

Diabetes Mellitus Measures Group

PQRI Data Collection Sheet*

Male Female

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy)
National Provider Identifier (NPI)		Date of Encounter

Step 1 Preliminary reporting requirements

You must identify your intent to report the Diabetes Mellitus Measures Group by submitting the G-code specified for this measures group on the first patient claim (G8485: I intend to report the Diabetes Mellitus Measures Group). You do not need to resubmit the measures group-specific G-code on more than one claim.

Step 2 Determine patient eligibility

(Codes determining a patient's eligibility must be reported on the **same claim** as the quality code(s) identified in Step 3 below.)

	Yes	No	
Patient is aged 18 through 75 years on date of encounter.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to date of birth listed above or on claim form.
Patient has a line item diagnosis of diabetes mellitus.	<input type="checkbox"/>	<input type="checkbox"/>	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, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
There is a CPT Code for a visit in the office, nursing facility, domiciliary, or home OR a code for medical nutrition therapy.	<input type="checkbox"/>	<input type="checkbox"/>	97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271

If **No** is checked for any of the above, STOP. This patient is not eligible for reporting on this measures group. Do not report a CPT category II code or G-code.

Step 3 Complete individual measures

Blood Pressure (BP) Management		Report one code for systolic BP AND one code for diastolic BP OR one code for NOT assessed.	
PQRI Measure #3 • <i>measure target: <140/80 mmHg</i> • <i>reporting frequency: BP must be assessed and reported once during the calendar year</i> • <i>most recent BP should be reported</i>	Systolic BP	< 130 mmHg	<input type="checkbox"/> 3074F
		130–139 mmHg	<input type="checkbox"/> 3075F
		≥ 140 mmHg	<input type="checkbox"/> 3077F
	Diastolic BP	< 80 mmHg	<input type="checkbox"/> 3078F
		80–89 mmHg	<input type="checkbox"/> 3079F
		≥ 90 mmHg	<input type="checkbox"/> 3080F
		OR	
		Blood pressure NOT assessed	<input type="checkbox"/> 2000F–8P

continued on next page

*For additional information on the PQRI program and reporting on measures groups, please visit the CMS Web site at <http://www.cms.hhs.gov/pqri>.

Diabetes Mellitus Measures Group

continued from previous page

Hemoglobin A1c Management (poor control)		Report one code for A1c level OR one code for NOT assessed.		
PQRI Measure #1 <ul style="list-style-type: none"> • poor control: >9.0% • reporting frequency: A1c must be assessed and reported once during the calendar year • most recent A1c should be reported 	A1c level	< 7.0 %	<input type="checkbox"/> 3044F	
		7.0 to 9.0 %	<input type="checkbox"/> 3045F	
		> 9.0 %	<input type="checkbox"/> 3046F	
		OR		
		HbA1c NOT assessed	<input type="checkbox"/> 3046F-8P	
Lipid Profile		Report one code for LDL-C level OR one code for NOT assessed.		
PQRI Measure #2 <ul style="list-style-type: none"> • measure target: < 100 mg/dL (lower is better) • reporting frequency: LDL-C level must be assessed and reported once during the calendar year • most recent LDL-C level should be reported 	LDL-C level	< 100 mg/dL	<input type="checkbox"/> 3048F	
		100–129 mg/dL	<input type="checkbox"/> 3049F	
		≥ 130 mg/dL	<input type="checkbox"/> 3050F	
<i>Note: If unable to calculate LDL-C due to high triglycerides, CPT Category II code 3048F-8P should be reported</i>		OR		
		LDL-C level NOT assessed	<input type="checkbox"/> 3048F-8P	
Nephropathy Screening or Treatment		Report one code for nephropathy screening OR one code for nephropathy treatment OR one code for NOT performed.		
PQRI Measure #119 <ul style="list-style-type: none"> • reporting frequency: nephropathy screening (or documentation of treatment for nephropathy) must be performed and reported once during the calendar year 	Screened for nephropathy	Microalbuminuria positive test result	<input type="checkbox"/> 3060F	
		Microalbuminuria negative test result	<input type="checkbox"/> 3061F	
		Macroalbuminuria positive test result	<input type="checkbox"/> 3062F	
			OR	
	Receiving treatment for nephropathy	Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)	<input type="checkbox"/> 3066F	
Patient prescribed ACE inhibitor or ARB therapy		<input type="checkbox"/> G8506		
		OR		
		Nephropathy screening NOT performed	<input type="checkbox"/> 3060F-8P OR <input type="checkbox"/> 3061F-8P OR <input type="checkbox"/> 3062F-8P	
Comprehensive Foot Exam <i>(visual inspection, sensory exam with monofilament, or pulse exam)</i>		Report one of the following comprehensive foot exam codes OR one code for NOT completed.		
PQRI Measure #163 <ul style="list-style-type: none"> • reporting frequency: comprehensive foot exam must be completed and reported at least once within the prior 12 months 	Completed		<input type="checkbox"/> 2028F	
	Not Completed for medical reasons (eg, patient has bilateral foot amputation) <ul style="list-style-type: none"> • Document reason in medical chart 		<input type="checkbox"/> 2028F-1P	
		OR		
		Comprehensive foot exam NOT completed	<input type="checkbox"/> 2028F-8P	

continued on next page

Diabetes Mellitus Measures Group

continued from previous page

Eye Exam (including interpretation by an ophthalmologist or optometrist)		Report one of the following eye exam codes OR one code for NOT performed.	
PQRI Measure #117 • reporting frequency: eye exam (or evidence that patient is at low risk for retinopathy) must be performed and reported once during the calendar year	Eye exam completed by an eye care professional and results reviewed	Dilated retinal eye exam results reviewed	<input type="checkbox"/> 2022F
		Seven standard field stereoscopic photo results reviewed	<input type="checkbox"/> 2024F
		Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results	<input type="checkbox"/> 2026F
	Eye exam not required	Low risk for retinopathy: in the year prior to the reporting period, patient's retinal eye exam had no evidence of retinopathy	<input type="checkbox"/> 3072F
		OR	
		Eye exam NOT performed	<input type="checkbox"/> 2022F-8P OR 2024F-8P OR 2026F-8P

Step 4 Reporting Instructions

This measure can be reported for each eligible patient in one of two ways:

1. Report the corresponding CPT category II codes(s) as selected above for each of the six measures in the Diabetes Mellitus Measures Group.

OR

2. If **all** quality actions for the patient have been performed for each of the six measures in the Diabetes Mellitus Measures Group, **G8494** may be reported. *Note: G8494 is not appropriate for this patient if any of the following codes have been selected from Step 3: 3077F, 3079F, 3080F, 3044F, 3045F, 3049F, 3050F, any CPT category II code with the 8P modifier.*