CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-22 Medicare Quality Reporting Incentive Programs	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1	**Date: June 11, 2010**
	Change Request 6935

SUBJECT: Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Medicare Quality Reporting Incentive Programs Manual

I. SUMMARY OF CHANGES: This CR implements the new manual consisting of chapters 1 and 2, describing the Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Incentive Programs.

EFFECTIVE DATE: September 13, 2010
IMPLEMENTATION DATE: September 13, 2010

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N	1/Table of Contents
N	1/10 Background
N	1/20 Eligible Professionals
N	1/20.1 Professionals Eligible to Participate But Not Able to Participate
N	1/20.2 Professionals Not Eligible to Participate in the PQRI and Not Able to Qualify to Earn an Incentive Payment
N	1/20.3 Participation by Group Practices
N	1/30 Payment for Reporting
N	1/40 Reporting Period
N	1/50 Form and Manner of Reporting
N	1/50.1 Claims-based Reporting Mechanism
N	1/50.1.1 Coding and Reporting Principles for Claims-based Reporting
N	1/50.2 Registry-based Reporting Mechanism

N	1/50.3 Electronic Health Record-based (EHR-based) Reporting Mechanism
N	1/60 PQRI Measures
N	1/60.1 Reporting of Individual Quality Measures
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N	1/70 Criteria for Determination of Satisfactory Reporting
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N	1/70.1.3 Criteria for Determination of Satisfactory Reporting for EHR-based Reporting
N	1/70.2 Criteria for Determination of Satisfactory Reporting for Group Practices and Process for Reporting by Group Practices
N	1/80 Limitations on Review
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N	2/10 Background
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	2/20.1 Professionals Eligible to Participate But Not Able to Participate
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N	2/20.3 Participation by Group Practices
N	2/30 Payment for Reporting
N	2/40 Reporting Period
N	2/50 Form and Manner of Reporting
N	2/50.1 Claims-based Reporting Mechanism

N	2/50.1.1. Coding and Reporting Principles for Claims-based Reporting
N	2/50.2 Registry-based Reporting Mechanism
N	2/50.3 Electronic Health Record-based (EHR-based) Reporting Mechanism
N	2/60 Criteria for Determination of Successful Electronic Prescriber
N	2/60.1 Criteria for Determination of Successful Electronic Prescriber for Individual Eligible Professionals
N	2/60.2 Criteria for Determination of Successful Electronic Prescriber for Group Practices
N	2/70 Confidential Feedback Reports

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

Pub. 100-22	Transmittal: 1	Date: June 11, 2010	Change Request: 6935

SUBJECT: The Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Medicare Quality Reporting Incentive Programs Manual

Effective Date: September 13, 2010

Implementation Date: September 13, 2010

I. GENERAL INFORMATION

A. Background: The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program that provides an incentive payment to identified individual eligible professionals (EPs). Section 131 of the Medicare Improvements for Patients and Providers Act (MIPPA), enacted on July 15, 2008, made PQRI, initially established under the Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 MIEA-TRHCA permanent. Section 132 of the MIPPA required the Secretary to establish a new incentive program for individual eligible professional (EPs) who are successful electronic prescribers as defined by MIPPA beginning on January 1, 2009. This CR manualizes the information contained in existing CRs and MPFS legislation. This CR does not establish new requirements for the PQRI and eRx programs. It manualizes existing requirements to the programs. Changes to the programs are described in the annual MPFS legislation.

B. Policy: This CR implements the new manual describing the Physician Quality Reporting Initiative (PQRI) and E-Prescribing (eRx) Incentive Programs.

II. BUSINESS REQUIREMENTS TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6935.1	Contractors shall be aware of the new Pub.100-22 that manualizes the PQRI and e-Rx program requirements.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
							FISS	MCS	VMS	CWF	
6935.2	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements:

X-Ref Requirement Number	Recommendations or other supporting information:
CR 6514	Coding and Reporting Principles for the Physician Quality Reporting Initiative (PQRI) and the Electronic Prescribing (E-Prescribing) Incentive Programs
CR 6394	Program Overview: 2009 Physician Quality Reporting Initiative (PQRI) and the 2009 Electronic Prescribing (E-Prescribing) Incentive Program
CR 6187	2008 Physician Quality Reporting Initiative Claims-Based Reporting of Measures Groups

Section B: For all other recommendations and supporting information, use this space: N/A

V. CONTACTS

Pre-Implementation Contact(s): Diane Stern, diane.stern@cms.hhs.gov

Post-Implementation Contact(s): Diane Stern, diane.stern@cms.hhs.gov

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Quality Reporting Incentive Programs Manual

Chapter 1 – The Physician Quality Reporting Initiative (PQRI)

Table of Contents
(Rev.1, 06-11-10)

Transmittals for Chapter 1

10 - Background

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program that provides an incentive payment to identified individual eligible professionals (EPs) (and beginning with the 2010 PQRI, group practices) who satisfactorily report data on quality measures for covered professional services (defined below) furnished by EPs during a specified reporting period.

The PQRI was first implemented in 2007 as a result of section 101 of Division B – Medicare Improvements and Extension Act of 2006 of the Tax Relief and Health Care Act of 2006 (P.L. 109-432) (MIEA-TRHCA), which was enacted on December 20, 2006. Section 101(b) of the MIEA-TRHCA adds subsection (k) to section 1848 of the Social Security Act (the Act), which requires the establishment of a quality reporting system. Section 101(c) of the MIEA-TRHCA authorizes the Secretary to provide an incentive payment to EPs who satisfactorily report data on quality measures under the quality reporting system for covered professional services furnished to Medicare beneficiaries during the second half of 2007. CMS named both the quality reporting system and the incentive payment the PQRI. Section 1848(k)(3)(A) of the Act defines "covered professional services" as services for which payment is made under, or is based on, the Medicare Part B Physician Fee Schedule PFS and which are furnished by an EP.

Section 101(b)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173) (MMSEA), which was enacted on December 29, 2007, amends section 1848(k)(2)(B) of the Act (as added by the MIEA-TRHCA) and section 101(c) of the MIEA-TRHCA to extend the physician quality reporting system through 2009 and to authorize the Secretary to make PQRI incentive payments for covered PFS services furnished to Medicare Part B fee-for-service (FFS) beneficiaries in 2008. In addition, the MMSEA amends section 101(c) of the MIEA-TRHCA by requiring the Secretary, for 2008 and 2009, to establish alternative reporting criteria and alternative reporting periods for reporting on measures groups, and for registry-based reporting.

Section 131of the Medicare Improvements for Patients and Providers Act (P.L. 110-275) (MIPPA), which was enacted on July 15, 2008, makes the quality reporting system initially established under MIEA-TRHCA permanent. In addition, section 131(b)(2) of the MIPPA redesignates section 101(c) of the MIEA-TRHCA, as amended by MMSEA, as subsection (m) of section 1848 of the Act. Section 1848(m) of the Act, as redesignated and amended by the MIPPA, authorizes the Secretary to make PQRI incentive payments for covered PFS services furnished to Medicare Part B FFS beneficiaries in 2009 and 2010. The program requirements for the PQRI are summarized in this chapter.

