

## 2010 PQRI Measures for Consideration by Oncology Providers: Cancer Care Measures

The table below includes measures directly relevant to oncology providers as well as general measures that may be applicable.  
See [http://www.cms.hhs.gov/PQRI/Downloads/2010PQRIMeasSpecManIforClaimsRegisReptgIndivlMeasRelNotes\\_122109.zip](http://www.cms.hhs.gov/PQRI/Downloads/2010PQRIMeasSpecManIforClaimsRegisReptgIndivlMeasRelNotes_122109.zip)  
for a complete list of measures and specifications.

<b>Measure #67: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow</b>			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
<p>All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia</p> <p><b>ICD-9 diagnosis codes:</b> 204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 208.00, 208.22, 238.72, 238.73, 238.74, 238.75</p> <p><b>AND</b></p> <p><b>CPT E/M service codes:</b> 99201-99205, 99212-99215</p>	<p><b>Baseline Cytogenetic Testing Performed</b>  <b>CPT II 3155F:</b> Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment</p>	Once per reporting period	<i>Claims or Registry reporting.</i>
	<p><b>Baseline Cytogenetic Testing not Performed for Medical Reasons</b>  <b>CPT II 3155F 1P:</b> Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., no liquid bone marrow or fibrotic marrow)</p>		
	<p><b>Baseline Cytogenetic Testing not Performed for Patient Reasons</b>  <b>CPT II 3155F 2P:</b> Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., at time of diagnosis receiving palliative care or not receiving treatment as defined above)</p>		
	<p><b>Baseline Cytogenetic Testing not Performed for System Reasons</b>  <b>CPT II 3155F 3P:</b> Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., patient previously treated by another physician at the time cytogenetic testing performed)</p>		
	<p><b>Baseline Cytogenetic Testing not Performed, Reason Not Specified</b>  <b>CPT II 3155F 8P:</b> Cytogenetic testing not performed on bone marrow at time of diagnosis or prior to initiating treatment, reason not otherwise specified</p>		

Measure #68: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
<p>All patients aged 18 years and older with a diagnosis of MDS</p> <p><b>ICD-9 diagnosis codes:</b> 238.72, 238.73, 238.74, 238.75</p> <p><b>AND</b></p> <p><b>CPT E/M service codes:</b> 99201-99205, 99212-99215</p>	<p>Patients with documentation of iron stores prior to initiating erythropoietin therapy</p> <hr/> <p><b>QUALITY-DATA CODING OPTIONS FOR REPORTING SATISFACTORILY:</b></p> <p><b>Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy Performed</b> <i>(Two CPT II codes are required on the claim to submit this numerator option)</i></p> <p><b>CPT II 3160F:</b> Documentation of iron stores prior to initiating erythropoietin therapy</p> <p><b>AND</b></p> <p><b>CPT II 4090F:</b> Patient receiving erythropoietin therapy</p> <p><b><u>OR</u></b></p> <p><b>Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy NOT Performed for System Reasons</b> <i>(Two CPT II codes are required on the claim to submit this numerator option)</i></p> <p>Append a modifier (3P) to CPT II 3160F to report documented circumstances that appropriately exclude patients from the denominator</p> <p><b>CPT II 3160F with 3P:</b> Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy</p> <p><b>AND</b></p> <p><b>CPT II 4090F:</b> Patient receiving erythropoietin therapy</p> <hr/> <p><b>If patient is not eligible for this measure because patient is not receiving erythropoietin therapy, report:</b> <i>(One CPT II code is required on the claim form to submit this numerator option)</i></p> <p><b>CPT II 4095F:</b> Patient not receiving erythropoietin therapy</p> <p><b><u>OR</u></b></p>	<p>Once per reporting period</p>	<p><i>Claims or Registry reporting.</i></p> <p>Report this measure a minimum of once per reporting period for ALL MDS patients seen during the reporting period, regardless of when the documentation of iron stores occurs.</p> <p>The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. This may require the submission of multiple numerator codes.</p> <p><b>Definitions:</b></p> <p><b>Documentation of iron stores:</b> includes either bone marrow examination including iron stain OR serum iron measurement by ferritin or serum iron and TIBC.</p> <p><b>Erythropoietin therapy:</b> includes the following medications: epoetin and darbepoetin for the purpose of this measure.</p>

