



2013 Physician Quality Reporting System (PQRS): Implementation Guide – Claims-Based Reporting for Incentive

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Introduction

Note: This document applies to PQRS for incentive payment eligibility only. Those who report satisfactorily for the 2013 program year *may* avoid the 2015 PQRS payment adjustment. Additional information on how to avoid future PQRS payment adjustments can be found through supporting documentation available on the CMS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

This guide is provided to promote understanding about how to implement 2013 Physician Quality Reporting System (PQRS) claims-based reporting of measures in clinical practice and to facilitate satisfactory reporting of quality data by eligible professionals who wish to participate in PQRS. PQRS is a voluntary individual reporting program that provides an incentive payment to identified eligible professionals who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Medicare Part C–Medicare Advantage beneficiaries are not included in claims-based reporting of individual measures or measures groups.

Eligible professionals, using their individual rendering National Provider Identifier (NPI) to submit billable services on Part B claims for allowable PFS charges, may report the quality action for selected PQRS measure(s). Providers not defined as eligible professionals in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRS. Services payable under fee schedules or methodologies other than the PFS are not included in PQRS (for example, services provided in federally qualified health centers, portable x-ray suppliers, independent laboratories including place-of-service code “81”, independent diagnostic testing facilities, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). Suppliers of durable medical equipment (DME) are not eligible to participate in PQRS since DME is not paid under the PFS. A list of eligible professionals can be found on the PQRS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

In general, the quality measures consist of a unique denominator (eligible case) and numerator (clinical action) that permit calculating the percentage of a defined patient population receiving a particular process of care or achieving a particular outcome. It is important to review and understand each measure specification, which provides definitions and specific instructions for reporting a measure. The *2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures* can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>. Refer also to **Appendix A**, “Glossary of Terms,” which further defines the terms denominator and numerator as well as other terms commonly used in PQRS.

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PQRS Measure Selection Considerations

The measures in 2013 PQRS address various aspects of care, such as prevention, chronic- and acute-care management, procedure-related care, resource utilization, and care coordination. Measure selection begins with a review of the *2013 Physician Quality Reporting System (PQRS) Measures List* to determine which measures may be of interest to the practice and applicable to the eligible professional. The list is available as a downloadable document from the Measures Codes section of the CMS PQRS website. At a minimum, the following factors should be considered when selecting measures for reporting:

- Clinical conditions usually treated
- Types of care typically provided – e.g., preventive, chronic, acute
- Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite
- Quality improvement goals for 2013

After making a selection of potential measures, review the specifications for each measure under consideration and select those measures that apply to services most frequently provided to Medicare patients by the eligible

professional/practice. Individual eligible professionals should review each measure's denominator coding (including all diagnoses and services submitted on a claim) to determine which PQRS measures are applicable to each patient. See **Appendix B** (*Sample 2013 PQRS Measure*) to view the content included in a measure's specification, using PQRS Measure #19 as an example.

2013 PQRS submission of quality data may be performed via claims or via registry, each of which include multiple reporting options for each method of submission. 2013 PQRS submission of quality data may also be performed via a qualified electronic health record (EHR) or via the group practice reporting option (GPRO). **Appendix C** (*2013 PQRS Participation for Incentive Payment Decision Tree*) is a tool designed to help eligible professionals/practices select among the multiple reporting options available. Select the reporting option (i.e., reporting individual measures or measures groups) best suited for the practice. Eligible professionals should not choose individual measures that do not or infrequently apply to services provided to Medicare patients by the eligible professional/practice. Eligible professionals may choose to report on measures groups if all of the measures within the group are applicable to services provided to Medicare patients by the eligible professional. Instructions for reporting measures groups are included in a separate document, *2013 Physician Quality Reporting System (PQRS) Measures Groups Specifications Manual*, which can be found at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html>.

Ensure that the practice identifies and reports on all eligible cases for the measures selected by the practice. Consider implementing an edit on the billing software that will flag each claim every time a combination of codes listed in a measure's denominator is billed so the entry of quality-data codes (QDCs) is required prior to final submission. Additional PQRS educational resources are available as downloads at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

PQRS Denominators and Numerators

Measures consist of two major components:

- 1) A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator)
- 2) A numerator that describes the clinical action required by the measure for reporting and performance

Each component is defined by specific codes described in each measure specification along with reporting instructions and use of modifiers.

Use of Current Procedural Terminology (CPT) Category I Modifiers

PQRS measure specifications include specific instructions regarding inclusion of the CPT Category I modifiers. Unless otherwise specified, CPT Category I codes may be reported with or without CPT modifiers. Refer to each individual measure specification for detailed instructions regarding CPT Category I modifiers that qualify or do not qualify a claim for denominator inclusion.

Note that surgical procedures billed by an assistant surgeon(s) will be excluded from the denominator population so his/her performance rates will not be negatively impacted for PQRS. Analysis will exclude otherwise PQRS-eligible CPT Category I codes, when submitted with assistant surgeon modifiers 80, 81, or 82. The primary surgeon, not the assistant surgeon, is responsible for performing and reporting the quality action(s) in applicable PQRS measures.

Eligible CPT Category I procedure codes, billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population for applicable PQRS measure(s). Both surgeons participating in PQRS will be fully accountable for the clinical action(s) described in the PQRS measure(s).

Quality-Data Codes

QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure's numerator. Clinical actions can apply to more than one condition and, therefore, can also apply to more than one measure. Where necessary, to avoid shared CPT Category II codes, G-codes are used to distinguish clinical actions across measures.

Some measures require more than one clinical action and, therefore, have more than one CPT Category II code, G-code, or a combination associated with them. Eligible professionals should review numerator reporting instructions for each measure carefully.

CPT Category II Codes

CPT Category II or CPT II codes, developed through the CPT Editorial Panel for use in performance measurement, serve to encode the clinical action(s) described in a measure's numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter "F." CPT II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals and related documents for PQRS.

Use of CPT II Modifiers

CPT II modifiers are unique to CPT II codes and may be used to report measures by appending the appropriate modifier to a CPT II code as specified for a given measure. The modifiers for a code cannot be combined and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the measure specifications. Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Descriptions of each modifier are provided below to help identify circumstances when the use of a modifier may be appropriate. Note that reporting an exclusion or reporting modifier will alter an eligible professional's performance rate. Accurate reporting on all selected measures will count toward incentive, whether the clinical action is reported as complete or not complete (or performance met or not met).

Note: Measures with a 0% performance rate and measures groups containing a measure with a 0% performance rate will not be counted.

CPT II code modifiers fall into two categories: exclusion modifiers and the 8P reporting modifier.