20 – Eligible Professionals

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

As defined in section 1848(k)(3)(B) of the Act, eligible professional means any of the following:

1. *Physicians*

- *Doctor of Medicine*
- *Doctor of Osteopathy*
- *Doctor of Podiatric Medicine*
- *Doctor of Optometry*
- *Doctor of Dental Surgery*
- *Doctor of Dental Medicine*
- *Doctor of Chiropractic*

2. *Practitioners*
   - *Physician Assistant*
   - *Nurse Practitioner*
   - *Clinical Nurse Specialist*
   - *Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)*
   - *Certified Nurse Midwife*
   - *Clinical Social Worker*
   - *Clinical Psychologist*
   - *Registered Dietician*
   - *Nutrition Professional*
   - *Audiologists (as of 1/1/2009)*

3. *Therapists*
   - *Physical Therapist*
   - *Occupational Therapist*
   - *Qualified Speech-Language Therapist (began billing Medicare directly as of 7/1/09)*

Audiologists were added to the definition of EPs beginning with the 2009 PQRI as required by section 131(b)(4) of the MIPPA.

All Medicare-enrolled professionals in these categories are eligible to participate in the PQRI, regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims.

20.1 – Professionals Eligible to Participate But Not Able to Participate
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Some professionals who are included in the definition of "EP" above, although listed as eligible to participate in the PQRI, are not able to participate for one or more reasons described below.

These include EPs in certain settings in which Medicare PFS billing is processed by Medicare FIs/AB MACs. The FI/AB MAC claims processing systems for the following settings currently cannot accommodate billing at the individual EP level:

- *Critical access hospitals (CAHs), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI or Part A MAC for the covered professional services furnished by the EP.*

- *All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.*

20.2 – Professionals Not Eligible to Participate in the PQRI and Not Able to Qualify to Earn an Incentive Payment

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Providers and professionals not defined as EPs are not eligible to participate in PQRI and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the PFS are not included in PQRI (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRI since DME is not based on or paid under the PFS.

20.3 – Participation by Group Practices

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Prior to 2010, the PQRI was limited to EPs and the determination of whether an EP satisfactorily reported quality data was made at the individual professional level, based on the National Provider Identifier (NPI). No incentive payments were made to a group practice based on a determination that the group practice, as a whole, satisfactorily reported PQRI quality measure data. To the extent that individual EPs (based on individuals' NPIs) are associated with more than one practice, or Tax Identification Number (TIN), the determination of whether an EP satisfactorily reported PQRI quality measures data was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN (see §30 below).

As required by the MIPPA, group practices can qualify to earn a PQRI incentive payment beginning with the 2010 PQRI based on the determination that the group practice, as a whole, satisfactorily reports PQRI quality measures data. The criteria for satisfactory reporting for group practices and the process for reporting by group practices under the PQRI group practice reporting option (GPRO) are discussed in §70.2 below. For purposes of this reporting option, "group practice" is defined as a TIN with at least 200 individual EPs (as identified by NPIs) who have reassigned their billing rights to the TIN.

In order to participate in the PQRI GPRO, group practices are required to complete a self-nomination process and to meet the following requirements:

- *Have an active Individuals Authorized Access to CMS Systems (IACS) user account;*
- *Agree to attend and participate in all mandatory training sessions;*
- *Have billed Medicare Part B on or after January 1, 2009 and prior to October 29, 2009;*

- *Provide CMS with an electronic file (such as, a Microsoft® Excel file) with the self-nomination letter that includes the group practice's TIN and the individual NPI numbers, name of the group practice, and names of all EPs who will be participating as part of the group practice (that is, all individual NPI numbers associated with the group practice's TIN);*
- *Provide a single point of contact for handling administrative issues as well as a single point of contact for technical support purposes;*
- *Have technical capabilities, at a minimum: standard PC image with Microsoft® Office and Microsoft® Access software installed; and minimum software configurations;*
- *Be able to comply with a secure method for data submission; and*
- *Provide CMS access (if requested) to review Medicare beneficiary data on which 2010 PQRI GPRO submissions are founded.*

CMS assesses whether the participation requirements are met by each self-nominated group practice and notifies group practices of a decision. Under section 1848(m)(3)(C)(iii) of the Act, an individual EP who is a member of a group practice selected to participate in the PQRI GPRO for a particular program year is not eligible to separately earn a PQRI incentive payment as an individual EP under that same TIN (that is, for the same TIN/NPI combination) for that year. Once a group practice (TIN) is selected to participate in the GPRO for a particular program year, this is the only PQRI reporting option available to the group and all individual NPIs who bill Medicare under that group's TIN for that program year.

30 – Payment for Reporting

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

A participating individual EP or group practice (see §20 above) who satisfactorily reports data on PQRI quality measures as described in §70.1 and §70.2, respectively, may earn an incentive payment with respect to covered professional services furnished by the EP or group practice during a specified reporting period (see §40 below). For 2007 and 2008, a participating individual EP who met the criteria for satisfactorily reporting data on PQRI quality measures for 2007 and 2008, respectively, qualified to earn a 1.5% incentive payment. For 2009, a participating individual EP who met the criteria for satisfactory reporting data on PQRI quality measures qualified to earn a 2.0% incentive payment. For 2010, a participating individual EP or group practice who meets the criteria for satisfactory reporting data on PQRI quality measures may qualify to earn a 2.0% incentive payment.

For each year, the PQRI incentive payment is calculated based on an EP's (or for the 2010 PQRI and subsequent years, a group practice's) total estimated Medicare Part B PFS allowed charges for all covered professional services: (1) furnished during the applicable reporting period, (2) received into the CMS National Claims History (NCH) file by no later than 2 months after the end of the reporting period, and (3) paid under or based upon the Medicare PFS. Because claims processing times may vary by time of the year and Medicare Carrier/AB MAC, participating EPs or group practices should submit claims from the end of a reporting period promptly, so that if, for example, the reporting period ends on December 31st of a particular year, claims from the end of the reporting period will reach the NCH file by February 28th of the

following year. PQRI incentive payments are paid as a lump sum. PQRI incentive payments are generally made in the middle of the year following the year in which the reporting period falls. There is no beneficiary co-payment or notice to the beneficiary regarding the PQRI incentive payments.

The PQRI incentive payment amount is calculated using estimated allowed charges for all covered professional services under the Medicare Part B PFS, not just those charges associated with reported quality measures. The term "allowed charges" refers to total charges. Note that the amounts billed above the Medicare Part B PFS amounts for assigned and non-assigned claims do not apply to the incentive payment. The statute defines PQRI covered professional services as those paid under or based upon the Medicare Part B PFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a different methodology.

Other Part B services and items that may be billed by EPs but are not paid under or based upon the Medicare PFS do not apply to the PQRI incentive payment. In addition, any amounts owed to CMS, such as from overpayments or other withholds, are subtracted from the incentive payment amount.

The analysis of satisfactory reporting is performed at the individual EP level using individual-level NPI data, and beginning in 2010, for group practices participating in the GPRO, the group practice level using TIN data. For both participating individual EPs and group practices, CMS uses the TIN as the billing unit. Therefore, any PQRI incentive payments earned are paid to the TIN holder of record. For individual EPs, PQRI incentive payments are paid to the holder of the TIN, aggregating individual incentive payments for groups that bill under one TIN. For EPs who submit claims under multiple TINs, CMS groups claims by TIN for payment purposes. As a result, a provider with multiple TINs who qualifies for the PQRI incentive payment under more than one TIN would receive a separate PQRI incentive payment associated with each TIN.

In situations where EPs are employees or contractors who have assigned their payments to their employers or facilities, section 1848(m)(1)(A) of the Act specifies that any PQRI incentive payment earned be paid to the employers or facilities.

