



# Physician Quality Reporting Initiative (PQRI) Satisfactorily Reporting

## 2010 PQRI Measures - Claims and Registry February 2010

The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program that provides an incentive payment to practices whose eligible professionals (identified on claims by their individual National Provider Identifier [NPI]) satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (includes Railroad Retirement Board and Medicare Secondary Payer). Each eligible professional must satisfactorily report on at least 80 percent of eligible instances in which a measure is reportable to qualify for the incentive. For 2010 PQRI, there are several reporting options that eligible professionals may choose from to submit quality data to the Centers for Medicare & Medicaid Services (CMS). This tip sheet focuses on claims-based and registry-based reporting. Although Medicare Part C-Medicare Advantage (MA) beneficiaries are not included in **claims-based** reporting of measures or measures groups, they may be included in **registry-based** reporting in certain circumstances. There is no requirement to register prior to submitting quality data. However, there are some preparatory steps that eligible professionals/practices should take prior to undertaking PQRI reporting. This tip sheet describes those steps and provides helpful tips for eligible professionals and their billing staff.

It is recommended that you, the eligible professional, and your billing staff establish an office work flow that allows accurate identification of each denominator-eligible Medicare Part B beneficiary claim (i.e., claims for services listed in the denominator coding section of each measure specification). The work flow process should also ensure that all eligible claims are accurately coded using PQRI quality-data codes (QDCs) found in the numerator section of the measure specification. The work flow process should also include discussions and coordination with your billing software vendor/clearinghouse to ensure they are reporting all PQRI codes accurately on your behalf. Consider implementing an edit on your billing software to ensure all eligible claims are flagged to include PQRI QDC coding for each measure you select to report prior to submitting claims to the Medicare Carrier/Medicare Administrative Contractor (MAC).

## How to Get Started

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### STEP 1:

Determine if you are eligible to participate. A list of eligible professionals who are eligible and able to participate in PQRI is available on the PQRI web page at <http://www.cms.hhs.gov/PQRI> on the CMS website. Read this list carefully, as not all entities are considered eligible because they are reimbursed by Medicare under other methods or fee schedules other than the PFS.

### STEP 2:

Determine which PQRI reporting option(s) best fits your practice (claims-based or registry-based reporting of either individual measures or measures groups) as well as the PQRI reporting period (12 months or 6 months where applicable), which varies with the reporting option selected. Refer to the 2010 PQRI Participation Decision Tree in Appendix C of the 2010 PQRI Implementation Guide, which is available as a downloadable document in the Measures Codes section of the PQRI web page at <http://www.cms.hhs.gov/PQRI> on the CMS website.

### STEP 3:

Review the 2010 PQRI Measures List, available as a downloadable document in the Measures Codes section of the PQRI web page at <http://www.cms.hhs.gov/PQRI> on the CMS website and determine which PQRI measures apply.

Eligible professionals who choose to report 2010 PQRI individual measures should select at least three applicable measures to submit to attempt to qualify for a PQRI incentive payment. If fewer than three measures are reported, CMS will apply a measure-applicability validation (MAV) process when determining incentive eligibility.

Eligible professionals who choose to report 2010 PQRI measures groups should select at least one measures group to submit to attempt to qualify for a PQRI incentive payment. Refer to the Measures Groups Specifications Manual to review measures group(s) applicable to your practice.

If you have already been participating in PQRI, there is no requirement to select new/different measures for the 2010 PQRI. Please note that all PQRI measure specifications are updated and posted prior to the beginning of each program year; therefore, eligible professionals will need to review them for any revisions.

### STEP 4:

#### *Individual PQRI Measures*

Once you have selected the measures (at least three), carefully review the following documents:

1. 2010 PQRI Measure Specifications Manual for Claims and Registry for instructions on how to report claims-based or registry-based individual measures. Just print the pages for the measure specifications you are reporting.
2. 2010 PQRI Implementation Guide which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in Form CMS-1500 format.

Both documents can be found as downloadable documents in the Measures Codes section of the PQRI web page at <http://www.cms.hhs.gov/PQRI> on the CMS website.