	<p><b>Documentation of Iron Stores Prior to Initiating Erythropoietin Therapy NOT Performed, Reason not Specified</b>  <i>(Two CPT II codes are required on the claim form to submit this numerator option)</i>  Append a reporting modifier (8P) to CPT II 3160F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified  <b>CPT II 3160F with 8P:</b> Iron stores prior to initiating erythropoietin therapy NOT documented, reason not otherwise specified  AND  <b>CPT II 4090F:</b> Patient receiving erythropoietin therapy</p>		
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<b>Measure #69: Multiple Myeloma: Treatment with Bisphosphonates</b>			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
<p>All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission</p> <p><b>ICD-9 diagnosis code:</b> 203.00, 203.02</p> <p><b>AND</b></p> <p><b>CPT E/M service codes:</b> 99201-99205, 99212-99215</p>	<p><b>Intravenous Bisphosphonate Therapy Prescribed or Received</b>  <b>CPT II 4100F:</b> Bisphosphonate therapy, intravenous, ordered or received</p>	Once per reporting period	<p><i>Claims or Registry reporting.</i></p> <p>For the purpose of this measure, bisphosphonate therapy includes pamidronate and zoledronate.</p> <p>Measure applies to all patients aged 18 and over with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonate therapy within the 12 month reporting period.</p>
	<p><b>Intravenous Bisphosphonate Therapy not Prescribed or Received for Medical Reasons</b>  <b>CPT II 4100F 1P:</b> Documentation of medical reason(s) for not prescribing bisphosphonates (e.g. patients who do not have bone disease; patients with dental disease; patients with renal insufficiency)</p>		
	<p><b>Intravenous Bisphosphonate Therapy not Prescribed or Received for Patient Reasons</b>  <b>CPT II 4100F 2P:</b> Documentation of patient reason(s) for not prescribing bisphosphonates (e.g. patient declined, economic, social religious, other patient reason)</p>		
	<p><b>Intravenous Bisphosphonate Therapy not Prescribed, Reason Not Specified</b>  <b>CPT II 4100F 8P:</b> Bisphosphonate therapy, intravenous, not ordered or received, reason not otherwise specified</p>		

<b>Measure #70: Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry</b>			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
<p>All patients aged 18 years and older with a diagnosis of CLL</p> <p><b>ICD-9 diagnosis code:</b> 204.10, 204.12</p> <p><b>AND</b></p> <p><b>CPT E/M service codes:</b> 99201-99205, 99212-99215</p>	<p><b>Baseline Flow Cytometry Studies Performed</b>  <b>CPT II 3170F:</b> Flow cytometry studies performed at time of diagnosis or prior to initiating treatment</p>	Once per reporting period	<p><i>Claims or Registry reporting.</i></p> <p>Baseline flow cytometry studies refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include anti-neoplastic therapy.</p>
	<p><b>Baseline Flow Cytometry Studies not Performed for Medical Reasons</b>  <b>CPT II 3170F 1P:</b> Documentation of medical reason(s) for not performing baseline flow cytometry studies (e.g. not indicated, contraindicated, other medical reason)</p>		
	<p><b>Baseline Flow Cytometry Studies not Performed for Patient Reasons</b>  <b>CPT II 3170F 2P:</b> Documentation of patient reason(s) for not performing baseline flow cytometry studies (e.g. receiving palliative care or not receiving treatment as defined above)</p>		
	<p><b>Baseline Flow Cytometry Studies not Performed for System Reasons</b>  <b>CPT II 3170F 3P:</b> Documentation of system reason(s) for not performing baseline flow cytometry studies (e.g. patient previously treated by another physician at the time baseline flow cytometry studies were performed)</p>		
	<p><b>Baseline Flow Cytometry Studies not Performed, Reason Not Specified</b>  <b>CPT II 3170F 8P:</b> Flow cytometry studies not performed at time of diagnosis or prior to initiating treatment, reason not otherwise specified</p>		