40 – Reporting Period

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For the 2007 PQRI, which was the first program year, the reporting period was July 1, 2007 through December 31, 2007, as required by section 1848(m)(6)(C)(i)(I) of the Act.

For 2008, 2009, 2010, and 2011, section 1848(m)(6)(C)(i)(II) of the Act defines "reporting period" to be the entire calendar year. Under section 1848(m)(6)(C)(ii) of the Act, however, for years after 2009, the Secretary is authorized to revise such reporting periods. In addition, section 1848(m)(5)(F) of the Act requires the Secretary to, beginning with the 2008 PQRI, establish alternative reporting periods for reporting groups of measures, or measures groups, and for reporting using a medical registry.

Beginning with the 2008 PQRI, there are 2 reporting periods for each program year: (1) a 12-month reporting period consisting of the entire calendar year and (2) a 6-month reporting period beginning July 1st and ending December 31st. Depending upon the particular program year, the second reporting period beginning July 1st may not apply to all of the PQRI reporting options that are available for that program year (see §70 below for further details).

50 – Form and Manner of Reporting
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

EPs may choose to report quality measures data to CMS using one of the following established reporting mechanisms:

- *Claims-based reporting;*
- *Registry-based reporting; or*
- *EHR-based reporting (beginning in 2010).*

For the 2007 PQRI, CMS implemented the claims-based reporting mechanism based on submission of quality measures data on Medicare Part B claims. The registry-based reporting mechanism became available to EPs beginning with the 2008 PQRI. The registry-based reporting mechanism is available for reporting either individual PQRI quality measures or PQRI measures groups (see §60.1 and §60.2, respectively)

The EHR-based reporting mechanism became available to EPs beginning with the 2010 PQRI and is available for reporting on individual PQRI quality measures only (see §60.1 below).

50.1 – Claims-based Reporting Mechanism
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

EPs who choose to participate in PQRI via the claims-based reporting mechanism do not have to enroll or register with CMS to begin reporting PQRI quality measures data to CMS.

Participating EPs whose Medicare patients fit the specifications of the PQRI quality measures and/or measures groups will simply report on their claims the corresponding appropriate quality-data codes (QDCs), which are CPT Category II codes or G-codes (where CPT Category II codes are not yet available). CPT Category II codes and G-codes are Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P.

50.1.1 – Coding and Reporting Principles for Claims-based Reporting
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

The following principles apply to the reporting of QDCs for PQRI measures:

- *The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:*

- *on the same claim(s) as the denominator billing code(s) for the same date of service (DOS)*
- *for the same beneficiary*
- *for the same date of service (DOS)*
- *by the same EP (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator.*

- *All diagnoses reported on the claim will be included in PQRI analysis, as some PQRI measures require reporting more than one diagnosis on a claim. For line items containing a QDC, only a single reference number in the diagnosis pointer field will pass into the NCH file. 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 (base claim diagnoses) are considered in PQRI analysis.*

- *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. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically. The PQRI 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 professional identified by his or her rendering individual NPI. In other words, base claim diagnoses apply to all rendering TIN/NPIs on the claim. EPs should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL reported measures applicable to that patient's care.*

- *If the EPs billing software limits the number of line items available on a claim, an EP 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. CMS will look across all claims data for common occurrences of carrier claim control numbers, equated beneficiary claim numbers (HIC), and carrier numbers.*

  Only final action claims will be analyzed for PQRI. For PQRI measure calculation purposes, claims will be combined based on the same beneficiary for the same date-of-service, for the same 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 or QDCs are not dropped.

- *QDCs must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered professional service is performed.*
  - *The submitted charge field cannot be blank.*
  - *The line item charge should be $0.00.*
  - *If an EPs billing software does not allow a $0.00 line-item charge, a nominal amount can be substituted such as 1 penny ($0.01) – the beneficiary is not liable for this nominal amount.*

- *Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)*
- *Whether a $0.00 charge or a nominal amount is submitted to the carrier/contractor, the PQRI QDC code line is denied and tracked.*

- *QDC line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. EPs will receive a Remittance Advice (RA) associated with the claim which will contain the PQRI quality-data code line-item and will include a standard remark code (N365) and a message that confirms that the QDCs passed into the NCH file. N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does **NOT** indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.*
  - *Keep track of all PQRI cases reported so that the EP can verify QDCs reported against the remittance advice notice sent by the carrier/MAC. Each QDC line-item will be listed with the N365 denial remark code.*

- *Multiple EPs' QDCs can be reported on the same claim using their individual NPI. Therefore, when a group is billing, the group should follow its normal billing practice of placing the NPI of the individual EP who rendered the service on each line item on the claim including the QDC line(s).*

- *Some measures require the submission of more than one QDC in order to properly report the measure. EPs may report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.*

- *Use of CPT II modifiers (1P, 2P, 3P, 8P) 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. Do not append CPT I modifiers to CPT II codes or vice versa.*

- *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).*

- *EPs may submit multiple codes for more than one measure on a single claim.*

- *Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.*

- *If a denied claim is subsequently corrected through the appeals process to the Carrier/AB 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.*

- *Claims may **NOT** be resubmitted for the sole purpose of adding or correcting QDCs.*

- *EPs 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.

Submission through Carriers/MACs
QDCs shall be submitted to carriers/MACs either through:
Electronic submission, *which is accomplished using the* ***ASC X 12N Health Care Claim Transaction (Version 4010A1).***

CPT Category II and/or temporary G-codes should be submitted in the ***SV101-2*** *"Product/Service ID" Data Element on the* ***SV1*** *"Professional Service" Segment of the* ***2400 "Service Line" Loop****.*

- *It is also necessary to identify in this segment that a HCPCS code (HC) is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.*
- *Diagnosis codes are submitted at the claim level,* ***Loop 2300, in data element HI01****, and if there are multiple diagnosis codes, in* ***HI02 through HI08*** *as needed with a single reference number in the diagnosis pointer.*
- *In general for group billing, report the NPI for the rendering provider in* ***Loop 2310B*** *(Rendering Provider Name, claim level) or* ***2420A*** *(Rendering Provider Name, line level), using data elements* ***NM109 (NM108=XX)****.*

OR

Paper-based submission*, which is accomplished by using the* ***CMS-1500 claim form (version 08-05)****. Relevant ICD-9-CM diagnosis codes are entered in* ***Field 21. Service codes*** *(including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in* ***Field 24D*** *with a single reference number in the diagnosis pointer* ***Field 24E*** *that corresponds with the diagnosis number in Field 21.*

- *For group billing, the* ***National Provider Identifier (NPI)*** *of the rendering provider is entered in* ***Field 24J****.*
- *The* ***Tax Identification Number (TIN)*** *of the employer is entered in* ***Field 25****.*

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

Individual NPI Submission
The individual NPI of the solo practitioner must be included on the claim line as is the normal billing process for submitting Medicare claims. For the PQRI, the QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in PQRI analysis.

CMS-1500 Claim Example
An example of a claim in CMS-1500 format that illustrates how to report several PQRI measures is available in the PQRI Implementation Guide, a downloadable document that is updated for each program year and posted on the CMS PQRI website http://www.cms.hhs.gov/PQRI.

Satisfactorily Reporting Measures

PQRI participants should also refer to a PQRI Tip Sheet: "Satisfactorily Reporting 2010 PQRI Measures," an educational resource to assist professionals and their staff with accurately reporting PQRI measures. This Tip Sheet provides helpful information on how to get started with PQRI reporting and is available as a downloadable document in the Educational Resources section of the CMS PQRI website http://www.cms.hhs.gov/PQRI.