As you read the specifications and reporting instructions, you will notice that each of the measures has a QDC (a Current Procedural Terminology [CPT] II code or G-code) associated with it. Note that several measures allow the use of CPT II modifiers: 1P, 2P, 3P, and the 8P reporting modifier. Only allowable CPT II modifiers may be used with a CPT II code. Eligible professionals should use the 8P reporting modifier judiciously for applicable measures they have selected to report. The 8P modifier may not be used indiscriminately in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

To qualify for the incentive, the correct numerator QDC must be reported on at least 80 percent of the claims that are eligible for each selected measure. A claim is considered "eligible" in PQRI when the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis and the CPT Category I service codes on the claim match the diagnosis and encounter codes listed in the denominator criteria of the measure specification.

You will also notice that each measure has a reporting frequency or timeframe requirement (called a "measure tag" in PQRI analysis) for each eligible patient seen during the reporting period for each individual eligible professional (NPI). The reporting frequency (i.e., report each visit, once during the reporting period, each episode, etc.) is found in the Instructions section of each measure specification. Ensure that all members of the team understand and capture this information in the clinical record to facilitate reporting.

**Or:** As an alternative to reporting three individual measures, you can select to report one or more measures groups.

#### *PQRI Measures Groups*

Once you have selected a measures group(s) to report, carefully review the following documents:

1. 2010 PQRI Measures Groups Specifications Manual for claims-based or registry-based reporting of measures groups. Just print the pages for the measure specifications, including denominator coding, you are reporting. Note that the specifications for a measures group are different from those for individual measures because they identify a common denominator across the measures group. Be sure you use the correct specifications.
2. Getting Started with 2010 PQRI Reporting of Measures Groups is the implementation guide for reporting measures groups.
3. 2010 PQRI Fact Sheet: PQRI Made Simple For Reporting the Preventive Care Measures Group provides a useful worksheet to keep track of each unique patient reported when using the 30 patient sample method to report a measures group.

You can find the first two documents as downloadable documents in the Measures Codes section of the PQRI web page at <http://www.cms.hhs.gov/PQRI> on the CMS website. The third document can be found as a downloadable document in the Educational Resources section of the PQRI web page.

## Tips for PQRI Reporting

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The following tips are offered to assist eligible professionals and their staff to submit PQRI measures accurately.

### Claims-Based Reporting of Individual Measures

- Ensure all staff understand the measures you have selected to report. The primary authoritative source for measure specifications are those posted on the PQRI web page.
- Ensure the practice has a method to flag eligible cases when billing Medicare, including Medicare as a secondary payer, so that QDCs on those cases are also reported. Review **all** the denominator codes that can affect **claims-based** reporting, particularly for broadly applicable measures or measures that do not have an associated diagnosis (e.g., #110 Influenza Vaccine, #154 Falls Risk Assessment, #47 Advance Care Planning, etc.) because you will need to report on each eligible claim as instructed in the measure specifications.
- Ensure you identify and capture **all** eligible claims per the measure denominator for each measure selected. Note that several measures apply broadly across various settings of care (not only office practices, but also hospitals, nursing homes, and home health). For example, the table below shows some measures that include only CPT Category I service codes in the denominator; no ICD-9-CM diagnosis code is required for denominator inclusion. Therefore, each individual eligible professional who chooses to report these broadly applicable measures will need to report the QDC on each eligible claim that falls into the denominator. Failure to submit a QDC on claims for these Medicare patients will result in a “missed” PQRI reporting opportunity that can impact incentive eligibility.

**Table 1: PQRI Measures With CPT Category I Codes**

Measure Number	Measure Title	PQRI Reporting
47	Advance Care Plan	Report a minimum of <b>once</b> for all patients aged 65 years and older meeting denominator encounter codes.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Report a minimum of <b>once</b> for all patients aged 50 years and older meeting denominator encounter codes.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	Report a minimum of <b>once</b> for all patients aged 65 years and older meeting denominator encounter codes.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Report a minimum of <b>once</b> for all patients aged 18 years and older meeting denominator encounter codes.
130	Documentation and Verification of Current Medications in the Medical Record	Report at <b>each visit</b> - all patients aged 18 years and older meeting denominator encounter codes.