Measure #71: Hormonal Therapy for Stage IC-IIIc, ER/PR Positive Breast Cancer			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
Description: Percentage of female patients aged 18 years and older with Stage IC through IIIc, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period			
<p><u>All</u> female patients aged 18 years and older with Stage IC through IIIc, ER or PR positive breast cancer</p> <p><b>ICD-9 diagnosis codes:</b> 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, V10.3</p> <p><b>AND</b></p> <p><b>CPT E/M service codes:</b> 99201-99205, 99212-99215</p>	<p>Patients who were prescribed tamoxifen or aromatase inhibitor (AI) within the 12 months reporting period.</p> <hr/> <p><b>QUALITY-DATA CODING OPTIONS FOR REPORTING SATISFACTORILY:</b></p> <p><b>Tamoxifen or Aromatase Inhibitor Prescribed</b> <i>(Three CPT II codes are required on the claim to submit this numerator option)</i></p> <p><b>CPT II 4179F:</b> Tamoxifen or AI prescribed</p> <p><b>AND</b></p> <p><b>CPT II 3374F:</b> AJCC Breast Cancer Stage I, TIC (Tumor size &gt; 1 cm to 2 cm), documented</p> <p><b>OR</b></p> <p><b>CPT II 3376F:</b> AJCC Breast Cancer Stage II, documented</p> <p><b>OR</b></p> <p><b>CPT II 3378F:</b> AJCC Breast Cancer Stage III, documented</p> <p><b>AND</b></p> <p><b>CPT II 3315F:</b> ER or PR positive breast cancer</p> <hr/> <p><b>Tamoxifen or Aromatase Inhibitor NOT Prescribed for Medical, Patient, or System Reasons</b> <i>(Three CPT II codes are required on the claim to submit this numerator option)</i></p> <p>Append a modifier (1P, 2P or 3P) to CPT II code 4179F to report documented circumstances that appropriately exclude patients from the denominator:</p> <p><b>CPT II 4179F with 1P:</b> Documentation of medical reason(s) for not prescribing tamoxifen or AI (eg, patient’s disease has progressed to metastatic; patient is receiving a gonadotropin-releasing hormone analogue; patient has received oophorectomy; patient is receiving radiation or chemotherapy; patient’s diagnosis date was &gt;= 5 years from reporting date)</p>	Once per reporting period	<p><i>Claims or Registry reporting.</i></p> <p>The correct combination of codes must be reported on the claim form in order to properly report this measure. The “correct combination” of codes may require the submission of multiple numerator codes (see “measure coding” column).</p> <p>All measure-specific coding should be reported <b>ON THE SAME CLAIM.</b></p>