Timeliness of Quality Data Submission

Claims processed by the Carrier/MAC must reach the National Claims History (NCH) file by no later than 2 months after the end of the reporting period to be included in the analysis. For the 2010 PQRI, for example, claims processed by the Carrier/MAC must reach the NCH file by no later than February 28, 2011 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 for PQRI.

50.2 – Registry-based Reporting Mechanism

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Individual EPs may choose to participate in the PQRI Incentive Program via the registry-based reporting mechanism (this option became available beginning with the 2008 PQRI). EPs who choose to participate in the PQRI via the registry-based reporting mechanism do not have to enroll or register to begin registry-based reporting of PQRI quality measures data to CMS. However, to report PQRI quality measures data via the registry-based reporting mechanism, an EP must select a qualified PQRI registry and enter into and maintain an appropriate legal arrangement with the selected PQRI registry. Such arrangements should provide for the registry's receipt of patient-specific data from the EP and the registry's disclosure of quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of the EP to CMS. An EP choosing the registry-based reporting mechanism must submit information on PQRI individual quality measures or measures groups to his or her selected registry in the form and manner and by the deadline specified by the registry. Thus the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide clinical quality measures results and numerator and denominator data on individual quality measures or measures groups on behalf of the eligible professional for the PQR.

CMS qualifies registries to participate in each program year through a self-nomination process. Registries that were qualified to submit data on behalf of EPs in a prior program year are not required to go through the qualification process again unless they were unsuccessful at submitting PQRI data for the prior program year by the registry's data submission deadline. The final list of qualified registries for a particular program year is made available on the CMS PQRI website at http://www.cms.hhs.gov/PQRI. The list is usually made available in the

summer of the program year in question. For example, the list of qualified registries for the 2008 PQRI was made available in the summer of 2008.

50.3 – Electronic Health Record-based (EHR-based) Reporting Mechanism
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

To report PQRI quality measures data via the EHR-based reporting mechanism, an EP must select a qualified EHR product. An EP choosing the EHR-based reporting mechanism must:

- *Have an active IACS user account that will be used to submit clinical quality data extracted from the EHR to CMS;*
- *Submit a test file containing real or dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse; and*
- *Submit a file containing the EP's PQRI clinical quality data extracted from the EHR for the entire reporting period via IACS by no later than 2 months after the end of the reporting period. For 2010 PQRI, date for data submission is extended to March 31, 2010.*

CMS qualifies EHR vendors and their specific product(s) for use by EPs to submit PQRI quality measures data to CMS. The list of qualified EHR vendors and products for a specific program year are made available on the CMS PQRI website at http://www.cms.hhs.gov/PQRI. The list of 2010 qualified EHR vendors and products is posted. New 2011 qualified HER vendors and their products will be posted in late 2010 or early 2011.

60 – PQRI Measures
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

To qualify to earn the PQRI incentive payment, an EP must report data on quality measures. Beginning with the 2008 PQRI, EPs have the option of reporting data on individual quality measures or on measures groups. PQRI measures groups are created by CMS by grouping 4 or more PQRI measures that have a clinical condition or focus in common. The PQRI measures that comprise a measures group share a common denominator specification and therefore differ in their specifications from that of individual measures.

60.1 – Individual PQRI Quality Measures
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

When the PQRI was first implemented in 2007, the program consisted of 74 individual quality measures. In 2008, CMS retired some of the 2007 measures but added new measures so that the total number of PQRI individual quality measures expanded to 119. The 2009 PQRI included a total of 153 individual quality measures. Data on 53 of the 2009 PQRI measures may only be reported through a qualified registry and may not be reported through claims-based reporting (see §50 above). The 2010 PQRI includes a total of 175 individual quality measures. Data on 10 of the 2010 PQRI measures may be reported via a qualified EHR product, however, two of these may not be reported through claims-based reporting. In addition, data on 50 of the 2010 PQRI measures may not be reported through claims-based reporting. Such data must be reported through a qualified registry, or if the measure is 1 of the 10 measures designated for EHR reporting, via a qualified EHR product.

A complete list of the individual PQRI quality measures for a specific program year, as well as their detailed measure specifications can be found on the CMS PQRI website at http://www.cms.hhs.gov/PQRI. Measure specifications for the current or upcoming program year can be found on the Measures Codes page of the CMS PQRI website. Measure specifications for prior program years are archived to the appropriate PQRI Program page of the CMS PQRI website.

When measures for a particular program year are selected from a prior year's measure set, the detailed measure specifications for such measures may have been updated or modified during the National Quality Forum endorsement process or for other reasons. The PQRI quality measure specifications for any given measure selected for use in a specific program year may, therefore, be different from specifications for the same quality measure used for a prior program year. For example, the 2009 PQRI specifications for a measure that was used in the 2008 PQRI may be different from the 2008 PQRI specifications for the same measure. EPs must ensure that they are using the published specifications for the correct program year.

60.2 – Reporting of Measures Groups

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For the 2008 PQRI, CMS established 4 measures groups to address the following clinical topics:
(1) Diabetes Mellitus,
(2) Chronic Kidney Disease (CKD),
(3) Preventive Care, and
(4) End Stage Renal Disease (ESRD).

For the 2009 PQRI, CMS removed the ESRD measures group, but added 4 additional measures for a total of 7 measures groups. The 2009 PQRI measures groups address the following clinical topics:
(1) Diabetes Mellitus,
(2) CKD,
(3) Preventive Care,
(4) Coronary Artery Bypass Graft (CABG) Surgery,
(5) Rheumatoid Arthritis,
(6) Perioperative Care, and
(7) Back Pain.

For the 2010 PQRI, CMS retained all of the 2009 PQRI measures groups and added 6 new measures groups for a total of 13 measures groups. The 2010 PQRI measures groups address the following clinical topics:
(1) Diabetes Mellitus,
(2) CKD,
(3) Preventive Care,
(4) CABG Surgery,
(5) Rheumatoid Arthritis,
(6) Perioperative Care,
(7) Back Pain,

(8) Coronary Artery Disease (CAD),
(9) Heart Failure,
(10) Hepatitis C,
(11) Ischemic Vascular Disease (IVD),
(12) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS), and
(13) Community-Acquired Pneumonia (CAP).

Generally, an EP can choose to report the measures that form a particular measures group as either individual measures or to report the measures group. The measures in the Back Pain measures group, however, are reportable only as a measures group and may not be reported as individual measures. In addition, data on the CABG, CAD, Heart Failure, and HIV/AIDS measures groups must be reported through a qualified registry only and may not be reported through claims-based reporting (see §50 above).

Measures groups specifications are different from the specifications for individually reported measures that form the group. Therefore, the specifications, including the list of measures selected for inclusion in each of the PQRI measures groups, and reporting instructions for the PQRI measures groups are provided separately from the specifications for the individual PQRI measures. The specifications manual for measures groups can be found on the CMS PQRI website at http://www.cms.hhs.gov/PQRI. Measures group specifications for the current or upcoming program year can be found on the Measures Codes page of the CMS PQRI website. Measures group specifications for prior program years are archived to the appropriate PQRI Program page of the CMS PQRI website.