- 1) Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not allow performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:
 - **1P Performance measure exclusion modifier due to *medical reasons*** includes:
 - Not indicated (absence of organ/limb, already received/performed, other)
 - Contraindicated (patient allergy history, potential adverse drug interaction, other)
 - Other medical reasons
 - **2P Performance measure exclusion modifier due to *patient reasons*** includes:
 - Patient declined
 - Economic, social, or religious reasons
 - Other patient reasons
 - **3P Performance measure exclusion modifier due to *system reasons*** includes:
 - Resources to perform the services not available (e.g., equipment, supplies)
 - Insurance coverage or payer-related limitations
 - Other reasons attributable to health care delivery system
- 2) The 8P reporting modifier is available for use only with CPT II codes to facilitate reporting an eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this reporting modifier to CPT Category II codes are included in applicable measures. Use of the 8P reporting modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.
 - **8P Performance measure reporting modifier** - action not performed, reason not otherwise specified

The 8P reporting modifier facilitates reporting an eligible case on a given measure when the clinical action does not apply to a specific encounter. Eligible professionals can use the 8P modifier to receive credit for satisfactory reporting but will not receive credit for performance. Eligible professionals should use the 8P reporting modifier sensibly for applicable measures they have selected to report. The 8P modifier may not be used freely in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

For example, an eligible professional has selected and submitted QDCs during the reporting period for 2013 PQRS Measure #6, Coronary Artery Disease (CAD): Antiplatelet Therapy. The eligible professional sees a patient for whom he does not choose to prescribe oral antiplatelet therapy and the reason is not specified. However, the claim(s) for services for that encounter contains International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), and CPT codes that will draw the patient into the measures' denominator during analysis. The 8P modifier serves to include the patient in the numerator when reporting rates are calculated for PQRS.

Note: International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis codes have been incorporated into the *2013 PQRS Measures Specifications*. These codes are for REFERENCE ONLY and will **not** count toward satisfactorily reporting the measures within PQRS in the 2013 program year.

Claims-Based Reporting Principles

Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim.

- Only one diagnosis can be linked to each line item
- PQRS analyzes claims data using ALL diagnoses from the base claim (Item 21 of the CMS-1500 or electronic equivalent) and service codes for each individual eligible professional (identified by individual NPI)
- **Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL chosen measures applicable to that patient's care.**

All diagnoses reported on the base claim will be included in PQRS analysis, as some measures require reporting more than one diagnosis on a claim.

- For line items containing a QDC, only one diagnosis from the base claim should be referenced in the diagnosis pointer field.
- To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, all diagnoses on the claim(s) are considered in PQRS analysis.

If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny to one of the line items on that second claim for a total charge of one penny.

- PQRS analysis will subsequently join claims based on the same beneficiary for the same date-of-service, for the same Taxpayer Identification Number/National Provider Identifier (TIN/NPI) and analyze as one claim.

Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses, QDCs, or nominal charge amounts are not dropped.

A sample CMS-1500 form can be found in Appendix D of this document.

Principles for Reporting QDCs

The following principles apply for claims-based reporting of PQRS measures:

1. QDCs must be reported:
 - On the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B PFS encounter
 - For the same beneficiary

- For the same date of service (DOS)
 - By the same eligible professional (individual rendering NPI) who performed the covered service, applying the appropriate encounter codes (ICD-9-CM, CPT Category I or HCPCS codes). These codes are used to identify the measure's denominator.
2. QDCs must be submitted with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed.
 - The submitted charge field cannot be blank
 - The line item charge should be \$0.00
 - If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted – the beneficiary is not liable for this nominal amount
 - Entire claims with a zero (\$0.00) charge will be rejected
 - Whether a \$0.00 charge or a nominal amount is submitted to the Carrier or A/B Medicare Administrative Contractor (MAC), the PQRS code line will be denied but will be tracked in the National Claims History (NCH) for analysis
 3. When a group bills, the group NPI is submitted at the claim level; therefore, the individual rendering/performing physician's NPI must be placed on each line item, including all allowed charges and quality-data line items. Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field (#33a on the CMS-1500 form or the electronic equivalent)

Note: Claims may **NOT** be resubmitted for the sole purpose of adding or correcting QDCs. If a denied claim is subsequently corrected through the appeals process to the Carrier or A/B MAC, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.

Remittance Advice (R/A) / Explanation of Benefits (EOB)

The RA/EOB denial code **N365** is your indication that the PQRS codes were received into the National Claims History.

- **N365** reads: "This procedure code is not payable. It is for reporting/information purposes only."
- The **N365** denial code is just an indicator that the QDC codes were received. It does not guarantee the QDC was correct or that incentive quotas were met. However, when a QDC is reported satisfactorily (by the individual eligible professional), the **N365** can indicate that the claim will be used for calculating incentive eligibility.
- Keep track of all cases reported so that you can verify QDCs reported against the remittance advice notice sent by the Carrier or A/B MAC. Each QDC line-item will be listed with the **N365** denial remark code.

Submission through Carriers or A/B MACs

QDCs shall be submitted to Carriers or A/B MACs either through:

- **Electronic-based Submission:**
PQRS QDCs are submitted on the claim just like any other code; however, QDCs will have a \$0.00 (or nominal) charge. **Electronic submission**, which is accomplished using the **ASC X 12N Health Care Claim Transaction (Version 5010)**, should follow the current HIPAA standard version of the ASC x12 technical report 3.

OR

- **Paper-based Submission**
Paper-based submissions are accomplished using the **CMS-1500 claim form (version 08-05)** as described in the sample claim provided in Appendix D.

Group NPI Submission

When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering eligible professional's NPI must be placed on each line item, including all allowed charges and quality-data line items.

Solo NPI Submission

The individual NPI of the solo practitioner must be included on the claim as is the normal billing process for submitting Medicare claims. For PQRS, the QDC must be included on the claim(s) representing the eligible encounter that is submitted for payment at the time the claim is initially submitted in order to be included in PQRS analysis.

CMS-1500 Claim Example

An example of a claim in CMS-1500 format that illustrates how to report several PQRS measures is provided. See **Appendix D**.

Satisfactorily Reporting Measures

PQRS participants should also refer to *Satisfactorily Reporting 2013 Physician Quality Reporting System (PQRS) Measures – Claims Reporting Made Simple* and *Satisfactorily Reporting 2013 Physician Quality Reporting System (PQRS) Measures – Registry Reporting Made Simple*. These documents serve as educational resources to assist professionals and their staff with accurately reporting measures. These Fact Sheets provide helpful information on how to get started with PQRS and are available as downloadable documents in the Educational Resources section of the CMS PQRS website at <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS>.

Timeliness of Quality Data Submission

Claims processed by the Carrier or A/B MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 28, 2014 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

Analysis of PQRS Data Reporting Frequency (Measure Tag) and Performance Timeframes

Reporting frequency and performance timeframes are considered whether reporting through claims, registry, CMS qualified electronic health record, or the CMS group practice reporting option (GPRO).

Claims-based reporting: Quality data reported to CMS through Medicare Part B claims (containing QDC line items for each individual professional's NPI) are processed to final action by the Carrier or A/B MAC and subsequently transferred to the NCH where it is available for PQRS analysis. See **Appendix E**. Quality measures data reported on claims denied for payment are not included in PQRS analysis. QDC line items from claims are analyzed according to the measure specifications, including coding instructions, reporting frequency, and performance timeframes. See **Appendix F** for a flow diagram of the PQRS claims-based process.

Note: Registries are not required to submit QDCs.

Instructions for some measures limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Some measures, due to their complexity, are reportable as registry only or reportable only as a measures group.

Each measure specification includes a reporting frequency (measure tag) for each denominator-eligible patient seen during the reporting period. The reporting frequency described in the instructions applies to each individual eligible professional participating in PQRS. PQRS uses the reporting frequency to analyze each measure for determination of satisfactory reporting, according to the following measure tags:

- Patient-Process: Report a minimum of once per reporting period per individual eligible professional (NPI).
- Patient-Intermediate: Report a minimum of once per reporting period per individual eligible professional (NPI).

