources are outside the scope of this requirements document:

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- Additional claims-based "Testing Measures"
- Registry measures
- Claims-based validation against Registry data
- Calculation of the amount of allowed charges or incentive amount for professionals who are determined to have satisfactorily reported on services furnished in 2008.

In general, PQRI 2008 quality measures are required to have been:

- Proposed in the Federal Register no later than August 15, 2007.
- Subject to public comment on their appropriateness for use in the 2008 PQRI, following the publication in the Federal Register of their proposed availability for eligible professionals' use in reporting quality data on services furnished in 2008.
- Published in the Federal Register as available for professionals to use to report quality data on services furnished in 2008 no later than November 15, 2007.
- Adopted or endorsed, by October 31, 2007, by a consensus process organization featuring at least the level of consensus represented by the AQA Alliance as it was organized in December, 2006.

Measure Tags

The 119 core claims-based measures are divided into seven general types of measures (AKA "measure tags"):

- Procedure measures that are reported each time a procedure are performed during the PQRI healthcare delivery period.
- Patient-process measures that are reported a minimum of once per NPI/TIN/beneficiary combination for the PQRI healthcare delivery period. When an NPI/TIN reports on a specific patient-process measure for a beneficiary more than once, the most favorable instance is counted once for the reporting period.
- Patient-periodic measures that are reported a minimum of once per timeframe specified by the measure during the PQRI healthcare delivery period.
- Patient-intermediate measures that are reported a minimum of once per NPI/TIN/beneficiary combination for the PQRI healthcare delivery period. When an NPI/TIN reports on a specific patient-intermediate measure for a beneficiary more than once, the most recent instance is counted once for the reporting period.
- Episode measures are typically reported a minimum of once for each occurrence of a particular illness/condition during the PQRI healthcare delivery period. When an NPI/TIN reports on a specific episode measure for a beneficiary more than once, unless otherwise specified, the most favorable instance is counted once for the reporting period.
- Visit measures that are reported each time a patient is seen by the eligible professional during the PQRI healthcare delivery period.
- Selective-visit measures that are reported each time a patient is seen by the eligible professional according to the timeframe specified by the measure.

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Data Processing and Analysis Components

All 2008 PQRI claims-based measures calculations are based on Medicare Part B claims data. Incentive payment calculations are based on Medicare Part B data received via claims or registries. There are multiple components and steps involved in the end-to-end data processing and analysis as follows:

- Pre-Processing – Includes data extraction and preparation of claims data for subsequent measure calculations as well as post-processing routines
- Measure-Specific Analysis – Includes measure-level identification of reporting and performance denominators and numerators
- Claims- Based Measures Groups Analysis – Includes processing requirements for the four measures groups.
- External File Creations – Includes translating the above processing outcomes to data files used for feedback reports, management reports and payment files

The specific requirements related to the above PQRI 2008 data and analytic processes are reflected and summarized below. These requirements should be used as a guide for developing test and production code for extracting and analyzing data for PQRI 2008 reporting rates and performance rates.

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Section 2 – Considerations

Product Assumptions

Assumptions are factors that have an effect on the product, but that are not mandated requirements. Assumptions can also contain statements about what the product will specifically not do. Include any statements about user guides or training that will be provided.

I.D.	Assumption Description	Release
ASR-1	CMS Medicare Claims Processing Systems will not exclude CPT II or G- codes reported by eligible professionals via Part B Claims data from the time it is originally submitted to the time the claims data appears in CMS National Claims History.	*R.1.0*
ASR-2	All necessary Data Use Agreements (DUA) will be in place for any transfer of IFMC-generated analytic data to other CMS contractors.	*R.1.0*
ASR-3	The Part B dimensional database will be available in production.	*R.1.0*
ASR-4	During the ETL process, the Part B dimensional database will identify whether a claim has been resubmitted for the sole purpose of adding Quality-Data Codes. Note: CMS has determined that allowing QDC resubmits could delay PQRI processing due to an increase in data. Claims resubmitted for the sole purpose of adding QDC(s) will be excluded from PQRI analysis.	*R.1.0*

Product Risks

Identify the risks associated with the release of this product as well as risks associated with delayed completion or no completion of the product.

I.D.	Risk Description	Release
RSK-1	The absence of clearly defined PQRI 2008 claims-based measure analytics will impact the accuracy of PQRI results and adversely affect PQRI participation. Measure analytics defines the rules and algorithms for calculating PQRI measures and must be approved by CMS.	*R.1.0*
RSK-2	Delays in the availability of Medicare claims data will delay the data and analytic processes required for PQRI analysis.	*R.1.0*

Product Dependencies

List standard business practices that this product is dependent upon, or are dependant upon this product.

I.D.	Dependency Description	Release
DEP-1	PQRI 2008 data and analytic processing relies on a stable release of PQRI 2008 measure specifications.	*R.1.0*

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I.D.	Dependency Description	Release
DEP-2	PQRI 2008 Management Reports include results based on PQRI 2008 data and analytic processing.	*R.1.0*
DEP-3	PQRI 2008 integrated final feedback reports include results based on PQRI 2008 data and analytic processing.	*R.1.0*
DEP-4	PQRI 2008 incentive calculations and resultant integrated payment file generation processes include results based on PQRI 2008 data and analytic processing.	*R.1.0*
DEP-5	Carriers and A/B MACs must make modifications to their systems to recognize new or modified PQRI 2008 QDCs and pass the quality line items from the claim to the data source used for PQRI data analysis.	*R.1.0*
DEP-6	Clearing Houses must make modifications to their systems to recognize new or modified PQRI 2008 QDCs and pass the quality line items on the claim to Carriers and A/B MACs.	*R.1.0*
DEP-7	Monthly Part B claims TAP file availability from CMS on the 10th of every month.	*R.1.0*
DEP-8	The Part B TAP file data will be loaded to the Part B Dimensional database using the existing SDPS extract, transform and load (ETL) schedule and process.	*R.1.0*

Product Constraints

This section describes constraints on the requirements that will affect the eventual design of the product, and include solution design constraints, implementation environment constraints, external interfacing applications, and the use of off-the-shelf software, where appropriate. Specify any constraints to how the project must be designed, or mandated technology solutions/design preferences.

I.D.	Constraint Description	Release
CON-1	The analysis shall be performed on data residing in the Part B dimensional database containing the most recent TAP file results processed by the existing ETL processes.	*R.1.0*
CON-2	The system shall only analyze specific Medicare Part B claims processed by local carriers and A/B MACs (indicated by a NCH_CLM_TYPE_CD value of '71' or '72').	*R.1.0*
CON-3	The system shall only include claims for services furnished from January 1, 2008 through December 31, 2008 and processed into the NCH by February 27, 2009. In addition, claims for services furnished from November 1, 2007 through December 31, 2007 shall be included for a specific measure look back period.	*R.1.0*

Glossary

Term	Definition
Base QDC	The first five digits of a Quality-Data Code
Carriers and A/B	Part B Medicare Carriers and Part A & B Medicare Administrative Contractors

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Term	Definition
MACs	
DX	ICD-9 diagnosis code
EP	Eligible Professional
MPFS	Medicare Physician Fee Schedule
NCH	National Claims History
NPI	National Provider Identifier
OIS	CMS Office of Information Services (OIS)
PFS	Physician Fee Schedule
PPIC	Physician Performance Information Center
PQRI	Physician Quality Reporting Initiative
PQRI healthcare delivery period	Medicare Physician Fee Schedule services provided January 1, 2008 to December 31, 2008 or July 1, 2008 to December 31, 2008 depending on the reporting method
QDC	Quality Data Code (i.e., CPT Category II codes or specially designated HCPCS Level II G-codes that provide PQRI reporting- and performance-rate numerator information)
Quality-Data Submission Period	The period of time that claims from the NCH will be examined for quality data codes (January 1, 2008 – February 27, 2009)
TIN	Taxpayer Identification Number, whether individual or corporate Taxpayer Identification Number, Employer Identification Number, or individual professional's Social Security Number

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Section 3 – Customer Requirements

The intention of the Customer Requirements document is to list *what* basic functionality is required from the customer – not *how* the requirements will be fulfilled. If the *how* is inferred in this document, it must be recognized that it should be analyzed technically to determine the best way to provide the required functionality. Those requirements would be documented in the Technical Specifications.

3.0 – Access (Roles)/Security

List user roles and what each role should be able to accomplish with the system. Include who has authorized access (to both functionality and to data) and under what circumstances it is granted.

I.D.	Requirement Description	Release	Trace
ACC-1	The data used in PQRI analysis shall be accessible to IFMC internal users only.	*R.1.0*	

3.1 – User Requirements

Describe user goals or tasks that the user must be able to perform with the product. Include a listing of applicable use cases.

I.D.	Requirement Description	Release	Trace
N/A			

3–2 - Operating Environment Requirements

Operational requirements describe the environment in which the product is to be used. Are there specific platforms on which the product must be constructed?

I.D.	Requirement Description	Release	Trace
N/A			

3–3 - Data and Analytical Requirements

The requirements below define 'what' the PQRI 2008 measure analytics accomplish and are not intended to provide a detailed technical specification for determining PQRI measure reporting and performance calculations.