To initiate claims-based reporting of measures groups, it is necessary that the EP indicate the intention to begin reporting a measures group by submitting a measures group-specific G-code on the patient claim. There is one defined measures group-specific G-code for each PQRI measures group. It is not necessary to submit the measures group-specific G-code on more than one claim. If the measures group-specific G-code for a given group is submitted multiple times during the reporting period, only the submission with the earliest date of service will be included in the PQRI analyses; subsequent submissions of that code will be ignored. It is not necessary to submit the measures-group specific G-code for registry-based submissions. In addition, beginning for the 2009 PQRI, if ***all*** *quality actions for the applicable measures in a measures group have been performed for the patient,* ***one PQRI composite G-code*** *may be reported in lieu of the individual quality-data codes for each of the measures within the group. There is one defined composite G-code for each PQRI measures group.*

Similar to the specifications for individual PQRI measures, when measures groups for a particular program year are selected from a prior year's measures group set, the detailed measures group specifications for such a measures group may have been updated or modified during the National Quality Forum endorsement process or for other reasons. In addition, the individual measures that comprise a specific measures group may change from year to year. Therefore, the PQRI measures group specifications for any given measures group selected for use in a specific program year may be different from specifications for the same measures group used for a prior program year. For example, the measures that form the Diabetes Mellitus and CKD measures groups for the 2009 PQRI are different from the measures that were included in these measures groups for 2008.

Not only do EPs need to ensure that they are using the measures groups specifications rather than the specifications for the individual PQRI measures, but EPs also must ensure that they are using the measures groups specifications for the correct program year.

70 – Criteria for Determination of Satisfactory Reporting
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

In order to qualify to earn a PQRI incentive payment, EPs and group practices must meet the criteria for satisfactorily reporting data on PQRI quality measures. The criteria that are applicable depend on whether participation is at the individual EP level or at the group practice level and may differ from one program year to another.

70.1 – Criteria for Determination of Satisfactory Reporting for Individual EPs
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For EPs participating in the PQRI at the individual EP level, the criteria for satisfactory reporting differ depending on the reporting period an EP chooses to report, the manner in which an EP reports (whether the EP chooses the claims-based, registry-based, or EHR-based reporting mechanism), and whether an EP chooses to report on individual quality measures or on measures groups. For the 2007 PQRI, there was only 1 reporting option and a single reporting period, that an EP could use to attempt to satisfactorily report quality measures. There was no option of reporting on measures groups, or reporting through a qualified registry or qualified EHR.

In 2008, with the introduction of registry-based reporting, reporting on measures groups, and alternative reporting periods for the PQRI, multiple reporting options became available. For the 2008 PQRI, there were a total of 9 reporting options. For the 2009 PQRI, 9 reporting options were also available but there were some differences between the 2008 PQRI reporting options and the 2009 PQRI reporting options. For the 2010 PQRI, 11 reporting options are available. To qualify for a PQRI incentive payment for a particular program year, each EP must ensure that he or she meets the criteria for satisfactory reporting for the relevant reporting period, relevant reporting mechanism, and for reporting either individual measures or measures groups, as appropriate.

Although there are multiple reporting options for satisfactory reporting, an EP only needs to satisfactorily report under one option for a specific program year to qualify for the incentive payment applicable to a reporting period for the program year. An EP who qualifies for more than one reporting period for a particular program year will receive the incentive payment for the longest reporting period for which the professional qualifies for that program year. Only one incentive payment per program year may be obtained regardless of how many reporting options the EP chooses.

For purposes of determining satisfactory reporting, if an EP attempts to submit data for a quality measure or measures group at least once, then the measure or measures group is presumed to be applicable to the EP. EPs are responsible for selecting the quality measures and/or measures groups that are applicable to their practices.

70.1.1 – Criteria for Determination of Satisfactory Reporting for Claims-based Reporting

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

As discussed in §60 above, EPs have the option of reporting on individual quality measures or on measures groups. The criteria for determining whether an EP satisfactorily reports data on PQRI quality measures for reporting individual quality measures are different from the criteria for satisfactory reporting of measures groups.

To qualify for a PQRI incentive payment through claims-based reporting of individual measures, each EP must meet the following criteria for satisfactory reporting during the applicable reporting period:

- *Report at least 3 PQRI measures for the relevant program year, or 1-2 measures, if less than 3 measures apply to an EP; and*
- *Report each measure on at least 80 % of the Medicare Part B FFS patients to whom the measure applies.*

For the 2007 PQRI, these criteria applied to the 6-month reporting period beginning July 1st only. For the 2008 and 2009 PQRI, these criteria applied to the 12-month reporting period beginning January 1st only. For the 2010 PQRI, these criteria apply to both the 12-month reporting period beginning January 1st and the 6-month reporting period beginning July 1st for claims-based reporting of individual measures. This results in a total of 2 reporting options for claims-based reporting of individual measures for the 2010 PQRI. The 2010 PQRI criteria for satisfactorily reporting individual quality measures through claims-based reporting that each EP must meet under these 2 reporting options are summarized in ***Table 1*** *below along with the relevant reporting period for each reporting option.*

Table 1: Criteria for Satisfactory Reporting of Individual Quality Measures through Claims

Reporting Criteria	***Reporting Period***
• *Report at least 3 PQRI measures, or 1-2 measures if less than 3 measures apply to an EP; and* • *Report each measure for at least 80% of Medicare Part B FFS patients to whom the measure applies.*	*January 1, 2010– December 31, 2010*

• *Report at least 3 PQRI measures, or 1-2 measures if less than 3 measures apply to an EP; and* • *Report each measure for at least 80% of Medicare Part B FFS patients to whom the measure applies.*	*July 1, 2010– December 31, 2010*

For EPs who have fewer than three measures applicable to the services that they furnish, the claims-based reporting mechanism is the only option available for these EPs to report individual PQRI quality measures. EPs who report on fewer than three individual PQRI individual quality measures may be subject to a two-step measure-applicability validation (MAV) process. The purpose of the MAV is to determine whether the EP should have submitted quality-data codes for additional measures. If CMS finds that EPs who have reported fewer than three quality measures have not reported additional measures that are also applicable to the services they furnished during the reporting period, then those EPs cannot earn the incentive payment. More information on the MAV process for a specific program year is available in the Analysis and Payment section of the CMS PQRI website at http://www.cms.hhs.gov/PQRI.

When claims-based reporting of measures groups was introduced in the 2008 PQRI program, the only reporting period available for claims-based reporting of measures groups was the 6-month reporting period beginning July 1, 2008. However, there were 2 reporting options for claims-based reporting of measures groups for 2008. The first reporting option for claims-based reporting of measures groups for the 2008 PQRI consisted of the following criteria for satisfactory reporting:

- *Report at least 1 measures group; and*
- *Report each measure in the measures group on at least 15 consecutively seen Medicare Part B FFS patients to whom the measures in the measures group apply for each participating EP.*

The term "consecutive' refers to the manner in which the patients are seen by the EP and are selected for inclusion in the EP's patient sample. The patient sample must consist of at least 15 unique Medicare Part B FFS patients seen consecutively, or in order, by date of service, by the EP.

The second reporting option for claims-based reporting of measures groups for the 2008 PQRI consisted of the following criteria for satisfactory reporting:

- *Report at least 1 measures group; and*
- *Report each measure in the measures group on at least 80% of Medicare Part B FFS patients for whom the measures in the measures group apply for each participating EP.*

Beginning with the 2009 PQRI, CMS implemented two reporting periods for claims-based reporting of measures groups: a 12-month reporting period beginning January 1st and a 6-month reporting period beginning July 1st.