- Patient-Periodic: Report once per timeframe specified in the measure for each individual eligible professional (NPI) during the reporting period.
- Episode: Report once for each occurrence of a particular illness/condition by each individual eligible professional (NPI) during the reporting period.
- Procedure: Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period.
- Visit: Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period.

A measure's performance timeframe is defined in the measure's description and is distinct from the reporting frequency requirement. The performance timeframe, unique to each measure, outlines the timeframe in which the clinical action described in the numerator may be completed. See **Appendix A**.

Appendix A: Glossary of Terms

Terms	Definitions
Base Claim Diagnosis	PQRS refers to all diagnoses listed (Item 21 of the CMS-1500 claim form) associated with physician office, outpatient, and inpatient visits for reporting.
Claim	For PQRS purposes, one or more claims will be reconnected based on TIN, NPI, beneficiary and date of service.
CPT Category II Codes	<p>A set of supplemental CPT codes intended to be used for performance measurement. These codes may be used to facilitate data collection about the quality of care rendered by coding certain services, test results or clinical actions that support nationally established performance measures and that the evidence has demonstrated to contribute to quality patient care.²</p> <p>For PQRS, CPT Category II codes are used to report quality measures on a claim for measurement calculation.</p>
Denominator (Eligible Cases)	<p>The lower part of a fraction used to calculate a rate, proportion, or ratio.</p> <p>The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements.</p> <p>PQRS measure denominators are identified by ICD-9-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc.), and place of service (if applicable).</p> <p>Note: ICD-10-CM diagnosis codes have been incorporated into the <i>2013 PQRS Measures Specifications</i>. These codes are for REFERENCE ONLY and will not count toward satisfactorily reporting the measures within PQRS in the 2013 program year.</p>
Denominator Statement	A statement that describes the population eligible for the performance measure. For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."
Diagnosis Pointer	<p>Item 24E of the CMS-1500 claim form or electronic equivalent. For PQRS, the line item containing the quality-data code (QDC) for the measure should point to one diagnosis (from Item 21) per measure-specific denominator coding.</p> <p>To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRS analysis.</p>
Eligible Professional	<p>Refer to http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS for a list of professionals eligible to participate in 2013 PQRS.</p> <p>Providers not defined as eligible professionals in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRS and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the Medicare Physician Fee Schedule (PFS) are not included in PQRS (for example, services provided in federally qualified health centers, portable x-ray suppliers, independent laboratories, independent diagnostic testing facilities, hospitals, rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRS since DME is not paid under the PFS.</p>
Encounter	Encounters with patients during the reporting period which include: CPT Category I E/M service codes, CPT Category I procedure codes, or HCPCS codes found in a PQRS measure's denominator. These codes count as eligible to meet a measure's inclusion requirements when occurring during the reporting period.

Terms	Definitions
G-codes for PQRS	A set of CMS-defined temporary HCPCS codes used to report quality measures on a claim. G-codes are maintained by CMS.
ICD-9-CM Diagnosis Codes	The International Classification of Diseases, 9th Revision, Clinical Modification ⁵ is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office visits for reporting in PQRS.
ICD-10-CM Diagnosis Codes	<p>ICD-10-CM is a clinical modification of the World Health Organization's ICD-10, which consist of a diagnostics classification system. ICD-10-CM includes the level of detail needed for morbidity classification and diagnostics specificity in the United States.⁹</p> <p>ICD-10-CM diagnosis codes have been incorporated into the <i>2013 PQRS Measures Specifications</i>. These codes are for REFERENCE ONLY and will not count toward satisfactorily reporting the measures within PQRS in the 2013 program year.</p>
Line-Item Diagnosis	<p>Six service lines in Section 24 of the CMS-1500 claim form to accommodate submission of the rendering NPI and supplemental information to support the billed service, including the pointed diagnosis from Item 21.</p> <p>ODCs are submitted on the line item in section 24 for PQRS.</p>
Measure	<p>Performance Measure</p> <ul style="list-style-type: none"> A quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process or outcome. See also process measure and outcome measure.^{1,6} <p>Measure Types</p> <ul style="list-style-type: none"> Process measure: A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.⁶ Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function(s) or process(es).⁶ Structure measure: A measure that assesses whether organizational resources and arrangements are in place to deliver health care, such as the number, type, and distribution of medical personnel, equipment, and facilities.⁶

Terms	Definitions
Measure Reporting Frequency (Measure Tag)	<ul style="list-style-type: none"> • Patient-Process: Report a minimum of once per reporting period per individual eligible professional (NPI). <ul style="list-style-type: none"> ○ If the measure is reported more than once during the reporting period, performance rates are calculated using the most advantageous QDC submitted. ○ Reflect quality actions performed throughout the reporting period or other timeframe. • Patient-Intermediate: Report a minimum of once per reporting period per individual eligible professional (NPI). <ul style="list-style-type: none"> ○ If the measure is reported more than once during the reporting period, performance rates are calculated using the most recent QDC submitted. ○ Often reflects lab or other test value, so the most recent measurement is desired. • Patient-Periodic: Report once per timeframe specified in the measure for each individual eligible professional (NPI) during the reporting period. <ul style="list-style-type: none"> ○ Examples include once per month and three times per year. • Episode: Report once for each occurrence of a particular illness/condition by each individual eligible professional (NPI) during the reporting period. <ul style="list-style-type: none"> ○ Usually reflects a clinical episode, difficult to determine from a single Part B claim. ○ Requires specialized analytics to determine the episode. • Procedure: Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period. • Visit: Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008.
MMSEA	Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007.
NPI	National Provider Identifier of the individual eligible professional billing under the Tax ID ("NPI within the Tax ID").
Numerator	<p>The upper portion of a fraction used to calculate a rate, proportion, or ratio.</p> <p>A clinical action to be counted as meeting a measure's requirements (i.e., patients who received the particular service or obtained a particular outcome that is being measured).⁶</p> <p>PQRS measure numerators are CPT Category II codes and G-codes.</p>
Numerator Statement	<p>A statement that describes the clinical action that satisfies the conditions of the performance measure.</p> <p>For example, "Patients who were assessed for the presence or absence of urinary incontinence."</p>
Performance Timeframe	A designated timeframe within which the action described in a performance measure should be completed. This timeframe is generally included in the measure description and may or may not coincide with the measure's data reporting frequency requirement.
Performance Measure Exclusion Modifiers	Modifiers developed exclusively for use with CPT Category II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure's denominator. ²

Terms	Definitions
Performance Measure Reporting Modifier 8P	The 8P reporting modifier is intended to be used as a “reporting modifier” to allow the reporting of circumstances when an action described in a measure’s numerator is not performed and the reason is not otherwise specified. 8P performance measure reporting modifier - action not performed, reason not otherwise specified ²
Place of Service	References Place of Service Codes (POS) from the list provided in section 10.5 of the <i>Medicare Claims Processing Manual</i> .
Quality-Data Code (QDC)	Specified CPT Category II codes with or without modifiers and G-codes used for submission of PQRS data. The <i>2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry</i> contains all codes associated with each PQRS measure and instructions for data submission through the administrative claims system.
Rationale	A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results. ⁴
Remittance Advice (RA)	Means utilized by Medicare contractors to communicate to providers claims processing decisions such as payments, adjustments, and denials. ⁷
Reporting Frequency	The number of times QDCs specified for a quality measure must be submitted on claims during the reporting period. The reporting frequency for each measure is described in the <i>2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry</i> posted on the CMS Web site at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html .
Reporting Options	2013 reporting methods available for incentive payment: claims-based; registry-based; electronic health record (EHR); measures group; or CMS-selected group practice reporting options. Refer to the “2013 PQRS Participation Decision Tree (Appendix C)”.
Reporting Period	The period during which PQRS measures are to be reported for covered professional services provided. 6-month (July 1, 2013 through December 31, 2013) or 12-month (January 1, 2013 through December 31, 2013) time periods are available depending upon the 2013 reporting option the eligible professional selects for submitting PQRS quality data.
TRHCA	Tax Relief and Health Care Act of 2006.