	<p><b>CPT II 4179 with 2P:</b> Documentation of patient reason(s) for not prescribing tamoxifen or AI (eg, patient refusal)  <b>CPT II 4179 with 3P:</b> Documentation of system reason(s) for not prescribing tamoxifen or AI (eg, patient is currently enrolled in a clinical trial)  <b>AND</b>  <b>CPT II 3374F:</b> AJCC Breast Cancer Stage I, TIC (Tumor size &gt; 1 cm to 2 cm), documented  <b>OR</b>  <b>CPT II 3376F:</b> AJCC Breast Cancer Stage II, documented  <b>OR</b>  <b>CPT II 3378F:</b> AJCC Breast Cancer Stage III, documented  <b>AND</b>  <b>CPT II 3315F:</b> ER or PR positive breast cancer</p> <hr/> <p><b>If patient is not eligible for this measure because patient is not stage IC through IIIC breast cancer, report:</b></p> <p><b>Patient NOT stage IC thorough IIIC Breast Cancer</b>  <i>(One CPT II code is required on the claim form to submit this numerator option)</i>  <b>NOTE:</b> If reporting a code from the category below (3370F or 3372F or 3380F), it is not necessary to report the patient's ER/PR status.  <b>CPT II 3370F:</b> AJCC Breast Cancer Stage 0, documented  <b>OR</b>  <b>CPT II 3372F:</b> AJCC Breast Cancer Stage I: T1 mic, T1a or T1b (tumor size &lt; 1 cm), documented  <b>OR</b>  <b>CPT II 3380F:</b> AJCC Breast Cancer Stage IV, documented</p> <hr/> <p><b>If patient is not eligible for this measure because patient is ER/PR negative, report:</b></p> <p><b>Patient is ER and PR Negative</b>  <i>(One CPT II code is required on the claim form to submit this numerator option)</i>  <b>NOTE:</b> If reporting code 3316F, it is not necessary to report the patient's AJCC Cancer Stage.  <b>CPT II 3316F:</b> Estrogen receptor (ER) and progesterone receptor (PR) negative breast cancer</p> <hr/> <p><b>If patient is not eligible for this measure because the</b></p>		
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	<p><b>cancer stage is not documented OR the ER/PR is not documented, report:</b></p> <p><b>Cancer Stage NOT documented OR ER/PR NOT documented</b>  <i>(One CPT II code is required on the claim form to submit this numerator option)</i>  Append a reporting modifier (8P) to CPT II codes 3370F OR 3316F to report circumstances when the patient is not eligible for the measure.  <b>CPT II 3370F with 8P:</b> NO documentation of cancer stage  <b>OR</b>  <b>CPT II 3316F with 8P:</b> NO documentation of ER and PR status</p> <hr/> <p><b>Tamoxifen or Aromatase Inhibitor (AI) NOT Prescribed, Reason not Specified</b>  <i>(Three CPT II codes are required on the claim form to submit this numerator option)</i>  Append a reporting modifier (8P) to CPT II code 4179F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.  <b>CPT II 4179F with 8P:</b> Tamoxifen or AI NOT prescribed, reason not otherwise specified  <b>AND</b>  <b>CPT II 3374F:</b> AJCC Breast Cancer Stage I, TIC (Tumor size &gt; 1 cm to 2 cm), documented  <b>OR</b>  <b>CPT II 3376F:</b> AJCC Breast Cancer Stage II, documented  <b>OR</b>  <b>CPT II 3378F:</b> AJCC Breast Cancer Stage III, documented  <b>AND</b>  <b>CPT II 3315F:</b> ER or PR positive breast cancer</p>		
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Measure #72: Chemotherapy for Stage III Colon Cancer Patients			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period			
<p><u>All</u> patients aged 18 and older with Stage IIIA through IIIC colon cancer</p> <p><b>ICD-9 diagnosis codes:</b> 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, V10.05</p> <p><b>AND</b></p> <p><b>CPT E/M service codes:</b> 99201-99205, 99212-99215</p>	<p>Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or who have previously received adjuvant chemotherapy within the 12 month reporting period</p> <hr/> <p><b>QUALITY-DATA CODING OPTIONS FOR REPORTING SATISFACTORILY:</b></p> <p><b>Adjuvant Chemotherapy Referred, Prescribed or Previously Received</b> <i>(Two CPT II codes are required on the claim form to submit this numerator option)</i></p> <p><b>CPT II 4180F:</b> Adjuvant chemotherapy referred, prescribed or previously received for Stage IIIA through Stage IIIC colon cancer</p> <p><b>AND</b></p> <p><b>CPT II 3388F:</b> AJCC Colon Cancer Stage III, documented</p> <p><b>OR</b></p> <p><b>Adjuvant Chemotherapy NOT Referred, Prescribed or Previously Received for Medical, Patient, or System Reasons</b> <i>(Two CPT II codes are required on the claim form to submit this numerator option)</i></p> <p>Append a modifier (1P, 2P or 3P) to CPT II code 4180F to report documented circumstances that appropriately exclude patients from the denominator</p> <p><b>CPT 4180F with 1P:</b> Documentation of medical reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, medical comorbidities; diagnosis date more than 5 years prior to the current visit date; patient’s cancer has metastasized; medical contraindication/allergy; poor performance status)</p> <p><b>CPT 4180F with 2P:</b> Documentation of patient reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient refusal)</p>	Once per reporting period	<p><i>Claims or Registry reporting.</i></p> <p>The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. This may require the submission of multiple codes.</p> <p><b>Definitions:</b></p> <p><b>Adjuvant Chemotherapy</b> – according to current NCCN guidelines, the following therapies are recommended: 5-fluorouracil/leucovorin or capecitabine, or 5-fluorouracil/leucovorin/oxaliplatin.</p> <p><b>Prescribed</b> – may include prescription ordered for the patient for adjuvant chemotherapy at one or more visits in the 12-month period OR patient already receiving adjuvant chemotherapy as documented in the current medication list.</p>