For the 2009 PQRI, there were 3 reporting options for claims-based submission of measures groups. Whereas for the 2008 PQRI only the 6-month reporting period was available for claims-based submission of measures groups, both the 12-month and the 6-month reporting periods are available for claims-based submission of measures groups for the 2009 PQRI. In addition, CMS eliminated the option of reporting on at least one measures group on 15 consecutive patients for the 6-month reporting period but added the option of reporting on at least 30 consecutive Medicare Part B FFS patients during the 12-month reporting period instead. We also added a minimum sample size requirement for EPs reporting on at least 80% of applicable Medicare Part B FFS patients. EPs reporting on 80% of applicable Medicare Part B FFS patients for the 12-month reporting period must have at least 30 applicable patients. EPs reporting on 80% of applicable Medicare Part B FFS patients for the 6-month reporting period must have at least 15 applicable patients.

The criteria for satisfactorily reporting measures groups via the claims-based reporting mechanism for the 2010 PQRI are nearly identical to the criteria for the 2009 PQRI. The exceptions are CMS: (1) eliminated the requirement that the 30 patients be seen consecutively to allow an EP to report on any 30 patients seen at any time during the reporting period; and (2) reduced the minimum patient sample size threshold for EPs reporting on at least 80% of applicable Medicare Part B FFS patients to 15 and 8 for the 12-month and 6-month reporting periods, respectively. The 2010 PQRI criteria for satisfactorily reporting measures groups through claims-based reporting that each EP must meet under these 3 reporting options are summarized in ***Table 2*** *below along with the relevant reporting period for each reporting option.*

Table 2: Criteria for Satisfactory Reporting of Measures Groups through Claims

Reporting Criteria	***Reporting Period***
• *Report at least one measures group; and* • *Report each measure within the measures group for at least 30 Medicare Part B FFS patients to whom the measures group apply*	*January 1, 2010 – December 31, 2010*
• *Report at least one measures group; and* • *Report each measure within the measures group for at least 80% of Medicare Part B FFS patients to whom the measures in the measures group apply; and* • *Report each measures group on at least 15 patients during the reporting period for which the measures group applies.*	*January 1, 2010– December 31, 2010*

• *Report at least one measures group; and* • *Report each measure within the measures group for at least 80% of Medicare Part B FFS patients to whom the measures in the measures group apply; and* • *Report each measures group on at least 8 patients during the reporting period for which the measures group applies.*	*July 1, 2010– December 31, 2010*

EPs choosing to participate in the PQRI through the claims-based reporting mechanism, regardless of whether they choose to report on individual measures or measures groups, must have their own individual-level NPI and must consistently use their individual NPI to correctly identify their services, procedures, and QDCs for an accurate determination of satisfactory reporting. As stated in §30 above, the analysis of whether an EP has satisfactorily reported is performed at the individual EP level using the individual-level NPI. The EP's individual NPI must be listed correctly along with the HCPCS codes for services, procedures, and QDCs on the claim. More information on reporting options for a specific program year is available on the CMS PQRI website at http://www.cms.hhs.gov/PQRI.

70.1.2 – Criteria for Determination of Satisfactory Reporting for Registry-based Reporting

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

In addition to the option of reporting on individual quality measures or on measures groups, EPs, beginning with the 2008 PQRI, also have the option of reporting PQRI quality measures information to CMS via a qualified registry instead of submitting the quality measures data on claims (see §50).

The criteria for determining whether an EP satisfactorily reports data on PQRI quality measures for reporting via a registry are different from the criteria for satisfactory reporting via claims.

When registry-based reporting of PQRI quality measures data was introduced in the 2008 PQRI, there were two reporting periods available for registry-based reporting of individual measures: the 12-month reporting period beginning January 1, 2008 and the 6-month reporting period beginning July 1, 2008. To qualify to earn a 2008 PQRI incentive payment through registry-based reporting of individual measures, each EP had to meet the following criteria for satisfactory reporting:

- *Report at least 3 individual PQRI measures; and*
- *Report each measure on at least 80 % of the Medicare Part B FFS patients to whom the measure applies.*

These criteria were applicable to both 2008 reporting periods for registry-based reporting. Consequently, there were 2 reporting options for registry-based reporting of individual measures.

*No changes have been made to the criteria for registry-based reporting of individual measures for subsequent program years. Therefore, 2 reporting options continue for registry-based reporting of individual measures as summarized in **Table 3** below for the 2010 PQRI.*

Table 3: Criteria for Satisfactory Reporting of Individual Quality Measures through Registries

Reporting Criteria	Reporting Period
• Report at least 3 PQRI measures; and • Report each measure for at least 80% of Medicare Part B FFS patients to whom the measure applies.	January 1, 2010 – December 31, 2010
• Report at least 3 PQRI measures; and • Report each measure for at least 80% of Medicare Part B FFS patients to whom the measure applies.	July 1, 2010 – December 31, 2010

For registry-based reporting of measures groups, there were 2 reporting periods available when registry-based reporting of measures groups was first introduced in the PQRI for 2008: the 12-month reporting period beginning January 1, 2008 and the 6-month reporting period beginning July 1, 2008.

For the 2008 PQRI, there were 2 reporting options available for registry-based reporting of measures groups for the 12-month reporting period. An EP could either:

- *Report on at least one measures group for at least 30 consecutive patients to whom the measures of the measures group apply; OR*
- *Report on at least one measures group for at least 80% of Medicare Part B FFS patients to whom the measures of the measures group apply.*

For the 2008 PQRI, there were 2 reporting options available for registry-based reporting of measures groups for the 6-month reporting period. An EP could either:

- *Report on at least one measures group for at least 15 consecutive patients to whom the measures of the measures group apply; OR*
- *Report on at least one measures group for at least 80% of Medicare Part B FFS patients to whom the measures of the measures group apply.*

There are 2 differences between the 2008 criteria for registry-based reporting of measures groups and the 2009 criteria. The first difference is the elimination of the reporting option based on reporting for at least 15 consecutive patients for the 6-month reporting period. The second difference is the addition of a minimum sample size requirement for EPs reporting on at least 80% of applicable Medicare Part B FFS patients. Identical to the 2009 criteria for claims-based

submission of measures groups discussed in §70.1.1 above, EPs reporting in 2009 on 80% of applicable Medicare Part B FFS patients for the 12-month reporting period were required to have at least 30 applicable patients. EPs reporting in 2009 on 80% of applicable Medicare Part B FFS patients for the 6-month reporting period were required to have at least 15 applicable patients.

The 2010 criteria for registry-based reporting of measures groups are similar to the 2009 criteria except for 2 differences. First, CMS eliminated the requirement that the 30 patients be seen consecutively to allow an EP to report on any 30 patients seen during the reporting period. The second difference is that CMS reduced the minimum sample size requirement for EPs reporting on at least 80% of applicable Medicare Part B FFS patients to 15 and 8 for the 12-month and 6-month reporting periods, respectively. The 2010 PQRI criteria for satisfactory reporting that each EP must meet to qualify to earn an incentive payment through registry-based reporting of measures groups are summarized in ***Table 4*** *below.*

Table 4: Criteria for Satisfactory Reporting of Measures Groups through Registries

Reporting Criteria	***Reporting Period***
• *Report at least one measures group; and* • *Report each measures group for at least 30 patients to whom the measures in the measures group apply. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients. There must be at least 2 Medicare FFS patients*	*January 1, 2010 – December 31, 2010*
• *Report at least one measures group; and* • *Report each measures groups for at least 80 % of Medicare Part B FFS patients to whom the measures in the measures group applies; and* • *Report each measures group on at least 15 Medicare Part B FFS patients during the reporting period to which the measures group applies.*	*January 1, 2010 – December 31, 2010*

• *Report at least one measures group; and* • *Report each measures group for at least 80 % of Medicare Part B FFS patients to whom the measures in the measures group applies; and* • *Report each measures group on at least 8 Medicare Part B FFS patients during the reporting period to which the measure group applies.*	*July 1, 2010 – December 31, 2010*

The 3 reporting options for registry-based reporting of measures groups are identical to the 3 reporting options for claims-based reporting of measures groups except for the fact that the 30 patient samples using the registry-based reporting mechanism may include some non-Medicare patients.