Sources:

1. Agency for Health Care Research & Quality (AHRQ) National Quality Measures Clearinghouse Glossary.
2. IBID, PSNet, Patient Safety Network Glossary.
3. American Medical Association (AMA), CPT® Category II Index of Alphabetic Clinical Topics.
4. Institute of Medicine (IOM), Performance Measurement Accelerating Improvement, Appendix A Glossary, National Academies Press.
5. Joint Commission on Accreditation of Health Care Organizations (JCAHO).
6. National Center for Health Statistics (NCHS) of the Centers for Disease Control (CDC).
6. QualityNet, QMIS Specification Manual for National Hospital Quality Measures, Appendix D-3, Glossary of Terms version 2.3b, 9-28-2007.

7. CMS Medicare Learning Network, Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers.
8. Medicare Claims Processing Manual: Chapter 26 – Completing and Processing Form CMS – 1500 Data Set.
9. American Health Information Management Association (AHIMA), Understanding ICD-10, retrieved from official AHIMA website.

This symbol (asterisk) represents the Measure Developer (as noted in the Symbol and Copyright Information section following the 2013 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry). The NQF number is also listed.

Appendix B: Sample 2013 PQRS Measure

Official measure title.

* Measure #19 (NQF 0089): Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care

2013 PHYSICIAN QUALITY REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

Each individual measure specification identifies the available reporting option(s).

DESCRIPTION:

This segment includes a high-level description of the measure.

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

INSTRUCTIONS:

Details when the measure should be reported and who should report.

This measure is to be reported a minimum of once per reporting period for all patients with diabetic retinopathy seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

Measure Reporting via Claims:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II and/or G-codes are used to report the numerator of the measure.

Measure #19 can be reported via claims and registry.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code AND/OR G-code OR the CPT Category II code with the modifier AND G-code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

To ensure satisfactory reporting, submit all measure-specific coding for the beneficiary on the claim(s) representing the eligible encounter. If criteria are met, claims may be reconnected based on TIN/NPI/Beneficiary/Date of Service.

Refer to PQRS measure specification #33 to view a registry only specification.

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

Review patient demographics, DX, and encounter codes to determine if the patient meets denominator criteria.

Review other PQRS measures for which the patient meets denominator inclusion.

Enter the correct combination of codes on the claim.

Denominator statement describes the population evaluated by the performance measure.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

Denominator Criteria (Eligible Cases):

Patients aged ≥ 18 years on date of encounter

AND

Diagnosis for diabetic retinopathy (ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

Patient population that may be counted as eligible to meet a measure's inclusion requirements.

Identified by ICD-9-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc), and place of service (if applicable).

ICD-10-CM codes are included in the 2013 PQRS Measure Specifications for reference purposes only. These codes can not be used for 2013 reporting purposes.

Diagnosis for diabetic retinopathy (ICD-10-CM) [REFERENCE ONLY/Not Reportable]: E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359, E09.311, E09.319, E09.321, E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E13.311, E13.319, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359

AND

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

A clinical action counted as meeting the measure's requirements (i.e., patients who received the particular service or obtained a particular outcome that is being measured).

NUMERATOR:

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Measures may or may not contain definitions.

Definition:

Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient's diabetic care OR a copy of a letter in the medical record to the clinician managing the patient's diabetic care outlining the findings of the dilated macular or fundus exam.

Findings – Includes level of severity of retinopathy AND the presence or absence of macular edema

Measure #19 is an example of a complex measure. Review carefully to submit the quality-data codes (QDCs) that meet the quality action being reported.

NUMERATOR NOTE: The correct combination of numerator code(s) 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.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Macular or Fundus Exam Findings Communicated

(One CPT II code & one G-code [5010F & G8397] are required on the claim form to submit this numerator option)

CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

Examples of QDCs.

Numerator section outlines applicable quality-data coding options for reporting the numerator.

OR

Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons
(One CPT II code & one G-code [5010F-1P & G8397] are required on the claim form to submit this numerator option)

Append a modifier (1P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator

5010F with 1P: Documentation of medical reason(s) for not communicating findings of the dilated macular or fundus exam to the physician managing the on-going care of the patient with diabetes

Modifiers developed exclusively for use with CPT II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure's denominator.

Some measures allow no performance exclusions; some have only one or two.

Section 1:
Satisfactory
Reporting and
Performance.

Section 2:
Satisfactory
Reporting and
Excluded from
Performance.

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Measure #19 has two performance exclusion sections.

Section 2:
Satisfactory
Reporting and
Excluded from
Performance.

Dilated Macular or Fundus Exam Findings not Communicated for Patient Reasons

(One CPT II code & one G-code [5010F-2P & G8397] are required on the claim form to submit this numerator option)

Append a modifier (2P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.

5010F with 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the on-going care of the patient with diabetes

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:

(One G-code [G8398] is required on the claim form to submit this numerator option)

G8398: Dilated macular or fundus exam not performed

OR

Section 3:
Satisfactory
Reporting and
Performance Not
Met.

Dilated Macular or Fundus Exam Findings not Communicated, Reason not Specified

(One CPT II code & one G-code [5010F-8P & G8397] are required on the claim form to submit this numerator option)

Append a reporting modifier (8P) to CPT Category II code 5010F to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

5010F with 8P: Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.

Questions or comments regarding how the measure is constructed or suggestions for changes to a measure should be submitted to the measure's developer/owner.