	<p><b>CPT 4180F with 3P:</b> Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy)  <b>AND</b>  <b>CPT II 3388F:</b> AJCC Colon Cancer Stage III, documented</p> <hr/> <p><b>If patient is not eligible for this measure because patient is NOT Stage III colon cancer, report:  Patient NOT stage III Colon Cancer</b>  <i>(One CPT II code is required on the claim form to submit this numerator option)</i>  <b>CPT II 3382F:</b> AJCC Colon Cancer Stage 0, documented  <b>CPT II 3384F:</b> AJCC Colon Cancer Stage I, documented  <b>CPT II 3386F:</b> AJCC Colon Cancer Stage II, documented  <b>CPT II 3390F:</b> AJCC Colon Cancer Stage IV, documented</p> <hr/> <p><b>If patient is not eligible for this measure because cancer stage is not documented, report:  Cancer Stage NOT Documented</b>  <i>(One CPT II code is required on the claim form to submit this numerator option)</i>  Append a reporting modifier (8P) to CPT II 3382F to report circumstances when the patient is not eligible for the measure.  <b>CPT II 3382F with 8P:</b> NO documentation of cancer stage</p> <hr/> <p><b>Adjuvant Chemotherapy NOT Referred, Prescribed or Previously Received, Reason Not Specified</b>  <i>(Two CPT II codes are required on the claim form to submit this numerator option)</i>  Append a reporting modifier (8P) to CPT II code 4180F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified  <b>CPT II 4180F with 8P:</b> Adjuvant chemotherapy NOT prescribed or previously received, reason not otherwise specified  <b>AND</b>  <b>CPT II 3388F:</b> AJCC Colon Cancer Stage III, documented</p>		
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<b>Measure #99: Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic grade</b>			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
<p>All patients with breast cancer, regardless of age</p> <p><b>ICD-9 diagnosis codes:</b> 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, 175.0, 175.9</p> <p><b>AND</b></p> <p><b>CPT E/M procedure codes:</b> 88307, 88309</p>	<p><b>pT category, pN category, and histologic grade documented in pathology report</b></p> <p><b>CPT II 3260F:</b> pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report</p>	<p><b>Each time</b> a breast cancer resection surgical pathology examination is performed during the reporting period</p>	<p><i>Claims or Registry reporting.</i></p> <p>Independent diagnostic testing facilities (IDTFs), using indicator Place-of-Service 81, are not included in PQRI.</p>
	<p><b>pT category, pN category, and histologic grade not documented in pathology report for medical reason(s)</b></p> <p><b>CPT II 3260F 1P:</b> Documentation of medical reason(s) for not including pT category, pN category, and histologic grade in the pathology report (eg, re-excision without residual tumor; non-carcinomas)</p>		
	<p><b>pT category, pN category, and histologic grade not documented in pathology report, reason not specified</b></p> <p><b>CPT II 3260F 8P:</b> pT category, pN category, and histologic grade were not documented in pathology report, reason not otherwise specified</p>		

<b>Measure #100: Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade</b>			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
All patients with colorectal cancer, regardless of age  <b>ICD-9 diagnosis codes:</b> 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8  <b>AND</b> <b>CPT E/M procedure codes:</b> 88309	<b>pT category, pN category, and histologic grade documented in pathology report</b> <b>CPT II 3260F:</b> pT category (primary tumor), pN category (regional lymph nodes), and histologic grade documented in pathology report	<b>Each time</b> a colorectal cancer resection surgical pathology examination is performed during the reporting period	<i>Claims or Registry reporting.</i>  Independent diagnostic testing facilities (IDTFs), using indicator Place-of-Service 81, are not included in PQRI.
	<b>pT category, pN category, and histologic grade not documented in pathology report for medical reason(s)</b> <b>CPT II 3260F 1P:</b> Documentation of medical reason(s) for not including pT category, pN category, and histologic grade in the pathology report (eg, non-carcinomas; anal canal)		
	<b>pT category, pN category, and histologic grade not documented in pathology report, reason not specified</b> <b>CPT II 3260F 8P:</b> pT category, pN category, and histologic grade were not documented in pathology report, reason not otherwise specified		

Measure #102: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did NOT have a bone scan performed at any time since diagnosis of prostate cancer.			
<p>All patients regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy.</p> <p><b>ICD-9 diagnosis codes:</b> 185 <b>AND</b> <b>CPT E/M procedure codes:</b> 55810, 55812, 55815, 55840, 55842, 55845, 55866, 55873, 77427, 77776, 77777, 77778, 77787</p>	<p>Patients who did NOT have a bone scan performed at any time since diagnosis of prostate cancer</p> <hr/> <p><b>QUALITY-DATA CODING OPTIONS FOR REPORTING SATISFACTORILY:</b></p> <p><b>Bone Scan NOT Performed</b> <i>(Two CPT II codes are required on the claim form to submit this numerator option)</i> <b>CPT II 3270F:</b> Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer <b>AND</b> <b>CPT II 3271F:</b> Low risk of recurrence, prostate cancer</p> <hr/> <p><b>Bone Scan Performed for Medical or System Reasons</b> <i>(Two CPT II codes are required on the claim form to submit this numerator option)</i> Append a modifier (1P or 3P) to CPT II 3269F to report documented circumstances that appropriately exclude patients from the denominator <b>CPT 3269F with 1P:</b> Documentation of medical reason(s) for performing a bone scan (including documented pain, salvage therapy, other medical reasons) <b>OR</b> <b>CPT II 3269F with 3P:</b> Documentation of system reason(s) for performing a bone scan (including bone scan ordered by someone other than the reporting physician) <b>AND</b> <b>CPT II 3271F:</b> Low risk of recurrence, prostate cancer</p> <hr/> <p>(Continued below)</p>	<p><b>Once per episode of treatment</b> (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy).</p> <p>Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRI quality code needs to be submitted only once during the episode of radiation therapy (e.g. 8 weeks of therapy).</p>	<p><i>Claims or Registry reporting.</i></p> <p>The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. This may require the submission of multiple codes.</p> <p>Rationale: A bone scan is generally not required for staging prostate cancer in men with a low risk of recurrence and receiving primary therapy. This measure is written as a negative measure so that the performance goal is 100%, consistent with the other measures for this condition.</p> <p><b>Definitions:</b> <b>Risk Strata:</b> <b>Low, Intermediate or High</b> <b>Low Risk</b> – PSA ≤ 10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1cor T2a <b>Intermediate Risk</b> – PSA &gt; 10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk <b>High Risk</b> – PSA &gt; 20 mg/dL; OR Gleason score 8 to 10; OR</p>