- For measures that require capturing clinical values for coding, make sure that these clinical values are available to those who are coding claims for PQRI reporting.
- Some measures have specified patient demographics, such as age parameters and sex, for denominator inclusion.
- For measures that you have selected to report, carefully review all ICD-9-CM diagnoses (if applicable) and CPT service (encounter) codes that will qualify claims for inclusion in PQRI measurement calculations (i.e., claims that are denominator-eligible) and to ensure that each claim includes the appropriate QDC(s) or QDC with the allowable CPT II modifier with the individual eligible professional's NPI in the rendering provider ID field on the claim. Refer to the 2010 PQRI Implementation Guide. If the diagnosis or encounter code is different on the claim than those listed in the PQRI denominator, then that claim is considered as not applicable for the measure and will not count toward the determination of satisfactory reporting.
- For measures that require more than one QDC (CPT II or G-code), please ensure that **all** codes are captured on the claim. For example, when submitting codes for Measure #3 High Blood Pressure Control in Type I and Type II Diabetes Mellitus, be sure to include codes for both the systolic and diastolic blood pressure. Refer to the Form CMS-1500 Claim Sample, Appendix D of the 2010 PQRI Implementation Guide.

- If all billable services on the claim are denied for payment by the carrier/MAC, the QDCs will not be included in PQRI analysis. The claim, as a whole, must include the payment codes (usually ICD-9-CM, CPT Category I, or Healthcare Common Procedure Coding System [HCPCS] codes) which supply the denominator, as well as the QDCs, which supply the numerator in order for the measure's QDCs to be included in PQRI analysis. If the denied claim is subsequently corrected and paid through an adjustment, reopening, **or** the appeals process by the carrier/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 corrected claim as instructed in the measure specifications. Claims may **not** be resubmitted only to add or correct QDCs, and claims with only QDCs on them with a zero total dollar amount may not be resubmitted to the carrier. Remember that claim adjustments, reopenings, or appeals processed by the carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History [NCH] file) by February 25, 2011 to be included in the 2010 PQRI analysis.
- QDCs should be submitted on the line item of the claim as a zero charge or a nominal amount such as a penny may be entered if billing software does not permit a zero charge line item. The submitted charge field (\$Charges) cannot be left blank. Since there is no allowed charge for the PQRI QDC line items, all PQRI QDC line items will be denied by the carrier claims processing system and passed onto the NCH file for PQRI analysis and incentive-payment eligibility calculation. The Remittance Advice (RA) with denial code N365 is your indication that the PQRI codes were passed into the NCH file for use in calculating incentive eligibility. Review the measure specifications to determine the appropriate numerator codes to place on the claim. When applicable, utilize the 8P reporting modifier (or G-code equivalent) when the action required is not performed and the reason is not otherwise specified so that the claim will count toward satisfactory reporting.
- Check your RA notices regularly to ensure you receive a remark code N365 for each QDC submitted denoting that QDCs for individual measures and/or measures groups were passed into the NCH. This remark does not confirm QDC accuracy.

### **Claims-based Reporting of Measures Groups**

There are two reporting methods for submission of measures groups that involve a patient sample selection: either the 30 patient sample method or the 80 percent patient sample method.

An "intent G-code" must be submitted for either method to initiate your intent to report measures groups via claims.

- When reporting quality actions for the PQRI measures groups, the individual eligible professional may report QDCs on each individual measure within the measures group **or** report one (composite) G-code, which indicates that **all** quality actions for all the measures in the group were performed. For example, G8499 indicates all quality actions for the measures in the rheumatoid arthritis measures group have been performed for the patient.

If all of the quality actions for the measures within the measures group were performed at an encounter during the reporting period, the eligible professional could report the composite G-code instead of reporting QDCs for each measure individually. Note that performance exclusion modifiers (i.e., 1P, 2P, 3P, or G-code equivalent) and the 8P reporting modifier cannot apply to the reporting of any measure within the measures group if the composite G-code is used for reporting because **all** of the quality actions for each measure must have been performed and documented. Refer to the Getting Started with 2010 PQRI Reporting of Measures Groups document posted in the Measures Codes section of the PQRI web page.