RATIONALE:

The physician that manages the on-going care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS)

CLINICAL RECOMMENDATION STATEMENTS:

While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician. (Level A: III Recommendation) (AAO, 2003)

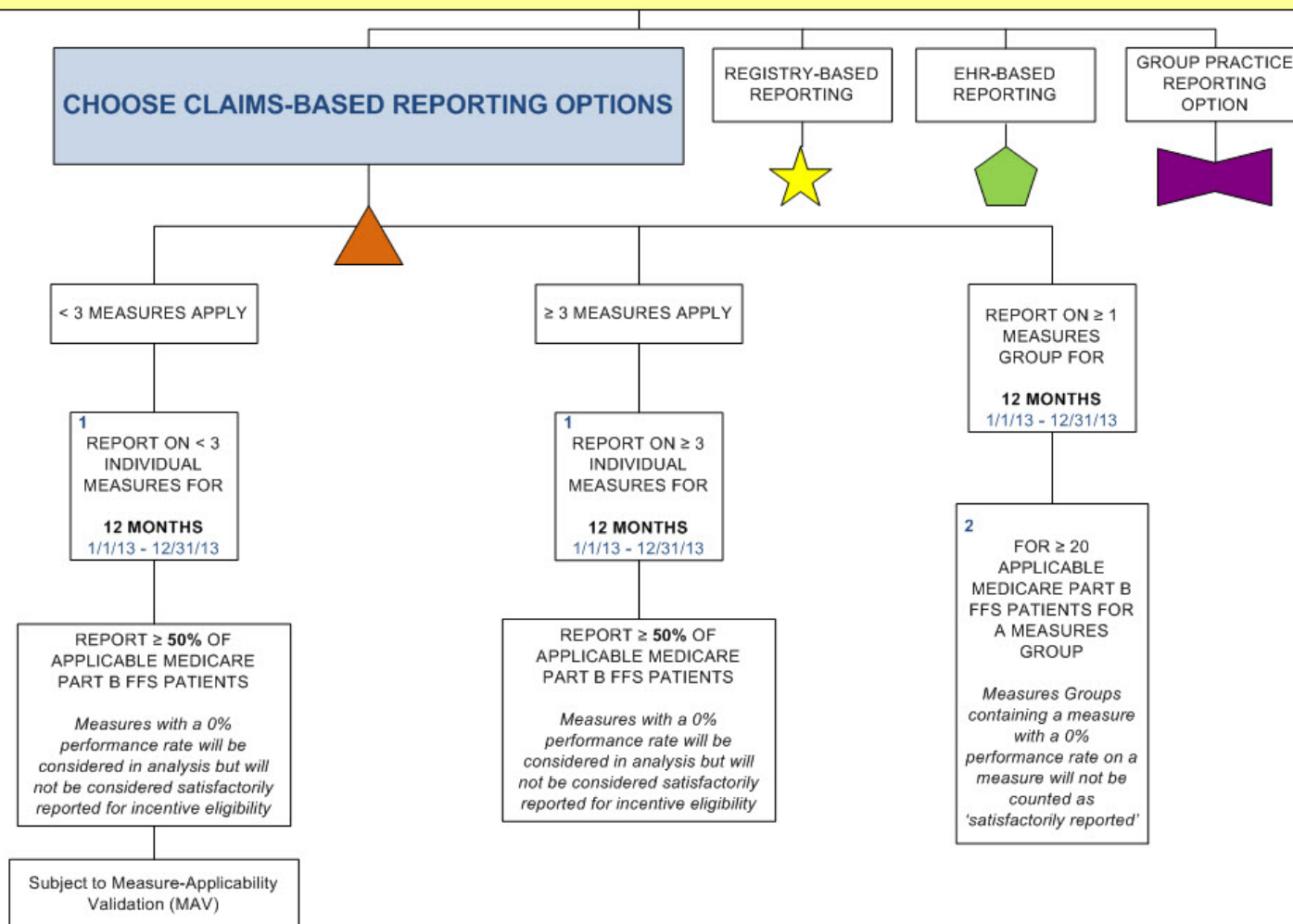
Although the ophthalmologist will perform most of the examination and all surgery, certain aspects of data collection may be conducted by other trained individuals under the ophthalmologist's supervision and review. Because of the complexities of the diagnosis and surgery for PDR, the ophthalmologist caring for patients with this condition should be familiar with the specific recommendations of the DRS, ETDRS, UKPDS, and DCCT/EDIC (see Appendices 3 and 5). [\[A:III\]](#) The ophthalmologist should also have training in and experience with the management of this particular condition. [\[A:III\]](#) (AAO, 2008)

Appendix C: 2013 PQRS Participation for Incentive Payment Decision Tree

I WANT TO PARTICIPATE IN THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

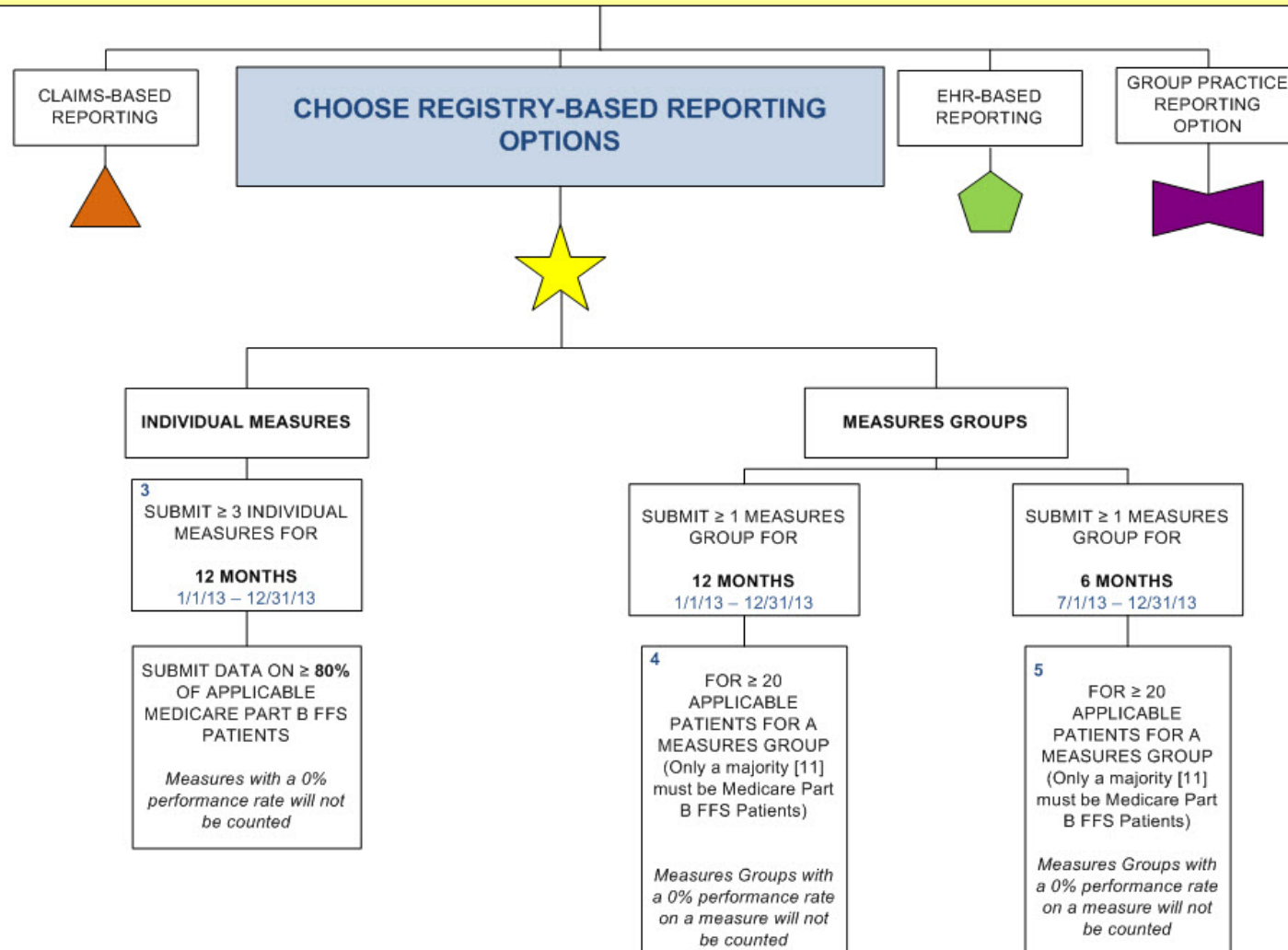
(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2013 PQRS)