I.D.	Requirement Description	Release	Trace
DAR-1.0	**Claims-Based Data Sources & General Requirements**	*R.1.0*	
DAR-1.1	The data for analysis shall be derived from the Part B dimensional database.	*R.1.0*	
DAR-1.2	The system shall only analyze specific Medicare Part B claims processed by local carriers and A/B MACs (indicated by a NCH_CLM_TYPE_CD value of '71' or '72').	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-1.3	The system shall identify and rejoin Part B claims that are split during Medicare Claims Processing due to having more than 13 line items.	*R.1.0*	
DAR-1.4	The system shall analyze claims using different specific data elements as the basis of aggregation depending on the system output:	*R.1.0*	
DAR-1.4.1	Analysis for reporting and payment shall be at the TIN/NPI level.	*R.1.0*	
DAR-1.5	The system shall identify valid line items on claims based on the first and last expense dates corresponding to a qualifying denominator code falling within the PQRI Health Care Service Delivery Period.	*R.1.0*	
DAR-1.6	The system shall exclude denied line items other than quality data code lines (CPT II and G- codes) from a claim, identified by Carrier Claim Payment Denial Code = 0 or Line Processing Indicator Code ≠ A.	*R.1.0*	
DAR-1.6.1	The system shall exclude line items containing CPT Category I codes with modifiers 80, 81, or 82.	*R.1.0*	
DAR-1.7	When Bene_ID is not found in the enrollment database the Beneficiary ID shall be identified as the Beneficiary ID number as it appears on the claim. The enrollment database is used to identify Beneficiary ID number changes.	*R.1.0*	
DAR-1.8	NPI values shall be set to null in cases where the value is alpha-numeric OR < 6 digits in length.	*R.1.0*	
DAR-1.9	The system shall be able to identify and flag NPI/TINs participating via the claims-based measures groups reporting method.	*R.1.0*	
DAR-1.10	Patient demographic information shall be drawn from Part B claims for the eligible patient.	*R.1.0*	
DAR-1.10.1	Beneficiary age shall be calculated once per claim based on the claim date of birth as of the claim from date.	*R.1.0*	
DAR-1.10.2	Line Item services will be excluded from analytic processing of any given measure if the calculated age from the claims falls outside of the defined age range in the measure specifications.	*R.1.0*	
DAR-1.10.3	Beneficiary gender shall be drawn from the Part B claim for the eligible patient.	*R.1.0*	
DAR-2	**Claims Pre-Processing Work**	*R.1.0*	
DAR-2.1	The system shall apply Carrier number conversions based on mappings provided by CMS/CMM.	*R.1.0*	
DAR-2.2	The system shall identify missing line item performing NPI numbers.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-2.3	The system shall be able to analyze PFS allowed charges for specific groups of TIN/NPI values provided by CMS for all system outputs with group identification (e.g., ORDI pilot participants).	*R.1.0*	
DAR-3	**Denominator and numerator values shall be calculated for each measure.**	*R.1.0*	
DAR-3.1	Claims eligible for inclusion in measure-specific calculations shall be identified based on the data elements, values, and combinations defined in the measure specifications, single-source, coding for quality handbook and claims-based reporting of measures groups handbook documentation.	*R.1.0*	
DAR-3.1.1	Qualifying diagnosis codes shall be identified using line item services only.	*R.1.0*	
DAR-3.1.2	Qualifying CPT Category I codes shall be identified using line item services only.	*R.1.0*	
DAR-3.1.3	Qualifying combinations of ICD-9, CPT Category I codes, HCPCS codes, and/or CPT Category II codes AND QDC(s) (designated CPT II codes OR specially assigned G-codes) can exist on different line items within the same claim for standard reporting and on any claim for measures group reporting.	*R.1.0*	
Aggregation for Individual Performing NPI within TIN Measure Calculations			
DAR-3.1.4	**Individual performing NPI within a TIN (NPI/TIN) reporting denominator and numerator values shall be calculated for each measure for which the NPI/TIN is eligible to report QDC.**	*R.1.0*	
DAR-3.1.4.1	Eligible cases shall be based on qualifying combinations of ICD-9, CPT Category I codes, HCPCS codes, and/or CPT Category II codes AND QDC (designated CPT II code OR specially assigned G-codes) for each NPI/TIN.	*R.1.0*	
DAR-3.1.4.1.1	The system shall be able to include qualifying combinations that are included on different line items within the same claim for standard reporting and on any claim for measures group reporting.	*R.1.0*	
DAR-3.1.4.1.2	CPT Category I codes and non-PQRI CPT Category II modifiers included with qualifying QDC shall be ignored for both reporting and performance calculations.	*R.1.0*	
DAR-3.1.4.1.3	Qualifying QDC with PQRI CPT Category II modifiers (1P, 2P, 3P, or 8P) that are not specified for the measure shall count towards the reporting numerator for that NPI/TIN combination.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.4.1.3.1	PQRI CPT Category II modifiers that are not specified for the measure do not count as performance denominator exclusions (i.e., qualifying QDC with PQRI CPT Category II modifiers that are not specified for the measure are counted in the performance denominator).	*R.1.0*	
DAR-3.1.4.1.3.2	PQRI CPT Category II modifiers that are not specified for the measure do not count toward the performance numerator.	*R.1.0*	
DAR-3.1.4.1.4	Any qualifying QDC for a measure that requires more than one QDC will count towards the reporting numerator for that NPI/TIN combination.	*R.1.0*	
DAR-3.1.4.1.4.1	For measures that require more than one QDC, all QDCs must be reported to be included in the performance numerator.	*R.1.0*	
DAR-3.1.4.1.5	Modifiers included with any G-code shall be ignored for both reporting and performance calculations.	*R.1.0*	
DAR-3.1.4.1.5.1	The G-code shall be treated as specified in the Measure Specifications for reporting and performance.	*R.1.0*	
DAR-3.1.4.1.6	Unless otherwise specified, the most favorable outcome for performance shall be selected when there are conflicting modifiers within the same line item or across line items on a claim or episode for the same measure for the same NPI/TIN.	*R.1.0*	
DAR-3.1.4.2	The same NPI and TIN must exist on the same billed line item(s) as the qualifying ICD-9 and CPT code(s) in order to count towards the reporting denominator for that NPI/TIN combination.	*R.1.0*	
DAR-3.1.4.3	The same NPI and TIN must exist on the same billed line item(s) as the qualifying QDCs in order to count towards the reporting numerator for that NPI/TIN combination.	*R.1.0*	
Procedure Measures Calculations			
Procedure measures are reported each time a procedure is performed during the reporting period. The beneficiary is counted once for each unique qualifying procedure code that exists per claim (e.g., if two different procedure codes exist and both qualify they both are counted).			
DAR- 3.1.5MPM1	*Procedure Measure Identified via Procedure (Measures 76)*	*R.1.0*	
DAR-3.1.5MPM1.1	The reporting denominator shall be increased by one (1) for each unique qualifying procedure CPT Category I code.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPM1.2	The reporting numerator shall be increased by one (1) for each qualifying procedure in the denominator with any measure-specific base QDC(s) reported on the same claim.	*R.1.0*	
DAR-3.1.5MPM1.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPM1.4	The performance numerator shall be increased by one (1) for the measure if the qualifying procedure in the performance denominator includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MPM2	*Procedure Measure Identified via Demographic + DX + Procedure* *(Measure 10, 11, 95)*	*R.1.0*	
DAR 3.1.5MPM2.1	The reporting denominator shall be increased by one (1) for each qualifying beneficiary demographic(s) AND ICD-9 AND each unique qualifying procedure CPT Category I code.	*R.1.0*	
DAR-3.1.5MPM2.2	The reporting numerator shall be increased by one (1) for each qualifying procedure in the denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPM2.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPM2.4	The performance numerator shall be increased by one (1) for the measure if the qualifying procedure in the performance denominator includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MPM3	*Procedure Measure Identified via DX + Procedure* *(Measure 99, 100, 102)*	*R.1.0*	
DAR 3.1.5MPM3.1	The reporting denominator shall be increased by one (1) for each qualifying beneficiary AND ICD-9 AND each unique qualifying procedure CPT Category I code.	*R.1.0*	
DAR-3.1.5MPM3.2	The reporting numerator shall be increased by one (1) for each qualifying procedure in the denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPM3.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of qualifying QDC(s) submitted with exclusion modifiers.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPM3.4	The performance numerator shall be increased by one (1) for the measure if the qualifying procedure in the performance denominator includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MPM4	*Procedure Measure Identified via Demographic + Procedure* *(Measures 20, 21, 22, 23, 45)*	*R.1.0*	
DAR-3.1.5MPM4.1	The reporting denominator shall be increased by one (1) for each qualifying beneficiary demographic(s) AND each unique qualifying procedure CPT Category I code.	*R.1.0*	
DAR-3.1.5MPM4.2	The reporting numerator shall be increased by one (1) for each qualifying procedure in the denominator with any measure-specific base QDC(s) reported on the same claim.	*R.1.0*	
DAR-3.1.5MPM4.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPM4.4	The performance numerator shall be increased by one (1) for the measure if the qualifying procedure in the performance denominator includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MPM5	*Procedure Measure Identified via Demographic + Specific CPT II* *(Measure 30)*	*R.1.0*	
DAR 3.1.5MPM5.1	The reporting denominator shall be increased by one (1) for the qualifying beneficiary demographic(s) AND CPT II code.	*R.1.0*	
DAR-3.1.5MPM5.2	The reporting numerator shall be increased by one (1) if the qualifying claim includes any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPM5.3	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MPM5.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim in the performance denominator includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.15MPM6	*Procedure Measure Identified via DX WITHOUT specific secondary DX + Procedure* *(Measure 105)*	*R.1.0*	
DAR-3.1.5MPM6.1	The reporting denominator shall be increased by one (1) for each qualifying ICD-9 AND unique procedure CPT Category I code.	*R.1.0*	
DAR – 3.1.5MPM6.1.1	The reporting denominator is NOT increased when the claim includes a specific secondary DX specified for the measure.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPM6.2	The reporting numerator shall be increased by one (1) for each qualifying procedure in the denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPM6.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPM6.4	The performance numerator shall be increased by one (1) for the measure if the qualifying procedure in the performance denominator includes measure-specific QDCs indicating numerator compliance.	*R.1.0*	
Patient-Process Measures Reporting Calculations			
Patient-Process measures are reported once per NPI/TIN/beneficiary combination for the PQRI healthcare delivery period. When an NPI/TIN reports on a specific patient-process measure for a beneficiary more than once, the measure is calculated once for the reporting period with the most favorable instance used for the performance numerators.			
DAR-3.15MPP1	*Patient-Process Measure Identified via Demographic + DX(s) + Patient Encounter (Measure 119, 120)*	*R.1.0*	
DAR-3.15MPP1.1	*Shares CPT II coding with Measure 5 (Measure 119)*	*R.1.0*	