- If a patient selected for inclusion in the 30 patient sample did not receive all the quality actions and that patient returns at a subsequent encounter, QDC(s) may be added (where applicable) to that subsequent claim to indicate that the quality action was performed during the reporting period. PQRI analysis will consider all QDCs submitted across multiple claims for patients included in the 30 patient sample.
- Eligible professionals need to only report the applicable measures for each patient that meets denominator inclusion in the patient sample. Denominator inclusion for both the 30 patient sample method and the 80 percent patient sample method are determined by diagnoses and/or encounters common to measures within a selected measures group. For example, if patient #3 in the sample does not meet the age requirements for all of the measures within the measures group, report those measures that **are** applicable to patient #3. All patients may not meet all of the measure criteria within the measures group.
- Eligible professionals who have contracted with MA health plans should not include their MA patients in **claims-based** reporting of measures groups using the 30 patient sample method. In addition, only Medicare Part B FFS patients should be included in claims-based reporting of measures groups.

### **Common Reporting Errors Associated with Claims-based Reporting**

- No QDC submitted on an eligible claim. Failure to submit a QDC on claims for these Medicare patients will result in a “missed” PQRI reporting opportunity that can impact incentive eligibility.
- Eligible claim without an individual NPI or with the NPI incorrectly placed on the claim will result in a claim rejection by the carrier and will not be included in PQRI analysis.
- Eligible claim submitted as a QDC-only claim (no denominator information is accompanied).
- QDC submitted on a denominator-ineligible claim for the PQRI measure:
  - Diagnosis is incorrect on claim for measure reported;
  - Encounter code is incorrect on claim for measure reported; or
  - Age/gender on claim is incorrect for measure reported.
- Billing software does not allow enough lines on the claim and splits the claim. CMS will reconnect split claims before PQRI analysis.

## Registry-based Reporting of Individual Measures or Measures Groups

Submission of at least three individual measures or at least one measures group via registry is governed by the 2010 PQRI Measure Specifications Manual for Claims and Registry and the 2010 PQRI Measures Groups Specifications Manual, respectively. The qualified registry is responsible for providing their clients with instructions on how to submit the selected measures or measures group through the registry. Information regarding qualified registries can be found in the Alternative Reporting Mechanisms section of the PQRI web page.

**NOTE:** Some 2010 PQRI individual measures and measures groups are reportable through the registry-based reporting option only.

When reporting 30 unique patients for the 30 patient sample method for measures groups via registry-based reporting, the patient sample may include Medicare Part B FFS patients as well as non-Medicare patients (minimum of two Medicare Part B FFS patients).

## Medical Record Documentation

Eligible professionals should document fulfillment of measure requirements in the medical record.

## Feedback Reports

Registration in Individuals Authorized Access to CMS Computer Services (IACS) after the conclusion of the program year is needed to receive a tax identification number (TIN)-level PQRI feedback report. Individual eligible professionals may request an NPI-level feedback report through their carrier/MAC, which does not require registration in IACS.

**Table 2: PQRI References**

PQRI Reference	PQRI Web Page
2010 PQRI Fact Sheet: What's New for the 2010 PQRI	<a href="#">Educational Resources Download</a>
Eligible Professionals List	<a href="#">Overview Download</a>
2010 PQRI Implementation Guide Appendix A: Glossary of Terms Appendix B: Sample 2010 PQRI Measure Appendix C: 2010 PQRI Participation Decision Tree Appendix D: CMS-1500 Claim Example	<a href="#">Measures Codes Download</a>
2010 PQRI Measures List	<a href="#">Measures Codes Download</a>
2010 PQRI Measure Specifications Manual for Claims and Registry	<a href="#">Measures Codes Download</a>



**Table 2: PQRI References (continued)**

PQRI Reference	PQRI Web Page
2010 PQRI Measures Groups Specifications Manual	<i>Measures Codes Download</i>
Getting Started with 2010 PQRI Reporting of Measures Groups Appendix A: Decision Tree Appendix B: CMS-1500 Claim Examples	<i>Measures Codes Download</i>
2010 PQRI Fact Sheet: PQRI Made Simple For Reporting Preventive Care Measures Group	<i>Educational Resources Download</i>
2010 PQRI Measure Applicability Validation Process for Claims-Based Reporting of Individual Measures	<i>Analysis and Payment Download</i>
PQRI National Provider Calls (NPC)	<i>CMS Sponsored Calls Download</i>
FAQs	<i>PQRI FAQs - Related Links Inside CMS, bottom of PQRI web page</i>



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