I WANT TO PARTICIPATE IN THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

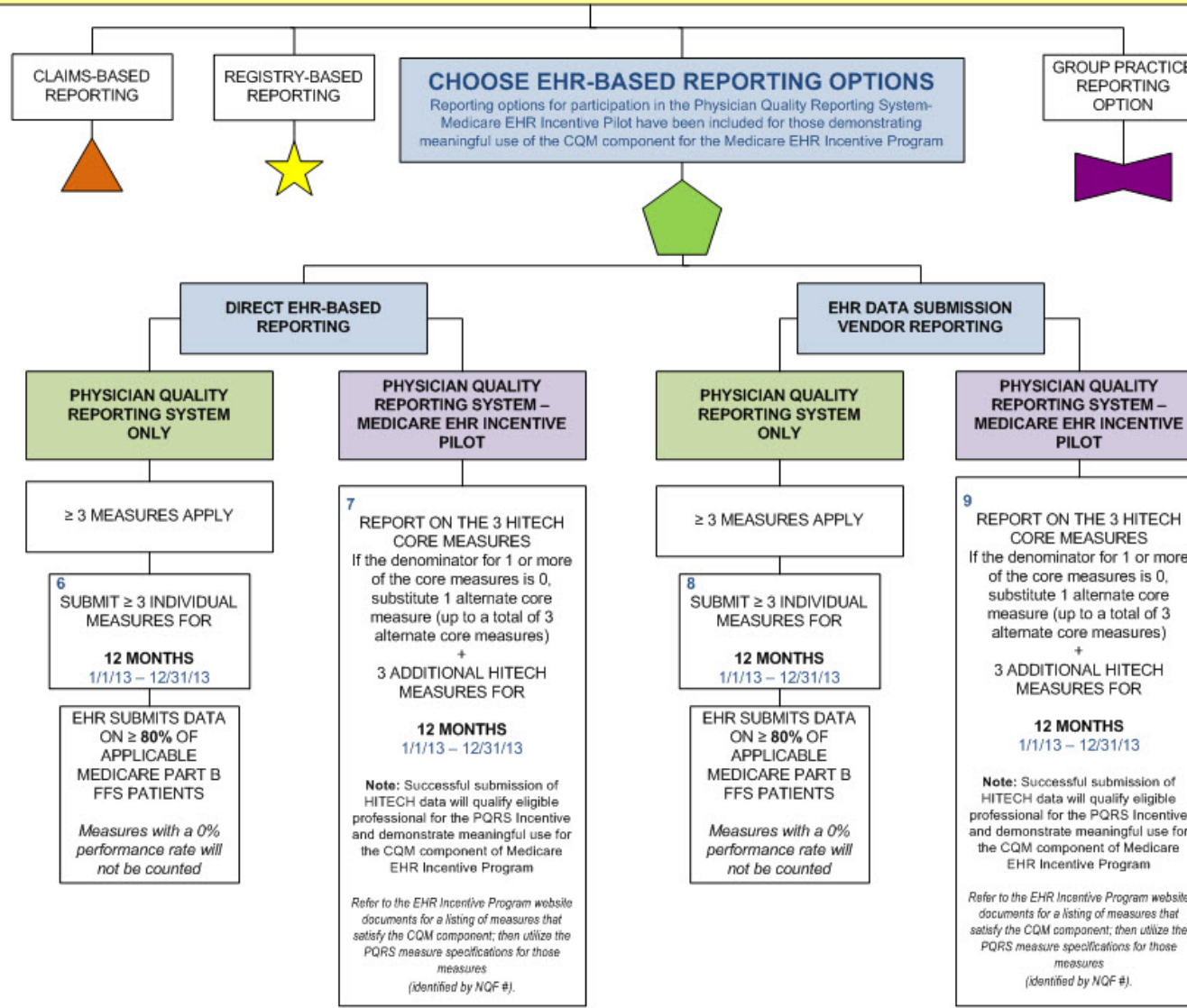
(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2013 PQRS)



I WANT TO PARTICIPATE IN THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

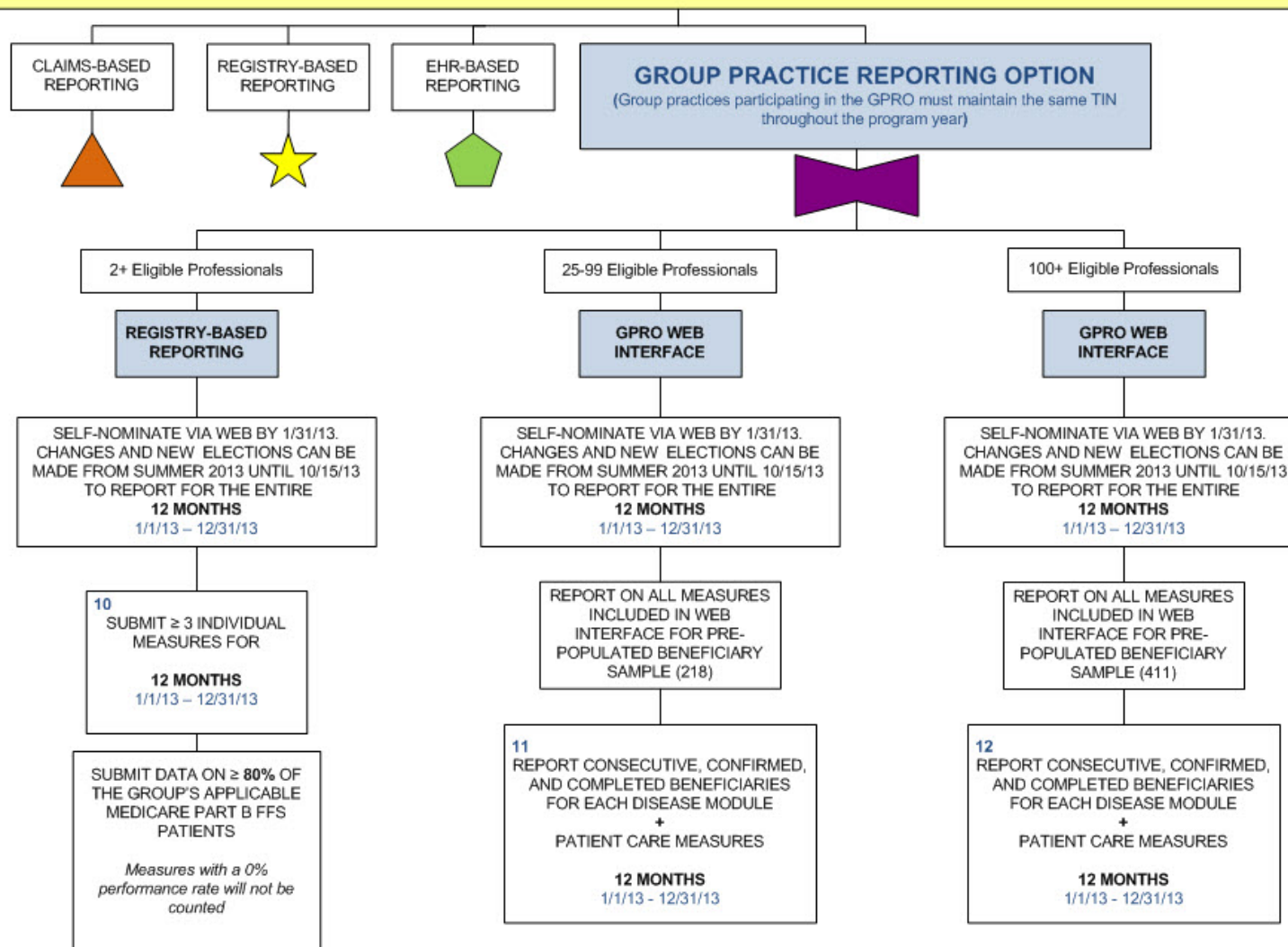
(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2013 PQRS)