DAR-3.15MPP1.2	The reporting denominator shall be increased by one (1) for each patient claim with qualifying demographic(s) AND ICD-9(s) AND patient encounter CPT Category I code for the PQRI healthcare delivery period when the following conditions are also met:	*R.1.0*	
DAR-3.15MPP1.2.1	Any measure-specific CPT II code not shared with Measure 5 is found on any other eligible claim for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.15MPP1.3	*No shared CPT II coding (Measure 120)*	*R.1.0*	
DAR-3.15MPP1.4	The reporting denominator shall be increased by one (1) for each patient claim with qualifying demographic(s) AND ICD-9(s) AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP1.5	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator when any measure-specific base QDC is reported on the same claim.	*R.1.0*	
DAR-3.15MPP1.6	*Measures with Exclusions (Measure 120)*	*R.1.0*	
DAR-3.1.5MPP1.6.1	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.15MPP1.7	*Measures without Exclusions (Measure 119)*	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPP1.7.1	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MPP1.8	The performance numerator shall be increased by one (1) for a beneficiary for the measure if a qualifying claim in the performance denominator includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.15MPP2	*Custom Coding Required: Patient-Process Measure Identified via Demographic + DX(s) + Patient Encounter (Measure 7)*	*R.1.0*	
DAR-3.15MPP2.1	The reporting denominator shall be increased by one (1) for each patient claim with qualifying demographic(s) AND ICD-9(s) AND patient encounter outpatient CPT Category I code (no inpatient CPT Category I codes on claim) for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.15MPP2.1.1	When inpatient and outpatient OR only outpatient CPT Category I codes are found on the SAME claim with a measure-specific QDC for all TIN/NPI claims with a measure-specific QDC during the PQRI healthcare delivery period, all claims with only outpatient coding shall be included in the reporting denominator.	*R.1.0*	
DAR-3.15MPP2.1.1.1	All claims where only inpatient CPT Category I codes are found shall be excluded from analysis.	*R.1.0*	
DAR-3.15MPP2.1.2	When only inpatient CPT Category I codes are found on at least one claim with a measure-specific QDC for a TIN/NPI in the PQRI healthcare delivery period, all claims with inpatient and/or outpatient coding shall be included in the reporting denominator.	*R.1.0*	
DAR-3.1.5MPP2.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP2.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of qualifying QDC submitted with exclusion modifiers.	*R.1.0*	
DAR-3.1.5MPP2.4	The performance numerator shall be increased by one (1) for the beneficiary for the measure if a qualifying claim in the performance denominator includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR- 3.1.5MPP3	*Patient-Process Measure Identified via Demographic + DX + Patient Encounter (Measures 8, 12, 14, 18, 19, 41, 49, 50, 51, 52, 53, 64, 67, 68, 69, 70, 71, 72, 74, 77, 78, 79, 84, 85, 86, 87, 89, 90, 108, 117, 121, 126, 127)*	*R.1.0*	
DAR-3.1.5MPP3.1	The reporting denominator shall be increased by one (1) for each patient claim with qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code OR patient encounter HCPCS code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP3.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP3.3	*Measures with Exclusions (Measures 8, 12, 14, 18, 19, 41, 51, 52, 53, 67, 68, 69, 70, 71, 72, 74, 77, 78, 79, 84, 85, 87, 90, 108, 121, 126, 127)*	*R.1.0*	
DAR-3.1.5MPP3.3.1	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPP3.4	*Measures without Exclusions (Measures 49, 50, 64, 86, 89, 117)*	*R.1.0*	
DAR-3.1.5MPP3.4.1	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MPP3.5	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPP4	*Custom Coding Required: Patient-Process Measure Identified via Demographic + DX + Patient Encounter (Measures 5, 6)*	*R.1.0*	
DAR-3.15MPP4.1	The reporting denominator shall be increased by one (1) for each patient claim with qualifying demographic(s) AND ICD-9 AND patient encounter outpatient CPT Category I code (no inpatient CPT Category I codes on claim) for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.15MPP4.1.1	When inpatient and outpatient OR only outpatient CPT Category I codes are found on the SAME claim with a measure-specific QDC for all TIN/NPI claims with a measure-specific QDC during the PQRI healthcare delivery period, all claims with only outpatient coding shall be included in the reporting denominator.	*R.1.0*	
DAR-3.15MPP4.1.1.1	All claims where only inpatient CPT Category I codes are found shall be excluded from analysis.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.15MPP4.1.2	When only inpatient CPT Category I codes are found on at least one claim with a measure-specific QDC for a TIN/NPI in the PQRI healthcare delivery period, all claims with inpatient and/or outpatient coding shall be included in the reporting denominator.	*R.1.0*	
DAR-3.1.5MPP4.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP4.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPP4.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPP5	*Custom Coding Required: Patient-Process Measure Identified via Demographic + DX + Patient Encounter (Measure 83)*	*R.1.0*	
DAR-3.1.5MPP5.1	The reporting denominator shall be increased by one (1) for each patient claim with qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP5.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP5.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPP5.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the first qualifying claim includes measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MPP6	*Patient-Process Measure Identified via Demographic + Patient Encounter (Measures 4, 39, 48, 110, 111, 112, 113, 114, 133, 134)*	*R.1.0*	
DAR 3.1.5MPP6.1	The reporting denominator shall be increased by one (1) for each patient claim with the qualifying beneficiary demographic(s) AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPP6.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP6.3	*Measures with Exclusions (Measures 4, 39, 48, 110, 111, 112, 113, 133, 134)*	*R.1.0*	
DAR-3.1.5MPP6.3.1	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPP6.4	*Measure with no Exclusions (Measure 114)*	*R.1.0*	
DAR-3.1.5MPP6.4.1	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MPP6.5	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MPP7	*Patient-Process Measure Identified via Demographic + Patient Encounter (Measure 115)*	*R.1.0*	
DAR-3.1.5MPP7.1	The reporting denominator shall be increased by one (1) for each patient claim with the qualifying beneficiary demographic(s) AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP7.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP7.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPP7.3.1	QDC G8456 shall not be considered an instance of measure-specific exclusion when QDC G8455 has been reported at any time during the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP7.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MPP8	*Patient-Process Measure Identified via Place of Service ≠ 23 + Demographic + Patient Encounter (Measure 47)*	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR 3.1.5MPP8.1	The reporting denominator shall be increased by one (1) for each patient claim with the qualifying beneficiary demographic(s) AND POS ≠ 23 AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR 3.1.5MPP8.1.1	Qualifying line items with CPT Category I code 99291 with POS = 23 shall be excluded from analysis.	*R.1.0*	
DAR-3.1.5MPP8.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP8.3	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MPP8.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MPP9	*Patient-Process Measure Identified via DX + Procedure (Measure 101)*	*R.1.0*	
DAR-3.1.5MPP9.1	The reporting denominator shall be increased by one (1) for each patient claim with the qualifying ICD-9 AND procedure CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP9.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP9.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPP9.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPP10	*Patient-Process Measure Identified via DX + Procedure + Patient Encounter (Measure 73)*	*R.1.0*	
DAR-3.1.5MPP10.1	The reporting denominator shall be increased by one (1) for each patient claim with the qualifying ICD-9 AND procedure CPT Category I code AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPP10.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP10.3	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MPP10.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPP11	*Treated as a Patient-Process: Episode Measure Identified via Demographic + DX + Patient Encounter (Measure 9)*	*R.1.0*	
DAR-3.1.5MPP11.1	The reporting denominator shall be increased by one (1) for each patient meeting the qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP11.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP11.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPP11.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPP12	*Patient-Process Measure Identified via DX WITHOUT specific secondary DX + Procedure (Measure 103)*	*R.1.0*	
DAR-3.1.5MPP12.1	The reporting denominator shall be increased by one (1) for each patient claim with the qualifying ICD-9 AND qualifying procedure CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR – 3.1.5MPP12.1.1	The reporting denominator is NOT increased when the claim also includes a specific secondary DX specified for the measure.	*R.1.0*	
DAR-3.1.5MPP12.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPP12.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPP12.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.15MPP13	*Patient-Process Measure Identified via Demographic + DX + Patient Encounter (Measure 88)*	*R.1.0*	
DAR-3.1.5MPP13.1	The reporting denominator shall be increased by one (1) for each patient claim with a qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP13.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP13.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDCs for both options included on qualifying claim(s).	*R.1.0*	
DAR-3.1.5MPP13.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim(s) include measure-specific QDCs according to the following:	*R.1.0*	
DAR-3.1.5MPP13.4.1	QDCs specific to numerator compliance for both options.	*R.1.0*	
DAR-3.1.5MPP13.4.2	One (1) QDC specific to numerator compliance for either option and one (1) exclusion QDC for either option.	*R.1.0*	
DAR-3.1.5MPP13.4.3	The performance numerator shall NOT be increased if the qualifying claim(s) include QDC specific for performance not met for either option.	*R.1.0*	
DAR-3.1.5MPP14	*Patient-Process Measure Identified via Demographic + (DX OR DXs) + Patient Encounter (Measure 118)*	*R.1.0*	
DAR-3.1.5MPP14.1	The reporting denominator shall be increased by a maximum of one (1) for the PQRI healthcare delivery period for either of the following options:	*R.1.0*	
DAR-3.1.5MPP14.1.1	Option 1: The reporting denominator shall be increased by one (1) for each patient with a qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPP14.1.2	Option 2: The reporting denominator shall be increased by one (1) for each patient with a qualifying demographic(s) AND ICD-9s AND patient encounter CPT Category I code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPP14.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPP14.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less any instances of measure-specific exclusion QDCs.	*R.1.0*	
DAR-3.1.5MPP14.4	The performance numerator shall be increased by one (1) for a beneficiary for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance for at least one reporting option.	*R.1.0*	
Patient-Periodic Measures Reporting Calculations			