	<p><b>If patient is not eligible for this measure because the risk of recurrence is intermediate, high or not determined, report:</b>  <i>(One CPT II code is required on the claim form to submit this numerator option)</i></p> <p><b>Intermediate Risk of Recurrence</b>  <b>CPT II 3272F:</b> Intermediate risk of recurrence, prostate cancer</p> <p><b>OR</b></p> <p><b>High Risk of Recurrence</b>  <b>CPT II 3273F:</b> High risk of recurrence, prostate cancer</p> <p><b>OR</b></p> <p><b>Risk of Recurrence NOT Determined</b>  <b>CPT II 3274F:</b> Prostate cancer risk of recurrence NOT determined or neither low, intermediate nor high</p> <hr/> <p><b>Bone Scan Performed</b>  <i>(Two CPT II codes are required on the claim form to submit this numerator option)</i></p> <p><b>CPT II 3269F:</b> Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer</p> <p><b>AND</b></p> <p><b>CPT II 3271F:</b> Low risk of recurrence, prostate cancer</p>		<p>clinically localized stage T3a1</p>
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Measure #104: Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist).			
<p>Male patients, regardless of age, with a diagnosis of prostate cancer at high risk of recurrence receiving external beam radiotherapy to the prostate</p> <p>NOTE: Only patients with prostate cancer with high risk of recurrence will be counted in the performance denominator of this measure</p> <p><b>ICD-9 diagnosis codes:</b> 185 <b>AND</b> <b>CPT E/M procedure codes:</b> 77427</p>	<p>Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)</p> <hr/> <p><b>QUALITY-DATA CODING OPTIONS FOR REPORTING SATISFACTORILY</b></p> <p><b>Adjuvant Hormonal Therapy Prescribed/Administered</b> <i>(One CPT II code and one G-code are required on the claim form to submit this numerator option)</i></p> <p><b>Adjuvant Hormonal Therapy Prescribed/Administered CPT II 4164F:</b> Adjuvant (i.e., in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered <b>AND</b> <b>G8465:</b> High risk of recurrence of prostate cancer</p> <hr/> <p><b>Adjuvant Hormonal Therapy NOT Prescribed/Administered for Medical or Patient Reasons</b> <i>(One CPT II code and one G-code are required on the claim form to submit this numerator option)</i></p> <p>Append a modifier (1P or 2P) to CPT II 4164F to report documented circumstances that appropriately exclude patients from the denominator.</p> <p><b>CPT II 4164F with 1P:</b> Documentation of medical reason(s) for not prescribing/administering adjuvant hormonal therapy (eg, salvage therapy) <b>OR</b> <b>CPT II 4164F with 2P:</b> Documentation of patient reason(s) for not prescribing/administering adjuvant hormonal therapy <b>AND</b> <b>G8465:</b> High risk of recurrence of prostate cancer</p>	<p>Once per episode of radiation therapy</p> <p>Claims data will be analyzed to determine unique episodes of radiation therapy. Each episode of radiation therapy in an eligible patient receiving external beam radiotherapy to the prostate occurring during the reporting period will be counted when calculating the reporting and performance rates. The PQRI quality code needs to be submitted only once during the episode of radiation therapy (e.g. 8 weeks of therapy).</p>	<p><i>Claims or Registry reporting.</i></p> <p><b>NOTE:</b> This measure uses G codes; codes related to risk of recurrence differ from those in measure #102.</p> <p>The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. This may require the submission of multiple codes.</p> <p><b>Definitions:</b> <b>Risk Strata: Low, Intermediate or High</b> <b>Low Risk</b> – PSA &lt;= 10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1cor T2a <b>Intermediate Risk</b> – PSA &gt; 10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk <b>High Risk</b> – PSA &gt; 20 mg/dL; OR Gleason score 8 to 10; OR clinically localized stage T3a1 <b>Prescribed</b> – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the</p>
			reporting period, even if the prescription for that medication was ordered prior to the