I WANT TO PARTICIPATE IN THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

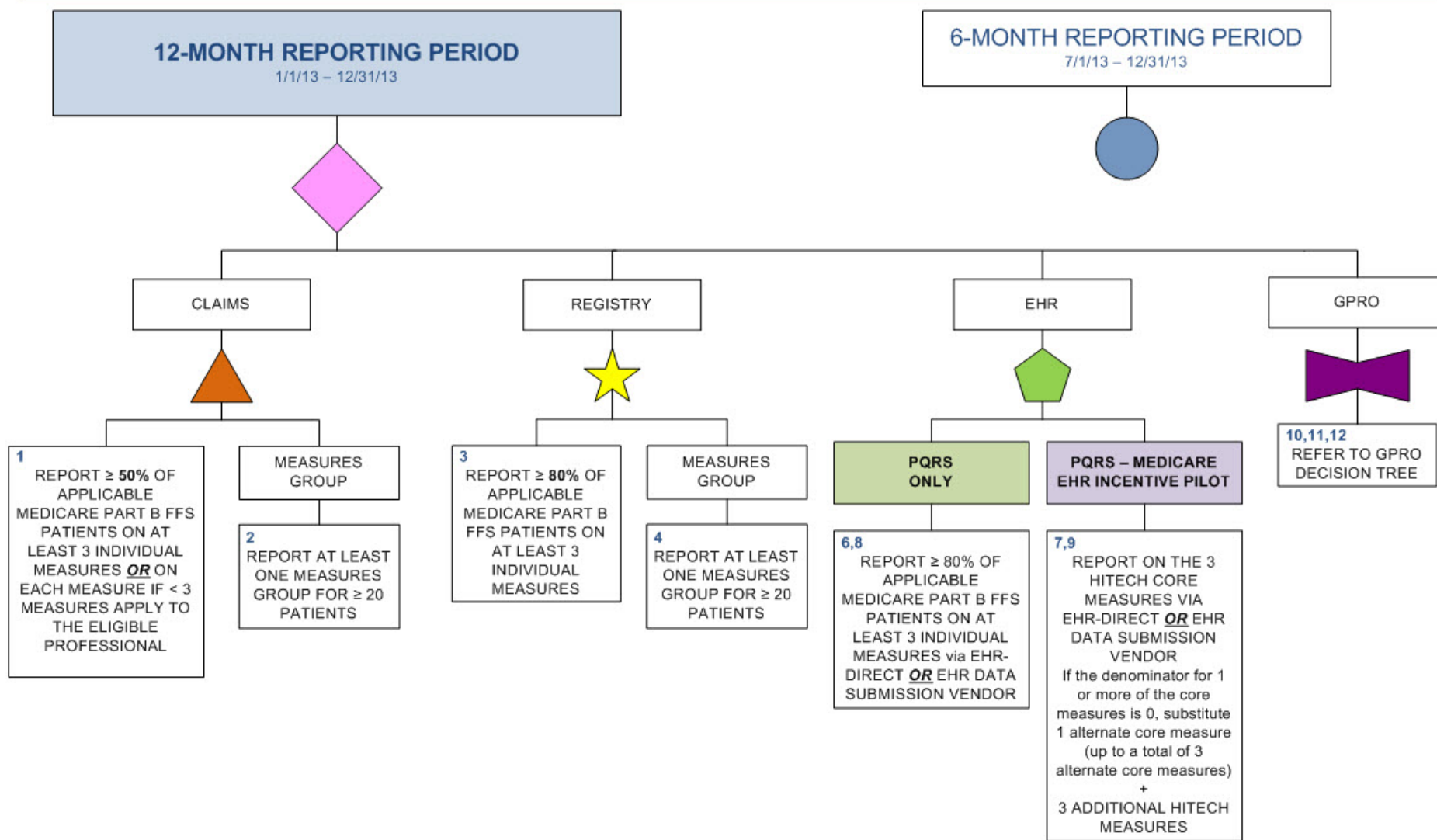
(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2013 PQRS)



I WANT TO PARTICIPATE IN THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2013 PQRS)



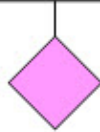
I WANT TO PARTICIPATE IN THE 2013 PHYSICIAN QUALITY REPORTING SYSTEM FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2013 PQRS)

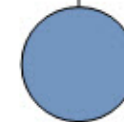
12-MONTH REPORTING PERIOD

1/1/13 – 12/31/13



6-MONTH REPORTING PERIOD

7/1/13 – 12/31/13



REGISTRY



MEASURES GROUP

5
REPORT AT LEAST ONE
MEASURES GROUP FOR
≥ 20 APPLICABLE PATIENTS

(Only a majority [11] must be
Medicare Part B FFS
Patients)

2013 Program Reporting Options

Number assigned coordinates with appropriate box on the Appendix C: 2013 PQRS Participation for Incentive Payment Decision Tree.

1. Claims-based reporting of individual measures (12 months)
2. Claims-based reporting of at least one measures group for 20 unique Medicare Part B FFS patients (12 months)
3. Registry-based reporting of at least 3 individual PQRS measures for 80% or more of applicable Medicare Part B FFS patients of each eligible professional (12 months)
4. Registry-based reporting of at least one measures group for 20 patients, the majority of which must be Medicare Part B FFS patients (12 months)
5. Registry-based reporting of at least one measures group for 20 patients, the majority of which must be Medicare Part B FFS patients (6 months)
6. Direct EHR-based reporting of at least 3 individual PQRS measures for 80% or more of applicable Medicare Part B FFS patients of each eligible professional (12 months)
7. Direct EHR-based reporting of a total of 3 HITECH core or alternate core measures AND at least 3 additional HITECH measures (12 months)
8. EHR Data Submission Vendor reporting of at least 3 individual PQRS measures for 80% or more of applicable Medicare Part B FFS patients of each eligible professional (12 months)
9. EHR Data Submission Vendor reporting of a total of 3 HITECH core or alternate core measures AND at least 3 additional HITECH measures (12 months)
10. GPRO-based reporting (2+ eligible professionals) of at least 3 individual PQRS measures via registry for 80% or more of the practice's applicable Medicare Part B FFS patients (12 months)
11. GPRO-based reporting (25-99 eligible professionals) of all applicable measures included in the submission web interface provided by CMS for consecutive, confirmed, and completed patients for each disease module and preventive care measures (12 months)
12. GPRO-based reporting (100+ eligible professionals) of all applicable measures included in the submission web interface provided by CMS for consecutive, confirmed, and completed patients for each disease module and preventive care measures (12 months)

Appendix D: CMS-1500 Claim PQRS Example

Example of an individual NPI reporting on a single CMS-1500 claim. See <http://www.cms.gov/manuals/downloads/clm104c26.pdf> for more information.