70.1.3 – Criteria for Determination of Satisfactory Reporting for EHR-based Reporting

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Beginning with the 2010 PQRI, an individual EP who chooses to report on individual PQRI quality measures rather than measures groups has the additional option of reporting on the individual PQRI quality measures via a qualified EHR product in lieu of submitting the quality measures data on claims or via a qualified registry (see §50). The EHR-based reporting mechanism, however, is available for a limited subset of the PQRI individual quality measures only.

The criteria for determining whether an EP satisfactorily reports data on individual PQRI quality measures for reporting via an EHR are identical to the criteria for satisfactory reporting of individual PQRI quality measures via a qualified registry. However, there is only one reporting period available for EHR-based reporting of individual measures: the 12-month reporting period beginning January 1st. Consequently, there is only one reporting option for EHR-based reporting of individual measures for the 2010 PQRI. To qualify to earn a 2010 PQRI incentive payment through EHR-based reporting of individual measures, each EP must meet the following criteria for satisfactory reporting:

- *Report at least 3 individual PQRI measures; and*
- *Report each measure on at least 80 % of the Medicare Part B FFS patients to whom the measure applies.*

70.2 – Criteria for Determination of Satisfactory Reporting for Group Practices and Process for Reporting by Group Practices

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

In accordance with section 1848(m)(3)(C)(i) of the Act, we established, beginning with the 2010 PQRI, a new process whereby group practices can qualify to earn a PQRI incentive based on a determination that the practice satisfactorily reports data on PQRI quality measures. Each

group practice selected to participate in the PQRI GPRO (see §20.3 for discussion of how a group practice can qualify to participate in the PQRI GPRO) is provided a pre-populated data collection tool with an assigned sample of patients and those patients' demographic and utilization information. The group practice is required to populate the remaining data fields necessary for capturing quality measure information on each of the consecutively assigned Medicare beneficiaries with respect to services furnished during the relevant PQRI reporting period. The selected group practices are provided access to the pre-populated tool no later than the first quarter of the year following the program year in which the practice is participating in the PQRI GPRO. For example, if the group practice is participating in the 2010 PQRI GPRO, the practice would be provided access to the pre-populated tool no later than the first quarter of 2011. Upon receipt of this pre-populated data collection tool, the practice must complete the remaining data elements for a specified number of patients and return the completed tool to CMS.

For purposes of determining whether a group practice satisfactorily submits PQRI quality measures data for a particular program year, each selected group practice is required to complete this data collection tool for a specified number of quality measures. The quality measures are grouped into disease modules plus a series of preventive care measures. Data from the January 1st through October 29th NCH file for the program year (10 months) is used by CMS to randomly assign Medicare beneficiaries to each physician group practice TIN. Medicare beneficiaries are retrospectively assigned to the TIN based on a determination by CMS that the group practice provided the plurality of office or other outpatient services to the beneficiary (with a minimum of at least two visits) in the 10-month period. Furthermore, part-year and managed care patients are not considered since CMS would have incomplete claims data for these beneficiaries and group practices may not have had sufficient time to impact the quality of their care.

For each disease module or preventive care measure, the selected PQRI GPRO practice must complete the data collection tool for the first 411 consecutively assigned and ranked Medicare beneficiaries. Assigned beneficiaries will be limited to those Medicare FFS beneficiaries with Medicare Part B for whom Medicare is the primary payer. If the pool of eligible assigned beneficiaries is less than 411 for any module/measure, then the group practice must report on 100% (all) of the assigned beneficiaries for that module/measure to satisfactorily participate in the PQRI GPRO. The reporting mechanism, reporting period, and criteria for satisfactory reporting under the GPRO for 2010 are summarized in the ***Table 5*** *below.*

Table 5: 2010 PQRI GPRO Reporting Mechanism, Reporting Period, and Criteria for Satisfactory Reporting

Reporting Mechanism	***Reporting Criteria***	***Reporting Period***
A pre-populated data collection tool provided by CMS	• *Report on all measures included in the data collection tool (26 measures); and* • *Complete the tool for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries.*	*January 1, 2010 – December 31, 2010*

80 – Limitations on Review

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Section 1848(m)(5)(E) of the Act specifically states that there shall be no administrative or judicial review or otherwise of the determination of: (1) quality measures applicable to services furnished by EPs, (2) satisfactory reporting, or (3) the incentive payment.

90 – Confidential Feedback Reports

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

CMS provides confidential feedback reports on PQRI reporting to participating EPs at or near the time that the lump sum incentive payments for a particular payment year are made. Feedback reports for the 2009 PQRI, for example, would be provided in 2010. Access to confidential feedback reports may require EPs to complete an identity-verification process. However, receipt of a report is not required to participate in the PQRI or to receive an incentive payment.

To receive a feedback report the EP must have had at least one valid PQRI submission. A valid submission is defined as receipt by CMS of the correct numerator, denominator codes, age and gender (where applicable) as listed in the applicable PQRI quality measure specifications manual. The PQRI quality measure specifications are subject to change for each program year. The PQRI quality measure specifications manual for the current or an upcoming program year is posted on the Measures Codes page at http://www.cms.hhs.gov/pqri. PQRI measure specifications for prior program years are archived on the appropriate PQRI Program page of the CMS PQRI website at http://www.cms.hhs.gov/pqri.

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS website, in an easily understandable format, a list of the names of the EPs who satisfactorily submitted data on quality measures under PQRI. Therefore, beginning with the 2009 PQRI, the names of EPs (and beginning with the 2010 PQRI, group practices) who satisfactorily submit data on quality measures for the PQRI will be posted on http://www.medicare.gov. The names of EPs (and group practices) who satisfactorily submit data on quality measures for a particular year are publicly posted after the lump sum incentive payments for that program year are made in the following year.

Medicare Quality Reporting Incentive Programs Manual

Chapter 2 – The Electronic Prescribing (eRx) Incentive Program

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(Rev.1, 06-11-10)

Transmittals for Chapter 2

10 - Background

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Chapter 2 of this manual focuses on the requirements for the Electronic Prescribing (eRx) Incentive Program, a quality reporting incentive program which promotes the adoption and use of eRx systems. eRx is the transmission of prescription or prescription-related information through electronic media. eRx takes place between a prescriber, dispenser, pharmacy benefit manager, or health plan. It can take place directly or through an intermediary (such as a network).

Section 132 of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required the Secretary to establish a new incentive program for individual eligible professional (EPs) who are successful electronic prescribers as defined by MIPPA, beginning on January 1, 2009. While the eRx Incentive Program has similarities in structure and processes to the Physician Quality Reporting Initiative (PQRI) described in Chapter 1 of this Publication, this program is a stand alone program with distinct reporting requirements and associated incentive payment.