Patient-Periodic measures are reported once per NPI/TIN/beneficiary combination for each measure-specific period for the PQRI healthcare delivery period. When an NPI/TIN reports on a specific patient-periodic measure for a beneficiary more than once for the measure-specified time period, the measure is calculated once for each measure-specified time period with the most favorable instance used for the performance numerators.			
DAR-3.15MPE1	*Patient-Periodic Measure Identified via Demographic + DX + Patient Encounter (Measure 123)*	*R.1.0*	
DAR-3.1.5MPE1.1	The reporting denominator shall be increased by one (1) for each calendar month if there are qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code within the calendar month.	*R.1.0*	
DAR-3.1.5MPE1.2	The reporting numerator shall be increased by one (1) for each calendar month in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPE1.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPE1.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes measure-specific QDCs indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPE2	*Patient-Periodic Measure Identified via Demographic + DX + Procedure (Measures 80, 81)*	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPE2.1	The reporting denominator shall be increased by one (1) for each calendar month if there are any qualifying demographic(s) AND ICD-9 AND CPT procedure code OR HCPCS procedure code for the calendar month.	*R.1.0*	
DAR-3.1.5MPE2.2	The reporting numerator shall be increased by one (1) for each calendar month (based on first expense date) in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPE2.3	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MPE2.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPE3	*Patient-Periodic Measure Identified via Demographic + DX + Procedure (Measure 82)*	*R.1.0*	
DAR-3.1.5MPE3.1	The reporting denominator shall be increased by one (1) if there are qualifying demographic(s) AND ICD-9 AND procedure CPT Category I code OR HCPCS procedure code for 1 to 4 calendar months (based on first expense date) in PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPE3.1.1	The reporting numerator shall be increased by one (1) if the at least one (1) of the qualifying claim(s) includes any measure-specific base QDC(s).	*R.1.0*	
DAR-3.1.5MPE3.2	The reporting denominator shall be increased by two (2) if there are qualifying demographic(s) AND ICD-9 AND procedure CPT Category I code OR HCPCS procedure code for 5 to 8 calendar months (based on first expense date) in PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPE3.2.1	The reporting numerator shall be increased by two (2) if at least two (2) of the qualifying claims include any measure-specific base QDC(s).	*R.1.0*	
DAR-3.1.5MPE3.3	The reporting denominator shall be increased by three (3) if there are qualifying demographic(s) AND ICD-9 AND procedure CPT Category I code OR HCPCS procedure code for 9 to 12 calendar months (based on first expense date) in PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPE3.3.1	The reporting numerator shall be increased by three (3) if at least three (3) of the qualifying claims include any measure-specific base QDC(s).	*R.1.0*	
DAR-3.1.5MPE3.4	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPE3.5	The performance numerator shall be increased by one (1) for the measure if at least one (1) qualifying claim includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPE3.6	The performance numerator shall be increased by two (2) for the measure if at least five (5) qualifying claims includes a measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPE3.7	The performance numerator shall be increased by three (3) for the measure if at least nine (9) qualifying claims includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
Patient-Intermediate Measures Reporting Calculations			
Patient-Intermediate measures are reported once per NPI/TIN/beneficiary combination for the PQRI healthcare delivery period. When an NPI/TIN reports on a specific patient-intermediate measure for a beneficiary more than once, the measure is calculated once for the reporting period and the most recent QDC instance is used for the reporting and performance numerators.			
DAR-3.1.5MPI1	*Patient-Intermediate Measure Identified via Demographic + DX + Patient Encounter (Measure 1 – Poor Control)*	*R.1.0*	
DAR-3.1.5MPI1.1	The reporting denominator shall be increased by one (1) for a qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code **OR** patient encounter HCPCS code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPI1.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPI1.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPI1.4	The performance numerator shall be increased by one (1) for the measure if the most recent qualifying claim does not include a measure-specific QDC indicating numerator compliance OR includes an incorrect QDC for this measure.	*R.1.0*	
DAR-3.1.5MPI1.4.1	When no measure-specific QDC (or an incorrect QDC for the measure) is reported, that instance will count as performance success and reporting failure.	*R.1.0*	
DAR-3.1.5MPI2	*Patient-Intermediate Measure Identified via Demographic + DX + Patient Encounter (Measures 2,3)*	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MPI2.1	The reporting denominator shall be increased by one (1) for a qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code OR patient encounter HCPCS code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPI2.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPI2.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPI2.4	The performance numerator shall be increased by one (1) for the measure if the most recent qualifying claim includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MPI3	*Patient-Intermediate Measure Identified via Demographic + Patient Encounter (Measures 128)*	*R.1.0*	
DAR-3.1.5MPI3.1	The reporting denominator shall be increased by one (1) for a qualifying demographic(s) AND patient encounter CPT Category I code OR patient encounter HCPCS code for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MPI3.2	The reporting numerator shall be increased by one (1) for each patient in the reporting denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MPI3.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MPI3.4	The performance numerator shall be increased by one (1) for the measure if the most recent qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
Visit Measures Reporting Calculations			
Visit measures are typically reported once for each patient visit during the reporting period. When an NPI/TIN reports on a specific visit measure for a beneficiary more than once on an individual claim, the measure is calculated once per claim with the most favorable instance used and applied to each eligible visit for the performance numerators.			
DAR-3.1.5MVT1	*Visit Measure Identified via Demographic + DX + Patient Encounter (Measures 92, 94, 109)*	*R.1.0*	
DAR-3.1.5MVT1.1	The reporting denominator shall be increased by one (1) for each qualifying demographic(s) AND ICD-9 AND each qualifying patient encounter CPT Category I code.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MVT1.2	The reporting numerator shall be increased by one (1) if the qualifying claim includes any base measure-specific QDC.	*R.1.0*	
DAR-3.1.5MVT1.3	*Measures with Exclusions (Measures 92, 94)*	*R.1.0*	
DAR-3.1.5MVT1.3.1	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MVT1.4	*Measures without Exclusions (Measures 109)*	*R.1.0*	
DAR-3.1.5MVT1.4.1	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MVT1.5	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MVT2	*Visit Measure Identified via Demographic + DX + Patient Encounter (Measure 122)*	*R.1.0*	
DAR-3.1.5MVT2.1	The reporting denominator shall be increased by one (1) for each qualifying demographic(s) AND ICD-9 AND each qualifying patient encounter CPT Category I code.	*R.1.0*	
DAR-3.1.5MVT2.2	The reporting numerator shall be increased by one (1) if the qualifying claim includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MVT2.3	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MVT2.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR3.1.5MVT3	*Visit Measure Identified via Demographic + Patient Encounter (Measures 130, 131)*	*R.1.0*	
DAR-3.1.5MVT3.1	The reporting denominator shall be increased by one (1) for each qualifying demographic(s) AND each qualifying patient encounter CPT Category I code OR patient encounter HCPCS code.	*R.1.0*	
DAR-3.1.5MVT3.2	The reporting numerator shall be increased by one (1) if the qualifying claim includes any measure-specific base QDC.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MVT3.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MVT3.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR3.1.5MVT4	*Visit Measure Identified via Demographic + Patient Encounter* *(Measures 124, 125)*	*R.1.0*	
DAR-3.1.5MVT4.1	The reporting denominator shall be increased by one (1) for each qualifying demographic(s) AND each qualifying patient encounter CPT Category I code OR patient encounter HCPCS code.	*R.1.0*	
DAR-3.1.5MVT4.2	The reporting numerator shall be increased by one (1) if the qualifying claim includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MVT4.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MVT4.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
Selective Visit Measures Reporting Calculations			
Selective visit measures are typically reported once for each patient visit during the reporting period each time a patient is seen by the eligible professional according to the timeframe specified by the measure. When an NPI/TIN reports on a specific visit measure for a beneficiary more than once on an individual claim, the measure is calculated once per claim with the most favorable instance used and applied to each eligible visit for the performance numerators.			
DAR-3.1.5MSV1	*Selective Visit Measure Identified via Demographic + DX + Patient Encounter* *(Measure 107)*	*R.1.0*	
DAR-3.1.5MSV1.1	The reporting denominator shall be increased by one (1) for each qualifying demographic(s) AND each qualifying patient encounter CPT Category I code WHEN they are within the qualifying episode defined by QDCs.	*R.1.0*	
DAR-3.1.5MSV1.2	The reporting numerator shall be increased by one (1) if the qualifying claim includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MSV1.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MSV1.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes measure-specific QDCs indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MSV2	*Selective Visit Measure Identified via Demographic + Patient Encounter* *(Measures 129)*	*R.1.0*	
DAR-3.1.5MSV2.1	The reporting denominator shall be increased by one (1) for each qualifying demographic(s) AND each qualifying patient encounter CPT Category I OR patient encounter HCPCS code during the months of January, February, March, October, November and December.	*R.1.0*	
DAR-3.1.5MSV2.2	The reporting numerator shall be increased by one (1) for the PQRI healthcare delivery period if the qualifying claim includes any measure-specific base QDC with first and last expense dates within one of the specified months.	*R.1.0*	
DAR-3.1.5MSV2.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MSV2.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
Episode Measures Reporting Calculations			
Episode measures are typically reported once for each occurrence of a particular illness/condition during the reporting period. Note that there are episode measures that require custom analysis to determine the start and end of the defined episode. When an NPI/TIN reports on a specific episode measure for a beneficiary more than once during the episode time period, the measure is calculated once per episode with the most favorable instance used for the performance numerators (unless otherwise specified in the measure-specific requirements).			