21. Review applicable PQRS measures related to ANY diagnosis (Dx) listed in Item 21. Up to 8 Dx may be entered electronically.

24D. Procedures, Services, or Supplies - CPT/HCPCS, Modifier(s) as needed

QDC codes must be submitted with a line-item charge of \$0.00 or \$0.01. Charge field cannot be blank.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE										ORIGINAL REF. NO.																																																																															
1. 250 .00 Diabetes Mellitus																																																																																																			
2. 414 .00 Coronary Artery Disease (CAD)																																																																																																			
23. PRIOR AUTHORIZATION NUMBER																																																																																																			
24. A. DATE(S) OF SERVICE										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. EPSDT Family Plan										I. ID. QUAL										J. RENDERING PROVIDER ID. #									
MM DD YY MM DD YY										MM DD YY										CPT/HCPCS										MODIFIER																																																																					
1 03 05 13 03 05 13 11																				99213																				1,2										47.00																																								NPI 0123456789									
2 03 05 13 03 05 13 11																				3048F																				1										0.00																																								NPI 0123456789									
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5 03 05 13 03 05 13 11																				4011F																				2																																																		NPI 0123456789									
6 03 05 13 03 05 13 11																				1090F																				1																																																		NPI 0123456789									
25. FEDERAL TAX I.D. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back)										28. TOTAL CHARGE										29. AMOUNT PAID										30. BALANCE DUE																																							
XX-XXXXXXX										X										XXXXXX										X YES NO										\$ 47.00										\$										\$ 47.00																																							
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & P																																																																															
SIGNED										DATE										a.										b.										a. XXXXXXXXXX										b.																																																	

Identifies claim line-item

If the system does not allow a \$0.00 line-item charge, a nominal amount can be substituted. The beneficiary is not liable for this nominal amount.

For group billing, the rendering NPI number of the individual eligible professional who performed the service will be used from each line-item in the PQRS calculations.

33a. The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; If a Group is billing, enter the NPI of the Group here. This is a required field.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0958-0995 FORM CMS-1500 (06/05)

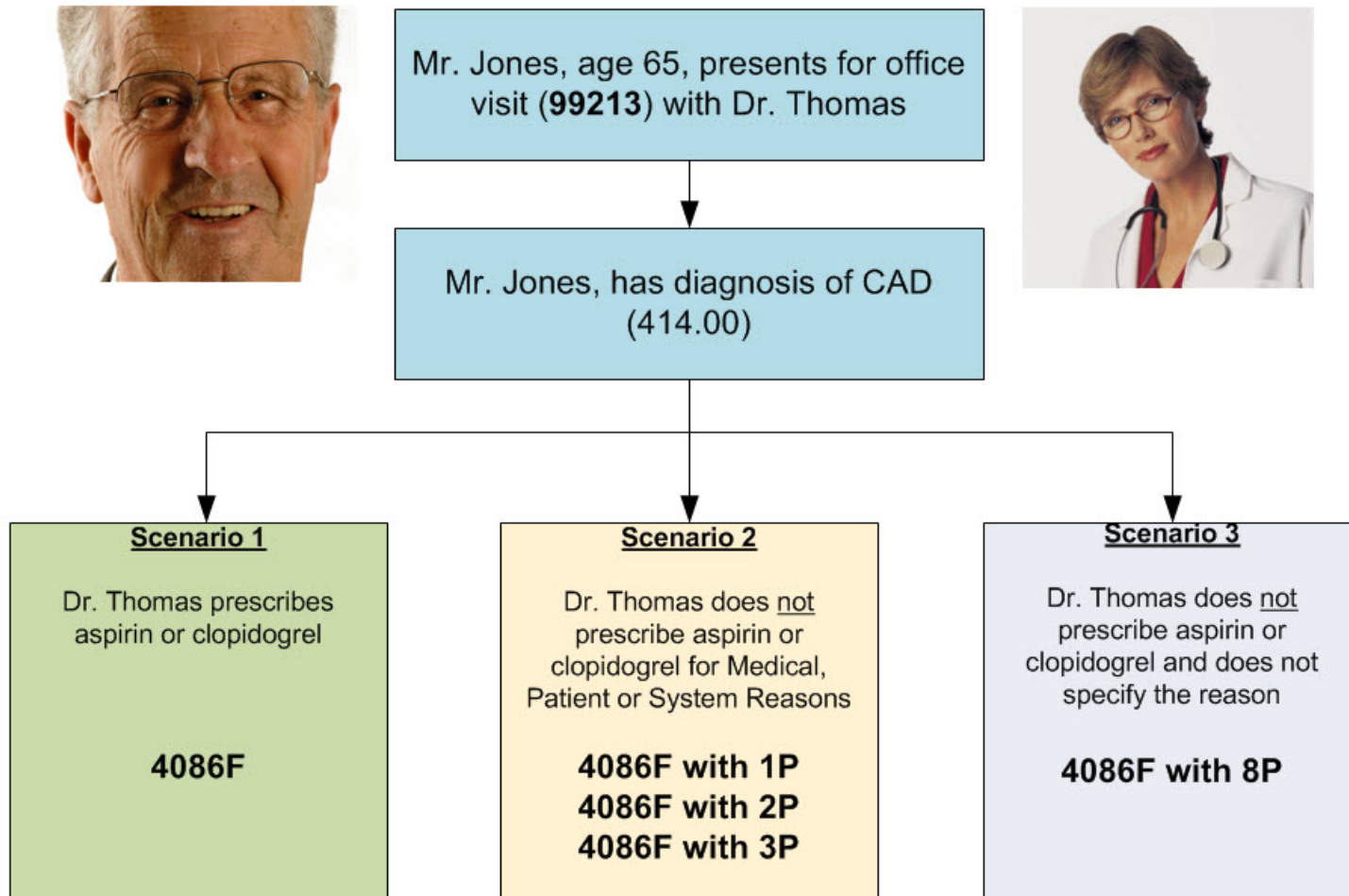
The patient was seen for an office visit (99213). The provider is reporting several measures related to diabetes, coronary artery disease (CAD), and urinary incontinence:

- Measure #2 (LDL-C) with QDC 3048F + diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);
- Measure #3 (BP in Diabetes) with QDCs 3074F + 3078F + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);
- Measure #6 (CAD) with QDC 4011F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and
- Measure #48 (Assessment - Urinary Incontinence) with QDC 1090F. For PQRS, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.
- Note: All diagnoses listed in Item 21 will be used for PQRS analysis. Measures that require the reporting of two or more diagnoses on claim will be analyzed as submitted as submitted in Item 21.
- NPI placement: Item 24J must contain the NPI of the individual provider who rendered the service when a group is billing.
- If billing software limits the line items on a claim, you may add a nominal amount such as a penny to one of the QDC line items on that second claim. PQRS analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

Appendix E: Satisfactory Reporting Scenarios

Satisfactorily Reporting Scenario

Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy



PQRS Claims-Based Process