	<p><b>If patient is not eligible for this measure because the risk of recurrence is low, intermediate or not determined, report:</b>  <i>(One G-code is required on the claim form to submit this numerator option)</i></p> <p><b>G8464:</b> Clinician documented that prostate cancer patient is not an eligible candidate for adjuvant hormonal therapy; low or intermediate risk of recurrence OR risk or recurrence not determined</p> <hr/> <p><b>Adjuvant Hormonal Therapy NOT Prescribed/ Administered, Reason not Specified</b>  <i>(One CPT II code and one G-code are required on the claim form to submit this numerator option)</i></p> <p>Append a reporting modifier (8P) to CPT II 4164F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.</p> <p><b>CPT II 4164F with 8P:</b> Patients who were not prescribed/administered adjuvant hormonal therapy, reason not otherwise specified</p> <p><b>AND</b></p> <p><b>G8465:</b> High risk of recurrence of prostate cancer</p>		<p>encounter.</p>
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Measure #105: Prostate Cancer: Three-dimensional (3D) Radiotherapy			
ELIGIBLE PATIENTS (DENOMINATOR)	MEASURE CODING (NUMERATOR)	REPORTING FREQUENCY	NOTES
Description: Percentage of patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam radiotherapy as a primary therapy to the prostate with or without nodal irradiation (no metastases, no salvage therapy) who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT).			
<p>All male patients, regardless of age, with a diagnosis of clinically localized prostate cancer receiving external beam radiotherapy as a primary therapy to the prostate with or without nodal irradiation (no metastases; no salvage therapy)</p> <p><b>ICD-9 diagnosis codes:</b> 185</p> <p><b>WITHOUT secondary malignant neoplasm diagnosis of a specified site – respiratory, digestive, and of other specified sites:</b> 197.0, 197.1, 197.2, 197.3, 197.4, 197.5, 197.6, 197.7, 197.8, 198.0, 198.1, 198.2, 198.3, 198.4, 198.5, 198.6, 198.7, 198.81, 198.82, 198.89</p> <p><b>AND</b> <b>CPT E/M procedure codes:</b> 77427</p>	<p>Patients who receive three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT)</p> <hr/> <p><b>QUALITY-DATA CODING OPTIONS FOR REPORTING SATISFACTORILY:</b></p> <p><b>3D-CRT or IMRT Received</b> (Two CPT II codes are required on the claim form to submit this numerator option) <b>CPT II 4165F:</b> Three-dimensional conformal radiotherapy (3D-CRT) or intensity modulated radiation therapy (IMRT) received <b>AND</b> <b>CPT II 4200F:</b> External beam radiotherapy as primary therapy to the prostate with or without nodal irradiation</p> <hr/> <p><b>If patient is not eligible for this measure because the 3D-CRT or IMRT is to region(s) other than the prostate only, report:</b> (One CPT II code is required on the claim form to submit this numerator option) <b>CPT II 4201F:</b> External beam radiotherapy with or without nodal irradiation as adjuvant or salvage therapy for prostate cancer patient</p> <hr/> <p>(Continued below)</p>	<p><b>Each time</b> patient receives external beam radiotherapy during the reporting period</p>	<p><i>Claims or Registry reporting.</i></p> <p>The correct combination of numerator codes must be reported on the claim form in order to properly report this measure. This may require the submission of multiple codes.</p>