DAR- 3.1.5MEP1	*Custom Coding Required: Episode Measure Identified via Demographic + DX + Patient Encounter with Qualifying Beneficiary Episode* *(Measures 31, 32, 34, 35, 36)*	*R.1.0*	
DAR-3.1.5MEP1.1	A qualifying episode shall be identified when beneficiary claims (not specific to NPI/TIN) with qualifying Inpatient CPT Category I codes listed in Appendix C are found on consecutive days for the PQRI healthcare delivery period.	*R.1.0*	
DAR-3.1.5MEP1.1.1	The last expense date corresponding with the qualifying line items (denominator DX or procedure codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine an episode.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MEP1.1.2	There shall be a maximum of one (1) episode per claim.	*R.1.0*	
DAR 3.1.5MEP1.2	The reporting denominator shall be increased by one (1) for the qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code for a qualifying episode.	*R.1.0*	
DAR-3.1.5MEP1.3	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP1.4	*Measures with exclusions (Measures 31, 32, 34, 35)*	*R.1.0*	
DAR-3.1.5MEP1.4.1	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP1.5	*Measures without exclusions (Measures 36)*	*R.1.0*	
DAR-3.1.5MEP1.5.1	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MEP1.6	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MEP2	*Custom Coding Required: Episode Measure Identified via Demographic + DX + Patient Encounter with Qualifying Beneficiary Episode (Measures 106)*	*R.1.0*	
DAR 3.1.5MEP2.1	A qualifying episode shall be identified by one G-code (G8467) on the claim indicating the start of an episode and a subsequent claim including a second G-code (G8466) indicating the end of an episode.	*R.1.0*	
DAR 3.1.5MEP2.1.1	The last expense date corresponding with the qualifying G-code line items on the claim starting the episode and the first expense date corresponding with the qualifying G-code line items on subsequent claims shall be used to determine an episode.	*R.1.0*	
DAR 3.1.5MEP2.2	The reporting denominator shall be increased by one (1) for the qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code for a qualifying episode.	*R.1.0*	
DAR-3.1.5MEP2.3	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MEP2.4	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP2.5	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes measure-specific QDCs indicating numerator compliance.	*R.1.0*	
DAR- 3.1.5MEP3	*Custom Coding Required: Episode Measure Identified via Demographic + DX + Patient Encounter with Qualifying Beneficiary Episode (Measures 116)*	*R.1.0*	
DAR 3.1.5MEP3.1	The reporting denominator shall be increased by one (1) for the qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code for all qualifying claims within a 21-day time frame.	*R.1.0*	
DAR 3.1.5MEP3.1.1	The last expense date corresponding with the qualifying line items (denominator DX or procedure codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine if those claim(s) fall within the 21-day time frame.	*R.1.0*	
DAR-3.1.5MEP3.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP3.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP3.4	The performance numerator shall be increased by one (1) for the measure if the first qualifying claim within the episode includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.15MEP4	*Custom Coding Required: Episode Measure Identified via Demographic + DX + Patient Encounter (Measures 56, 57, 58, 59)*	*R.1.0*	
DAR 3.1.5MEP4.1	The reporting denominator shall be increased by one (1) for the qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I code for all qualifying claims within a 45-day time frame.	*R.1.0*	
DAR 3.1.5MEP4.1.1	The last expense date corresponding with the qualifying line items (denominator DX or procedure codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine if those claim(s) fall within the 45-day time frame.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR 3.1.5MEP4.1.2	The reporting denominator shall NOT be increased when CPT Category I code 99291 is on the qualifying line item with POS ≠ 23.	*R.1.0*	
DAR-3.1.5MEP4.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR 3.1.5MEP4.2.1	CPT II 3027F-3P shall be considered to be a measure 57-specific QDC specific to numerator compliance.	*R.1.0*	
DAR 3.1.5MEP4.3	*Measures with Exclusions (Measures 57, 59)*	*R.1.0*	
DAR-3.1.5MEP4.3.1	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
3.1.5MEP4.4	*Measures with No Exclusions (Measures 56, 58)*	*R.1.0*	
DAR-3.1.5MEP4.4.1	The performance denominator value shall be calculated based on the reporting denominator for the measure.	*R.1.0*	
DAR-3.1.5MEP4.5	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP5	*Procedure Measure (Treated as an Episode Measure) Identified via Demographic + Isolated Procedure (Measures 43, 44)*	*R.1.0*	
DAR-3.1.5MEP5.1	The reporting denominator shall be increased by one (1) for each claim with a qualifying demographic AND qualifying procedure CPT Category I code with the following exception:	*R.1.0*	
DAR – 3.1.5MEP5.1.1	The reporting denominator is NOT increased when the claim includes CPT Category I codes listed in Appendix B.	*R.1.0*	
DAR-3.1.5MEP5.2	The reporting numerator shall be increased by one (1) for each claim in the denominator with any measure-specific base QDC reported on the same claim.	*R.1.0*	
DAR-3.1.5MEP5.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP5.4	The performance numerator shall be increased by one (1) for the measure if the qualifying procedure in the performance denominator includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP6	*Episode Measure Identified via Place of Service = 23 + Demographic + DX + Patient Encounter (Measures 54, 55)*	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR 3.1.5MEP6.1	The reporting denominator shall be increased by one (1) for each claim with qualifying demographic(s) AND POS = 23 AND ICD-9 AND patient encounter CPT Category I codes.	*R.1.0*	
DAR 3.1.5MEP6.1.1	Multiple ICD-9 codes on a single claim shall be counted once.	*R.1.0*	
DAR 3.1.5MEP6.1.2	POS = 23 shall only be included in analysis when it appears on a line item with a qualifying CPT Category I code.	*R.1.0*	
DAR-3.1.5MEP6.2	The reporting numerator shall be increased by one (1) if the qualifying claim includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP6.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP6.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-2.16MEP7	*Episode Measure Identified via Demographic + DX + Patient Encounter (Measure 65)*	*R.1.0*	
DAR 3.1.5MEP7.1	The reporting denominator shall be increased by one (1) for the qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I codes for all qualifying claims within a 10-day time frame.	*R.1.0*	
DAR 3.1.5MEP7.1.1	The last expense date corresponding with the qualifying line items (denominator DX or procedure codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine if those claim(s) fall within the 10-day time frame.	*R.1.0*	
DAR-3.1.5MEP7.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP7.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP7.4	The performance numerator shall be increased by one (1) for the measure if the first qualifying claim within the episode includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP8	*Episode Measure Identified via Demographic + DX + Patient Encounter (Measure 66)*	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR 3.1.5MEP8.1	The reporting denominator shall be increased by one (1) for each claim with qualifying demographic(s) AND ICD-9 AND patient encounter CPT Category I codes.	*R.1.0*	
DAR 3.1.5MEP8.1.1	Multiple ICD-9 codes on a single claim shall be counted once.	*R.1.0*	
DAR-3.1.5MEP8.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP8.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP8.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes measure-specific QDCs indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP9	*Episode Measure Identified via Place of Service = 23 + DX + Patient Encounter (Measure 28)*	*R.1.0*	
DAR-3.1.5MEP9.1	The reporting denominator shall be increased by one (1) for each claim with qualifying POS = 23 AND ICD-9 AND patient encounter CPT Category I code.	*R.1.0*	
DAR-3.1.5MEP9.1.1	Multiple ICD-9 codes on the same claim shall be counted once.	*R.1.0*	
DAR-3.1.5MEP9.1.2	POS = 23 shall only be included in analysis when it appears on a line item with a qualifying CPT Category I code.	*R.1.0*	
DAR-3.1.5MEP9.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP9.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP9.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP10	*Episode Measure Identified via DX + Procedure with a Qualifying Beneficiary Episode (Measure 104)*	*R.1.0*	
DAR 3.1.5MEP10.1	A qualifying episode shall be identified when beneficiary claims (not specific to NPI/TIN) with qualifying CPT Category I code(s) are found on consecutive days.	*R.1.0*	
DAR 3.1.5MEP10.1.1	A 30-day time period between claims with a qualifying denominator shall indicate a new qualifying episode.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR 3.1.5MEP10.1.1.1	The last expense date corresponding with the qualifying line items (denominator DX or procedure codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine if those claims fall within 30-days of the starting claim.	*R.1.0*	
DAR 3.1.5MEP10.2	The reporting denominator shall be increased by one (1) for the qualifying ICD-9 AND procedure CPT Category I code for a qualifying episode.		
DAR-3.1.5MEP10.3	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR- MEP10.4	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP10.5	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes measure-specific QDCs indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP11	*Custom Coding Required; Episode Measure Identified via Demographic + DX + Patient Encounter OR Procedure with Qualifying Beneficiary Episode (Measures 24, 40)*	*R.1.0*	
DAR-3.1.5MEP11.1	The reporting denominator shall be increased by one (1) for each qualifying beneficiary demographic(s) BOTH unique ICD9 code AND patient encounter CPT Category I code OR procedure CPT Category I code only.	*R.1.0*	
DAR-3.1.5MEP11.1.1	Multiple claims with any intersecting ICD-9 code shall be counted once (i.e. Unique ICD-9 codes appearing on more than one claim are only counted once. Other unique ICD-9 codes appearing within those claims and on qualifying claims beyond what is included in that instance are all counted as one episode).	*R.1.0*	
DAR-3.1.5MEP11.1.2	Multiple qualifying ICD-9 or CPT Category I codes on a single claim shall be counted a maximum of once per claim.	*R.1.0*	
DAR-3.1.5MEP11.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP11.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MEP11.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP12	*Custom Coding Required: Episode Measure Identified via Demographic + DX + DX + Patient Encounter with Qualifying Beneficiary Episode (Measure 33)*	*R.1.0*	
DAR 3.1.5MEP12.1	A qualifying episode shall be identified when beneficiary claims (not specific to NPI/TIN) with qualifying Inpatient CPT Category I codes listed in Appendix C are found on consecutive days for the PQRI healthcare delivery period.	*R.1.0*	
DAR 3.1.5MEP12.1.1	The last expense date corresponding with the qualifying line items (denominator DX or procedure codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine an episode.	*R.1.0*	
DAR 3.1.5MEP12.1.2	There shall be a maximum of one (1) episode per claim.	*R.1.0*	
DAR 3.1.5MEP12.2	The reporting denominator shall be increased by one (1) for each qualifying beneficiary demographic(s) AND two qualifying ICD-9s AND patient encounter CPT Category I code for a qualifying episode.	*R.1.0*	
