

Primary Open-Angle Glaucoma

Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

PQRI Data Collection Sheet

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy) / /	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
National Provider Identifier (NPI)		Date of Service	

Clinical Information			Billing Information
Step 1 Is patient eligible for this measure?			
	Yes	No	Code Required on Claim Form
Patient is aged 18 years and older on date of encounter.	<input type="checkbox"/>	<input type="checkbox"/>	Verify date of birth on claim form.
Patient has a line item diagnosis of primary open angle glaucoma.	<input type="checkbox"/>	<input type="checkbox"/>	Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
There is a CPT Code for this visit.	<input type="checkbox"/>	<input type="checkbox"/>	
If No is checked for any of the above, STOP. Do not report a CPT category II code.			
Step 2 Does patient also have the other requirements for this this measure?			
	Yes	No	Code to be Reported on Line 24D of Paper Claim Form (or Service Line 24 of Electronic Claim Form)
Is patient's IOP reduced by a value greater than or equal to 15% from the pre-intervention level?	<input type="checkbox"/>	<input type="checkbox"/>	If Yes , report only 3284F and STOP. If No (ie, IOP reduced by a value less than 15% from the pre-intervention level), report 3285F and proceed to Step 3. If IOP measurement not documented, report 3284F-8P and STOP.
Step 3 Does patient meet or have an acceptable reason for not meeting the measure?			
Plan of Care for Glaucoma¹	Yes	No	Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)
Documented	<input type="checkbox"/>	<input type="checkbox"/>	0517F
Document reason here and in medical chart. _____ _____			If No is checked for all of the above, report 0517F-8P (Glaucoma plan of care not documented, reason not otherwise specified.)

¹A plan of care may include: recheck of IOP at specified time, change in therapy, perform additional diagnostic evaluations, monitoring per patient decisions or unable to achieve due to health system reasons, and/or referral to a specialist.