	<p><b>3D-CRT or IMRT NOT Received, Reason not Specified</b>  <i>(Two CPT II codes are required on the claim form to submit this numerator option)</i></p> <p>Append a reporting modifier (8P) to CPT II 4165F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified</p> <p><b>CPT II 4165F with 8P:</b> Patients who did NOT receive 3D-CRT or IMRT, reason not otherwise specified</p> <p><b>AND</b></p> <p><b>CPT II 4200F:</b> External beam radiotherapy as primary therapy to the prostate with or without nodal irradiation</p>		
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<b>Measure #156: Radiation Dose Limits to Normal Tissues</b>			
<b>ELIGIBLE PATIENTS (DENOMINATOR)</b>	<b>MEASURE CODING (NUMERATOR)</b>	<b>REPORTING FREQUENCY</b>	<b>NOTES</b>
<p>All patients with pancreatic or lung cancer receiving 3D conformal radiation therapy, regardless of age</p> <p><b>ICD-9 diagnosis codes:</b> 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9</p> <p><b>AND</b></p> <p><b>CPT procedure code for 3D conformal radiation therapy:</b> 77295</p>	<p><b>Radiation Dose Limits Established</b>  <b>CPT II 0520F:</b> Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs</p>	<p>A minimum of once per reporting period</p>	<p><i>Claims or Registry reporting.</i></p> <p>It is anticipated that clinicians providing radiation therapy for patients with cancer will submit this measure.</p>
	<p><b>Radiation Dose Limits Not Established</b>  <b>CPT II 0520F-8P:</b> Radiation dose limits to normal tissues not established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues/organs, reason not otherwise specified</p>		

<b>Measure #194: Oncology: Cancer Stage Documented</b>			
<b>ELIGIBLE PATIENTS (DENOMINATOR)</b>	<b>MEASURE CODING (NUMERATOR)</b>	<b>REPORTING FREQUENCY</b>	<b>NOTES</b>
<p>All patients, regardless of age, with diagnosis of breast, colon or rectal cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once within 12 months.</p> <p><b>ICD-9 diagnosis codes:</b> 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.2, 154.3, 154.8, 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9, V10.3, V10.05, V10.06</p> <p><b>AND</b></p> <p><b>CPT procedure code:</b> 77261, 77262, 77263, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215</p>	<p><b>Stage Documented and Reviewed</b>  <b>CPT II 3300F:</b> American Joint Commission on Cancer (AJCC) stage documented and reviewed  OR  <b>CPT II 3301F:</b> Cancer stage documented in medical record as metastatic and reviewed</p>	Once per reporting period.	<p><i>Claims or Registry reporting.</i></p> <p>*"Cancer stage" refers to stage at diagnosis.</p>
	<p><b>Stage Not Documented, Reason not Specified</b>  <b>CPT II 3301F with 8P:</b> Cancer stage not documented, reason not otherwise specified</p>		

**2010 PQRI Measures for Consideration by Oncology Providers: *REGISTRY REPORTING ONLY***

See <http://www.cms.hhs.gov/PQRI/> for information about registry reporting and a full list of measures and specifications.

<b>Measure #136: Melanoma: Follow-up Aspects of Care</b>
<b>Measure #137: Melanoma: Continuity of Care – Recall System</b>
<b>Measure #138: Melanoma: Coordination of Care</b>
<b>Measure #143: Oncology – Medical and Radiation: Pain Intensity Quantified</b>
<b>Measure #144: Oncology – Medical Plan of Care for Pain</b>

## 2010 PQRI Measures for Consideration by Oncology Providers: General Measures

See <http://www.cms.hhs.gov/PQRI/> for a full list of measures and specifications.

<b>Measure #47: Advance Care Plan</b>	<i>Claims or Registry reporting.</i>
<b>Measure #110: Preventive Care and Screening: Influenza Vaccination for Patients ≥ 50 Years Old</b>	<i>Claims or Registry reporting.</i>
<b>Measure #111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older</b>	<i>Claims or Registry reporting.</i>
<b>Measure #112: Preventive Care and Screening: Screening Mammography</b>	<i>Claims or Registry reporting.</i>
<b>Measure #113: Preventive Care and Screening: Colorectal Cancer Screening</b>	<i>Claims or Registry reporting.</i>
<b>Measure #114: Preventive Care and Screening: Inquiry Regarding Tobacco Use</b>	<i>Claims or Registry reporting.</i>
<b>Measure #115: Preventive Care and Screening: Advising Smokers to Quit</b>	<i>Claims or Registry reporting.</i>
<b>Measure #124: Health Information Technology – Adoption/Use of Electronic Health Records (EHR)</b>	<i>Claims, Registry or EHR-based reporting.</i>
<b>Measure #130: Documentation and Verification of Current Medications in the Medical Record</b>	<i>Claims or Registry reporting.</i>
<b>Measure #131: Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up</b>	<i>Claims or Registry reporting.</i>
<b>Measure #173: Preventive Care and Screening: Unhealthy Alcohol Use - Screening</b>	<i>Claims or Registry reporting.</i>