DAR-3.1.5MEP12.3	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP12.4	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP12.5	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP13	*Custom Coding Required: Episode Measure Identified via Demographic + Patient Encounter (Measure 132)*	*R.1.0*	
DAR-3.1.5MEP13.1	The reporting denominator shall be increased by one (1) for the episode for all qualifying beneficiary demographic(s) AND patient encounter CPT Category I codes OR patient encounter HCPCS code.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MEP13.1.1	Multiple claims with any intersecting ICD-9 code shall be counted once (i.e. Unique ICD-9 codes appearing on more than one claim are only counted once. Other unique ICD-9 codes appearing within those claims and on qualifying claims beyond what is included in that instance are all counted as one episode).	*R.1.0*	
DAR-3.1.5MEP13.1.2	Multiple ICD-9 or patient encounter codes on a single claim shall be counted a maximum of once per claim.	*R.1.0*	
DAR-3.1.5MEP13.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP13.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP13.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP14	*Custom Coding Required: Episode Measure Identified via Demographic + DX + Patient Encounter (Measure 91, 93)*	*R.1.0*	
DAR-3.1.5MEP14.1	The reporting denominator shall be increased by one (1) for the qualifying beneficiary demographic(s) AND ICD-9 codes AND patient encounter CPT Category I codes for all qualifying claims within a 30-day time frame.	*R.1.0*	
DAR-3.1.5MEP14.1.1	The last expense date corresponding with the qualifying line items (denominator DX or procedure codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine if those claim(s) fall within the 30-day time frame.	*R.1.0*	
DAR-3.1.5MEP14.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP14.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP14.4	The performance numerator shall be increased by one (1) for the measure if the first qualifying claim within the episode includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MEP15	*Custom Coding Required: Episode Measure Identified via Demographic + Patient Encounter (Measure 46)*	*R.1.0*	
DAR-3.1.5MEP15.1	The reporting denominator shall be increased by one (1) for the episode look back period for all qualifying beneficiary demographic(s) AND patient encounter CPT Category I codes WHEN the qualifying CPT Category I code for the beneficiary was found within 60 days of the look back episode.	*R.1.0*	
DAR-3.1.5MEP15.1.1	The look back episode shall be the most recent beneficiary claim (not specific to NPI/TIN) with non-denominator inpatient codes listed in Appendix D.	*R.1.0*	
DAR-3.1.5MEP15.1.1.1	The last expense date corresponding with the qualifying line items (non-denominator inpatient codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine an episode.	*R.1.0*	
DAR-3.1.5MEP15.1.1.2	If multiple outpatient visits are identified on the same claim, the line item with the latest expense date shall be used.		
DAR-3.1.5MEP15.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP15.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP15.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes measure-specific QDCs indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP16	*Custom Coding Required: Episode Measure Identified via Demographic + DX + Patient Encounter (Measure 96, 97, 98)*	*R.1.0*	
DAR-3.1.5MEP16.1	The reporting denominator shall be increased by one (1) for the qualifying beneficiary demographic(s) AND ICD-9 codes AND patient encounter CPT Category I codes for all qualifying claims within a 90-day time frame.	*R.1.0*	
DAR-3.1.5MEP16.1.1	The last expense date corresponding with the qualifying line items (denominator DX or procedure codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine if those claim(s) fall within the 90-day time frame.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-3.1.5MEP16.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP16.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP16.4	The performance numerator shall be increased by one (1) for the measure if the first qualifying claim within the episode includes a measure-specific QDC indicating numerator compliance.	*R.1.0*	
DAR-3.1.5MEP17	*Episode Measure Identified via Demographic + Place of Service ≠ 23 + Patient Encounter (Measure 75)*	*R.1.0*	
DAR-3.1.5MEP17.1	A qualifying episode shall be identified when beneficiary claims (not specific to NPI/TIN) with qualifying CPT Category I codes are found on consecutive days.	*R.1.0*	
DAR-3.1.5MEP17.1.1	Beneficiary claim(s) with 99251-99255 CPT Category I codes shall be counted in the consecutive days of the episode.	*R.1.0*	
DAR-3.1.5MEP17.1.1.1	The last expense date corresponding with the qualifying line items (99251-99255 CPT Category I codes) on the claim starting the episode and the first expense date corresponding with the qualifying line items on subsequent claims shall be used to determine an episode.	*R.1.0*	
DAR-3.1.5MEP17.1.2	The reporting denominator shall be increased by one (1) for the qualifying beneficiary demographic(s) AND POS ≠ 23 AND patient encounter CPT Category I codes for a qualifying episode.	*R.1.0*	
DAR-3.1.5MEP17.1.2.1	Qualifying line items with POS = 23 shall be excluded from analysis.	*R.1.0*	
DAR-3.1.5MEP17.2	The reporting numerator shall be increased by one (1) if the qualifying episode includes any measure-specific base QDC.	*R.1.0*	
DAR-3.1.5MEP17.3	The performance denominator value shall be calculated based on the reporting denominator for the measure less instances of measure-specific exclusion QDC(s).	*R.1.0*	
DAR-3.1.5MEP17.4	The performance numerator shall be increased by one (1) for the measure if the qualifying claim within the episode includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-4	**Individual NPI within TIN reporting and performance rates shall be calculated for each measure by dividing the total reporting and performance numerators for the individual NPI/TIN by the total reporting and performance denominators.**	*R.1.0*	
DAR-5	**For the claims-based standard reporting methodly, the system shall determine the national comparison rates for clinical performance for each measure by dividing the sum performance numerator for all participating individual NPI/TINs divided by the total performance denominator.** **Note: The performance numerator includes only reportable instances for NPI/TINs submitting QDC appropriately (as specified for the measure) less applicable exclusions.**	*R.1.0*	
DAR-5	**For the claims-based standard reporting methodology, the system shall determine the national comparison rates for clinical performance for each measure by dividing the sum performance numerator for all participating individual NPI/TINs divided by the total performance denominator.** **Note: The performance numerator includes only reportable instances for NPI/TINs submitting QDC appropriately (as specified for the measure) less applicable exclusions.**	*R.1.0*	
DAR-5.1	**For the claims-based standard reporting method only, the system shall determine the number of NPI/TINs falling within specific national comparison rate percentile ranges for clinical performance for each measure by.**	*R.1.0*	
	Measures Groups Analytics		
DAR-6	Measures Groups Methods via Claims:	*R.1.0*	
DAR-6.1	The system shall analyze all Medicare Part B claims for professional services rendered between July 1, 2008 and December 31, 2008 and received into NCH by February 27, 2009 (i.e., through the February 2009 TAP file).	*R.1.0*	
DAR-6.2	There shall be four unique measures groups available for eligible professionals to report:	*R.1.0*	
DAR-6.2.1	Diabetes Measures 1, 2, 3, 117, 119	*R.1.0*	
DAR-6.2.2	ESRD Measures 78, 79, 80, 81	*R.1.0*	
DAR-6.2.3	Preventive Care Measures 39, 48, 110, 111, 112, 113, 114, 115, 128	*R.1.0*	
DAR-6.2.4	CKD Measures 120, 121, 122, 123.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-6.3	The measures within each measures group shall be processed as defined in the Aggregation for Individual Performing NPI within TIN Measure Calculations above.	*R.1.0*	
DAR-6.3.1	Measures 80, 81, 122, and 123 shall not be calculated as defined in the Aggregation for Individual Performing NPI within TIN Measure Calculations. For measures groups analysis they shall be calculated as patient-process type measures, once per reporting period.	*R.1.0*	
DAR-6.3.2	Performance calculations for patient-intermediate measures shall use the most recent qualifying claim that includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR-6.3.3	Performance calculations for patient-process measures (and those measures being treated as patient-process measures) shall use the most favorable qualifying claim that includes measure-specific QDC(s) indicating numerator compliance.	*R.1.0*	
DAR-6.4	There shall be one unique G-code assigned to each measures group.	*R.1.0*	
DAR-6.5	Measures Groups Consecutive Method	*R.1.0*	
DAR-6.5.1	The measures groups consecutive method start date shall be determined for a TIN/NPI by the earliest first expense date for the reporting period associated with a claim containing a measures group-specific G-code.	*R.1.0*	
DAR-6.5.2	The cohort of eligible claims for a TIN/NPI shall be determined by the following:	*R.1.0*	
DAR-6.5.2.1	Each eligible claim shall contain at least one measures group related code (common denominator codes as seen in Appendix E) that satisfies the denominator for at least one measure within the measures group AND the beneficiary shall satisfy the demographic requirements for at least one measure within the measures group.	*R.1.0*	
DAR-6.5.2.1.1	For the Preventive Care measures group only beneficiaries on the eligible claim that are $\geq$ 50 years of age shall be included in analysis.	*R.1.0*	
DAR-6.5.2.3	Each eligible claim shall have at least one first expense date corresponding to a measures group related code that is $\geq$ the start date.	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-6.5.3	The measures group consecutive method reference date shall be the earliest first expense date based on the line item corresponding to a measures group related code that is ≥ the start date.	*R.1.0*	
DAR-6.5.4	The cohort of eligible beneficiaries shall be determined by the following:	*R.1.0*	
DAR-6.5.4.1	At least fifteen eligible beneficiaries shall be selected chronologically from the cohort of eligible claims sorted by reference date.	*R.1.0*	
DAR-6.5.4.1.1	When multiple beneficiaries are identified with the same final reference date, the eligible cohort shall include those beneficiaries for which all measures group measures applicable to the beneficiary were reported.	*R.1.0*	
DAR-6.5.4.1.1.1	If the final number of beneficiaries where reporting criteria was met is < 15, all beneficiaries identified on the final reference date shall be included in the eligible cohort.	*R.1.0*	
DAR-6.5.5	Incentive eligibility via the measures groups consecutive method shall be determined by claims including the following:	*R.1.0*	
DAR-6.5.5.1	All measures within the measures group for which each eligible beneficiary within the cohort satisfies the demographic requirements on the claim that triggered cohort inclusion shall be reported.	*R.1.0*	
DAR-6.5.5.1.1	For measure 120 within the CKD measures group the TIN/NPI shall only be required to report on eligible beneficiaries for whom the additional diagnosis codes were found on the claim that triggered cohort inclusion (See Appendix E for the additional codes.)	*R.1.0*	
DAR-6.5.5.2	Valid QDC(s) identified on any claim with first and last expense dates during the reporting period shall be identified.	*R.1.0*	
DAR-6.5.5.2.1	For measures 80, 81, 122, and 123 only the QDC(s) identified within the calendar month for the eligible claim, which triggered cohort inclusion, was reported shall be included in the analysis.	*R.1.0*	
DAR-6.6	Measures Group 80% Method	*R.1.0*	
DAR-6.6.1	The cohort of eligible claims for a TIN/NPI shall be determined by the following:	*R.1.0*	

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I.D.	Requirement Description	Release	Trace
DAR-6.6.1.1	Each eligible claim shall contain at least one measures group related code (common denominator codes as seen in Appendix E) that satisfies the denominator for at least one measure within the measures group AND the beneficiary shall satisfy the demographic requirements for at least one measure within the measures group.	*R.1.0*	
DAR-6.6.1.2	Each eligible claim shall include line items corresponding to eligible denominator codes with first and last expense dates within the reporting period.	*R.1.0*	
DAR-6.6.2	All unique beneficiaries identified in the cohort of eligible claims shall be included in the cohort of eligible beneficiaries.	*R.1.0*	
DAR-6.6.3	Incentive eligibility via the measures group 80% method shall be determined by claims including the following:	*R.1.0*	
DAR-6.6.3.1	All measures within the measures group for which each eligible beneficiary within the cohort satisfing the demographic requirements shall be reported.	*R.1.0*	
DAR-6.6.3.2	Valid QDC(s) shall be identified on 80% of claims with first and last expense dates during the reporting period	*R.1.0*	

3.4 – Look and Feel/Usability Requirements

Define the requirements for the user interface to ensure the appearance of the product conforms to the customer's expectations. Consider any branding, style, colors, degree of interaction, etc.

I.D.	Requirement Description	Release	Trace
N/A			

3.5 - Performance and Support Requirements

Specify the speed and latency (response times) expected of the product. Identify the reliability and availability requirements.

I.D.	Requirement Description	Release	Trace
N/A			

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3.6 - Capacity/Scalability/Longevity Requirements

Define the volumes that the product must be able to support and the volume of data to be stored. Identify the expected increases in size that the product must be able to support. Identify the expected lifetime of the product.

I.D.	Requirement Description	Release	Trace
N/A			

3.7 - Compliance/Legal Requirements

Define the legislative and/or legal requirements for this system, including any external stakeholder agreements.

I.D.	Requirement Description	Release	Trace
CLR-1	PQRI 2008 measures shall be comprised of measures that are adopted or endorsed by a consensus process.	R.1.0	
CLR-2	PQRI 2008 measures shall be finalized and published in the Federal Register not later than November 15, 2007.	R.1.0	
CLR-3	PQRI 2008 measures shall be effective as published December 31, 2007 throughout the PQRI health care delivery period.	R.1.0	

3.8 - Reporting Requirements

Define the reporting needs expected from the product.

I.D.	Requirement Description	Release	Trace
N/A			

3.9 - External Interfacing Requirements

Define any external application that will interface with this project and a high level description of the possible requirements needed for that application.

I.D.	Requirement Description	Release	Trace
EI-1	PQRI 2008 data and analytic processing will produce data results used to populate PQRI claims-based integrated final feedback reports.	R.1.0	
EI-2	PQRI 2008 data and analytic processing will produce data results used to populate CMS management reports	R.1.0	
EI-3	PQRI 2008 data and analytic processing will produce data results used to populate CMM, ORDI and CPC payment files.	R.1.0	
EI-4	PQRI 2008 data and analytic processing will produce data results that feed the PQRI 2008 integrated incentive payment processing.	R.1.0	

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Section 4 – Functionality

4.0 – Functional Requirements

Functional requirements are things the product must do – an action that the product must take if it is to provide useful functionality for its user. They arise from the fundamental reason for the product's existence.

I.D.	Requirement Description	Release	Trace
N/A			

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Section 5 - Final Product Requirements Approved By:

By signing this document you are acknowledging that you have reviewed this document for technical accuracy for your area of responsibility/expertise along with acceptance and concurrence with this plan. This plan becomes effective the date all signatures have been obtained.

Role	Name	Signature	Date
OCSQ - QMHAG	Latousha Leslie		
PQRI Clinical Lead	Sylvia Pubil		
PQRI GTL	Karen McCoy		

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By signing this document you are acknowledging that you have reviewed this document for technical accuracy for your area of responsibility/expertise.

Role	Name	Signature	Date
Project Manager:	Molly Dragert		
PQRI Project Director:	Doug Young		
PPIC Manager:	Janet Reynolds		
PQRI Health Informatics Lead:	Becky Fender		
PQRI Health Informatics Analytic Lead:	Susie Joe		
PQRI Business Analysis Lead:	Rachel Merriam		
PQRI QA Lead:	Patsy Russo		
PQRI Development Lead:	Carolyn Owens		
Database Architect Lead:	Kevin Hill		

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Section 6 - Supporting Documentation

List all attachments applicable to this project (i.e. report or screen mock ups).

The PQRI 2008 Data and Analytics Requirements support the PQRI Requirements Document available in svn://c2r7u07/projects/system/Pqri/trunk/Documentation/PBR_PQRI Requirements Document IFMC.doc.

Reference Number	Document	Location/Filename	Release	Trace
SD-1	*Measure Descriptions*	*Appendix A*	R.1.0	
SD-2	*PQRI Coding for Quality Handbook Final*	*http://www.cms.hhs.gov/PQRI/Downloads/2008PQRICodingforQualityHandbook.pdf*	R.1.0	
SD-3	*2008 PQRI Specifications Document*	*http://www.cms.hhs.gov/PQRI/downloads/2008PQRIMeasureSpecifications123107.pdf?agree=yes&next=Accept*	R.1.0	
SD-4	*2008 PQRI Measures Groups Handbook*	*http://www.cms.hhs.gov/PQRI/Downloads/PQRI2008ClaimsBasedMeasuresGroupsHandbook.pdf*	R.1.0	

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Appendix A – Measure Descriptions

Below are the measures included for analysis.

Measure #	Measure Title	Formal Measure Type (Tag)*
1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus	Patient - Intermediate
2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus	Patient - Intermediate
3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus	Patient - Intermediate
4	Screening for Future Fall Risk	Patient - Process
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	Patient - Process
6	Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease	Patient - Process
7	Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)	Patient - Process
8	Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction	Patient - Process
9	Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression	Episode
10	Stroke: CT or MRI Reports	Procedure
11	Stroke: Carotid Imaging Reports	Procedure
12	Primary Open Angle Glaucoma: Optic Nerve Evaluation	Patient - Process
14	Age-Related Macular Degeneration: Dilated Macular Examination	Patient - Process
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy	Patient - Process
19	Diabetic Retinopathy: Communication with the PCP	Patient - Process
20	Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician	Procedure
21	Perioperative: Selection of Antibiotic - 1st OR 2nd Gen Cephalosporin	Procedure
22	Perioperative: Discontinuation of Prophylactic Antibiotics (Non-Cardiac)	Procedure
23	Perioperative: Venous Thromboembolism (VTE) Prophylaxis	Procedure
24	Osteoporosis: Communication with the Physician Managing Ongoing Care Post-Fracture	Episode
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI)	Episode
30	Perioperative Care: Timing of Prophylactic Antibiotics – Administering Physician	Procedure

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Measure #	Measure Title	Formal Measure Type (Tag)*
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage	Episode
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy	Episode
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge	Episode
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered	Episode
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia	Episode
36	Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services	Episode
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	Patient - Process
40	Osteoporosis: Management Following Fracture	Episode
41	Osteoporosis: Pharmacologic Therapy	Patient - Process
43	Use of Internal Mammary artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery	Procedure
44	Preoperative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery	Procedure
45	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)	Procedure
46	Medication Reconciliation	Episode
47	Advance Care Plan	Patient - Process
48	Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	Patient - Process
49	Characterization of Urinary Incontinence in Women Aged 65 Years and Older	Patient - Process
50	Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older	Patient - Process
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation	Patient - Process
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy	Patient - Process
53	Asthma: Pharmacologic Therapy	Patient - Process
54	Electrocardiogram Performed for Non-Traumatic Chest Pain	Episode
55	Electrocardiogram Performed for Syncope	Episode
56	Vital Signs for Community-Acquired Bacterial Pneumonia	Episode
57	Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia	Episode
58	Assessment of Mental Status for Community-Acquired Pneumonia	Episode
59	Empiric Antibiotic for Community-Acquired Bacterial Pneumonia	Episode
64	Asthma Assessment	Patient - Process

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Measure #	Measure Title	Formal Measure Type (Tag)*
65	Appropriate Treatment for Children with Upper Respiratory Infection (URI)	Episode
66	Appropriate Testing for Children with Pharyngitis	Episode
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow	Patient - Process
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy	Patient - Process
69	Multiple Myeloma: Treatment with Bisphosphonates	Patient - Process
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry	Patient - Process
71	Hormonal Therapy for Stage IC - III ER/PR Positive Breast Cancer	Patient - Process
72	Chemotherapy for Stage III Colon Cancer Patients	Patient - Process
73	Plan for Chemotherapy Documented Before Chemotherapy Administered	Patient - Process
74	Radiation Therapy Recommended for Invasive Breast Cancer Patients who have Undergone Breast Conserving Surgery	Patient-Process
75	Prevention of Ventilator-Associated Pneumonia – Head Elevation	Episode
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI) – Central Venous Catheter Insertion Protocol	Procedure
77	Assessment of GERD Symptoms in Patients Receiving Chronic Medication for GERD	Patient - Process
78	Vascular Access for Patients Undergoing Hemodialysis	Patient - Process
79	Influenza Vaccination in Patients with End Stage Renal Disease (ESRD)	Patient - Process
80	Plan of Care for ESRD Patients with Anemia	Patient-Periodic
81	Plan of Care for Inadequate Hemodialysis in ESRD Patients	Patient-Periodic
82	Plan of Care for Inadequate Peritoneal Dialysis	Patient-Periodic
83	Testing of Patients with Chronic Hepatitis C (HCV) for Hepatitis C Viremia	Patient - Process
84	Initial Hepatitis C RNA Testing	Patient - Process
85	HCV Genotype Testing Prior to Therapy	Patient - Process
86	Consideration for Antiviral Therapy in HCV Patients	Patient - Process
87	HCV RNA Testing at Week 12 of Therapy	Patient - Process
89	Counseling of Patients Regarding Use of Contraception Prior to Starting Antiviral Therapy	Patient - Process
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Treatment	Patient - Process
91	Acute Otitis Externa (AOE): Topical Therapy	Episode

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Measure #	Measure Title	Formal Measure Type (Tag)*
92	Acute Otitis Externa (AOE): Pain Assessment	Visit
93	Acute Otitis Externa (AOE): Systemic Antimicrobial Therapy – Avoidance of Inappropriate Use	Episode
94	Otitis Media with Effusion (OME): Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility	Visit
95	Otitis Media with Effusion (OME): Hearing Testing	Procedure
96	Otitis Media with Effusion (OME): Antihistamines or Decongestants - Avoidance of Inappropriate Use	Episode
97	Otitis Media with Effusion (OME): Systemic Antimicrobials – Avoidance of Inappropriate Use	Episode
98	Otitis Media with Effusion (OME): Systemic Corticosteroids – Avoidance of Inappropriate Use	Episode
99	Breast Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer	Procedure
100	Colorectal Cancer Patients who have a pT and pN Category and Histologic Grade for Their Cancer	Procedure
101	Appropriate Initial Evaluation of Patients with Prostate Cancer	Patient-Process
102	Inappropriate Use of Bone Scan for Staging Low-Risk Prostate Cancer Patients	Procedure
103	Review of Treatment Options in Patients with Clinically Localized Prostate Cancer	Patient-Process
104	Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients	Episode
105	Three-dimensional Radiotherapy for Patients with Prostate Cancer	Procedure
106	Patients who have Major Depression Disorder who meet DSM IV Criteria	Episode
107	Patients who have Major Depression Disorder who are Assessed for Suicide Risks	Selective-Visit
108	Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy in Rheumatoid Arthritis	Patient - Process
109	Patients with Osteoarthritis who have an Assessment of Their Pain and Function	Visit
110	Influenza Vaccination for Patients > 50 Years Old	Patient - Process
111	Pneumonia Vaccination for Patients 65 years and Older	Patient - Process
112	Screening Mammography	Patient - Process
113	Colorectal Cancer Screening	Patient - Process
114	Inquiry Regarding Tobacco Use	Patient - Process
115	Advising Smokers to Quit	Patient - Process

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Measure #	Measure Title	Formal Measure Type (Tag)*
116	Inappropriate Antibiotic Treatment for Adults with Acute Bronchitis	Episode
117	Dilated Eye Exam in Diabetic Patient	Patient - Process
118	Angiotensin Converting Enzyme Inhibitor (ACE) or Angiotensin Receptor Blocker (ARB) Therapy for Patients with Coronary Artery Disease and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	Patient - Process
119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients	Patient - Process
120	ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD	Patient - Process
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)	Patient - Process
122	Chronic Kidney Disease (CKD): Blood Pressure Management	Visit
123	Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)	Patient-Periodic
124	HIT- Adoption of Health Information Technology (Electronic Health Records)	Visit
125	HIT- Adoption/Use of e-Prescribing	Visit
126	Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation	Patient - Process
127	Diabetic Foot and Ankle Care, Ulcer Prevention – Evaluation of Footwear	Patient - Process
128	Universal Weight Screening and Follow-Up	Patient - Intermediate
129	Universal Influenza Vaccine Screening and Counseling	Selective Visit
130	Universal Documentation and Verification of Current Medications in the Medical Record	Visit
131	Pain Assessment Prior to Initiation of Patient Treatment	Visit
132	Patient Co-Development of Treatment Plan/Plan of Care	Episode
133	Screening for Cognitive Impairment	Patient - Process
134	Screening for Clinical Depression	Patient - Process

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Appendix B – Non-Isolated Cardiovascular Codes

33010, 33011, 33015, 33020, 33025, 33030, 33031, 33050, 33120, 33130, 33140, 33141, 33202, 33203, 33206, 33207, 33208, 33210, 33211, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33250, 33251, 33254, 33255, 33256, 33261, 33265, 33266, 33282, 33284, 33300, 33305, 33310, 33315, 33320, 33321, 33322, 33330, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33412, 33413, 33414, 33415, 33416, 33417, 33420, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33468, 33470, 33471, 33472, 33474, 33475, 33476, 33478, 33496, 33500, 33501, 33502, 33503, 33504, 33505, 33506, 33507, 33530, 33542, 33545, 33548, 33572, 33600, 33602, 33606, 33608, 33610, 33611, 33612, 33615, 33617, 33619, 33641, 33645, 33647, 33660, 33665, 33670, 33675, 33676, 33677, 33681, 33684, 33688, 33690, 33692, 33694, 33697, 33702, 33710, 33720, 33722, 33724, 33726, 33730, 33732, 33735, 33736, 33737, 33750, 33755, 33762, 33764, 33766, 33767, 33768, 33770, 33771, 33774, 33775, 33776, 33777, 33778, 33779, 33780, 33781, 33786, 33788, 33800, 33802, 33803, 33813, 33814, 33820, 33822, 33824, 33840, 33845, 33851, 33852, 33853, 33860, 33861, 33863, 33870, 33875, 33877, 33880, 33881, 33883, 33884, 33886, 33889, 33891, 33910, 33915, 33916, 33917, 33920, 33922, 33924, 33925, 33926, 33930, 33933, 33935, 33940, 33944, 33945, 34001, 34051, 34101, 34111, 34151, 34201, 34203, 34401, 34421, 34451, 34471, 34490, 34501, 34502, 34510, 34520, 34530, 34800, 34802, 34803, 34804, 34805, 34808, 34812, 34813, 34820, 34825, 34826, 34830, 34831, 34832, 34833, 34834, 34900, 35001, 35002, 35005, 35011, 35013, 35021, 35022, 35045, 35081, 35082, 35091, 35092, 35102, 35103, 35111, 35112, 35121, 35122, 35131, 35132, 35141, 35142, 35151, 35152, 35180, 35182, 35184, 35188, 35189, 35190, 35201, 35206, 35207, 35211, 35216, 35221, 35226, 35231, 35236, 35241, 35246, 35251, 35256, 35261, 35266, 35271, 35276, 35281, 35286, 35301, 35302, 35303, 35304, 35305, 35306, 35311, 35321, 35331, 35341, 35351, 35355, 35361, 35363, 35371, 35372, 35390, 35400, 35450, 35452, 35454, 35456, 35458, 35459, 35460, 35470, 35471, 35472, 35473, 35474, 35475, 35476, 35480, 35481, 35482, 35483, 35484, 35485, 35490, 35491, 35492, 35493, 35494, 35495, 35501, 35506, 35508, 35509, 35511, 35512, 35515, 35516, 35518, 35521, 35522, 35525, 35526, 35531, 35533, 35536, 35537, 35538, 35539, 35540, 35548, 35549, 35551, 35556, 35558, 35560, 35563, 35565, 35566, 35571, 35583, 35585, 35587, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 35681, 35682, 35683, 35685, 35686, 35691, 35693, 35694, 35695, 35697, 35700, 35701, 35721, 35741, 35761, 35800, 35820, 35840, 35860, 35870, 35875, 35876, 35879, 35881, 35883, 35884, 35901, 35903, 35905, 35907, 36000, 36002, 36005, 36010, 36011, 36012, 36013, 36014, 36015, 36100, 36120, 36140, 36145, 36160, 36200, 36215, 36216, 36217, 36218, 36245, 36246, 36247, 36248, 36260, 36261, 36262, 36299, 36400, 36405, 36406, 36410, 36415, 36416, 36420, 36425, 36430, 36440, 36450, 36455, 36460, 36468, 36469, 36470, 36471, 36475, 36476, 36478, 36479, 36481, 36500, 36510, 36511, 36512, 36513, 36514, 36515, 36516, 36522, 36540, 36550, 36555, 36556, 36557, 36558, 36560, 36561, 36563, 36565, 36566, 36568, 36569, 36570, 36571, 36575, 36576, 36578, 36580, 36581, 36582, 36583, 36584, 36585, 36589, 36590, 36595, 36596, 36597, 36598, 36600, 36620, 36625, 36640, 36660, 36680, 36800, 36810, 36815, 36818, 36819, 36820, 36821, 36822, 36823, 36825, 36830, 36831, 36832, 36833, 36834, 36835, 36838, 36860, 36861, 36870, 37140, 37145, 37160, 37180, 37181, 37182, 37183, 37184, 37185, 37186, 37187, 37188, 37195, 37200, 37201, 37202, 37203, 37204, 37205, 37206, 37207, 37208, 37209, 37210, 37215, 37216, 37250, 37251, 37500, 37501, 37565, 37600, 37605, 37606, 37607, 37609, 37615, 37616, 37617, 37618, 37620, 37650, 37660, 37700, 37718, 37722, 37735, 37760, 37765, 37766, 37780, 37785, 37799

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Appendix C – Inpatient CPT Category I Codes Used for Stoke Measure Analysis (Measures 31, 32, 34, 35, 36)

99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99291

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Appendix D – Non-denominator Inpatient Codes

99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236, 99238, 99239, 99251, 99252, 99253, 99254, 99255, 99291

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Appendix E – Common Denominator Coding for Measures Groups

DM – Encounter Codes

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

DM – DX Codes

250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04

ESRD – Encounter Codes

90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319

ESRD – DX Codes

585.6

Preventive – Encounter Codes

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

CKD – Encounter Codes

99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245

CKD – DX Codes

585.4, 585.5

Additional DX Codes for Measure 120:

401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93, 791.0

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Appendix F – PQRI 2008 Measure Flows

PQRI2008DataAndAnalyticProcessing_AppendixF.zip

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