The eRx Incentive Program encourages significant expansion of the use of eRx by authorizing a combination of financial incentives and payment differentials. Any incentive payment earned through the eRx Incentive Program is separate from and in addition to any incentive payment that EPs may earn through the PQRI program. Except for EPs who wish to participate in the eRx Incentive Program under the group practice reporting option (GPRO) for 2010 (see §20.3), EPs do not have to participate in PQRI to participate in the eRx Incentive Program or vice-versa.

See Chapter 1, "Physician Quality Reporting Initiative," for information on the PQRI.

20 – Eligible Professionals

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For purposes of the eRx Incentive Program, the definition of "eligible professional" is identical to that for the PQRI program. An EP is any one of the following:

- *Physician*
  - *Doctor of Medicine*
  - *Doctor of Osteopathy*
  - *Doctor of Podiatric Medicine*
  - *Doctor of Optometry*
  - *Doctor of Dental Surgery*
  - *Doctor of Dental Medicine*
  - *Doctor of Chiropractic*
- *Practitioner*
  - *Physician assistant*
  - *Nurse Practitioner*
  - *Clinical nurse specialist*
  - *Certified registered nurse anesthetist (and Anesthesiologist Assistant)*
  - *Certified nurse midwife*

- *Clinical social worker*
- *Clinical psychologist*
- *Registered dietitian*
- *Nutrition professional*
- *Audiologists (as of January 1, 2009)*

- *Therapist*
  - *Physical therapist*
  - *Occupational therapist*
  - *Qualified speech-language therapist (began billing Medicare directly as of July 1, 2009)*

All Medicare-enrolled professionals in these categories are eligible to participate in the eRx Incentive Program regardless of whether the professional has signed a Medicare participation agreement to accept assignment on all claims. However, eligibility is further restricted by scope of practice to those professionals who have prescribing authority under their respective state practice laws.

20.1 – Professionals Eligible to Participate But Not Able to Participate

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Some professionals who are included in the definition of "EP" above are eligible to participate but are not able to participate for one or more reasons. These include: EPs in certain settings in which Medicare Physician Fee Schedule billing is processed by Medicare fiscal intermediaries (FIs)/AB Medicare Administrative Contractors (MACs). The FI/MAC claims processing systems for the following settings currently cannot accommodate billing at the individual EP level:

• Critical access hospitals (CAHs), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI or Part A MAC for the covered professional services furnished by the EP.

• All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

20.2 – Professionals Not Eligible to Participate in the eRx Incentive Program and Not Able to Qualify to Earn an Incentive Payment

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Providers and professionals not defined as EPs are not eligible to participate in the eRx Incentive Program and do not qualify for an incentive. Services payable under or based on fee schedules or methodologies other than the PFS are not included in the eRx Incentive Program (for example, services provided in federally qualified health centers,

independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for the eRx Incentive Program since DME is not based on or paid under the PFS.

20.3 – Participation by Group Practices

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Prior to 2010, the eRx Incentive Program was limited to individual EPs and the determination of whether an EP is a successful electronic prescriber was made at the individual professional level, based on the National Provider Identifier (NPI). No incentive payments were available to a group practice based on a determination that the group practice, as a whole, was a successful electronic prescriber. To the extent that individual EPs (based on individuals' NPIs) are associated with more than one practice, or Taxpayer Identification Number (TIN), the determination of whether an EP is a successful electronic prescriber was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN (see §30 below).

As required by the MIPPA, beginning in 2010, group practices are eligible to qualify for an eRx incentive payment based on the determination that the group practice, as a whole, is a successful electronic prescriber. The criteria for determining whether a group practice is a successful electronic prescriber and the process for reporting by group practices under the GPRO are discussed in §60.2 below. For purposes of the eRx GPRO, "group practice" is defined as a TIN with at least 200 or more individual EPs (as identified by NPIs) who have reassigned their billing rights to the TIN.

In order to participate in the eRx Incentive Program through the GPRO, group practices must have been selected to participate in the PQRI GPRO (see Chapter 1, §20 for information on the requirements for participation in the PQRI GPRO). CMS assesses whether the participation requirements are met by each self-nominated group practice and notifies group practices of a decision.

As required by section 1848(m)(3)(C)(iii) of the Social Security Act (the Act), an individual EP who is a member of a group practice selected to participate in the eRx GPRO for a particular program year is not eligible to separately earn an eRx incentive payment as an individual EP under that same TIN (that is, for the same TIN/NPI combination) for that year. Once a group practice (TIN) is selected to participate in the GPRO for a particular program year, this is the only method of eRx Incentive Program participation available to the group and all individual NPIs who bill Medicare under the group's TIN for that program year.

30 – Payment for Reporting

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

A participating individual EP or group practice (see §20) who is determined to be a "successful electronic prescriber" (see §60) may earn an incentive payment with respect to

covered professional services furnished by the EP (or group practice) during a specified reporting period (see §40). Section 1848(k)(3)(A) of the Act defines "covered professional services" as services for which payment is made under, or is based on, the Medicare Part B PFS and which are furnished by an EP (or group practice).

An EP who is determined to be a successful electronic prescriber for 2009 and/or 2010, may qualify to earn an incentive payment equal to 2.0% of the total estimated Medicare Part B allowed charges for covered professional services furnished by the EP during the respective reporting period. Furthermore, incentive payments for successful electronic prescribers for future years are authorized as follows:

- *1.0 percent for 2011.*
- *1.0 percent for 2012.*
- *0.5 percent for 2013.*

The eRx incentive payment amount is calculated based on an EP's (or group practice's) total estimated allowed charges for all covered professional services: (1) furnished during the applicable reporting period, (2) received into the National Claims History (NCH) file by no later than 2 months after the end of the reporting period, and (3) paid under or based upon the Medicare PFS. Because claims processing times may vary by time of the year and Medicare Carrier/AB MAC, EPs should submit claims from the end of the reporting period promptly, so that if, for example, the reporting period ends on December 31st of a particular year, claims from the end of the reporting period will reach the NCH file by February 28th of the following year. The eRx incentive payments are paid as a lump sum.

Payment for this incentive program is calculated at the individual EP level using individual NPI data and beginning in 2010, for group practices participating in the eRx GPRO, at the group practice level using TIN data. CMS uses the TIN as the billing unit so that any eRx incentive payment earned (regardless of whether the incentive payment was earned by an individual EP or a group practice) is paid to the TIN holder of record. Individual incentive payments for groups that bill under one TIN are aggregated and paid to the holder of the TIN. Some individuals (NPIs) may be associated with more than one practice or TIN, and thus CMS groups claims by TIN for purposes of the incentive. In other words, the incentive payment is made for each unique TIN/NPI combination so that an EP who qualifies for the eRx incentive payment under more than one TIN would receive a separate eRx incentive payment associated with each TIN.

Under the statute, however, there is a limitation with regard to the application of the incentive. The incentive does not apply to EPs (and group practices participating in the eRx GPRO), for the reporting period, if the Medicare allowed charges for all covered professional services for the codes to which the eRx quality measure applies are less than 10% of the total allowed charges under Medicare Part B for all such covered professional services furnished by the EP (or group practice).

The eRx incentive payment amount is calculated using allowed charges for all covered professional services, not just those charges associated with eRx events. The term "allowed charges" refers to total charges, including the beneficiary deductible and co-payment, not just the 80% paid by Medicare or the portion covered by Medicare where Medicare is a secondary payer. Note that the amounts billed above the Medicare PFS amounts for assigned and non-assigned claims do not apply to the incentive. The statute defines eRx

covered professional services as those paid under or based upon the Medicare PFS only, which includes technical components of diagnostic services and anesthesia services, as anesthesia services are considered fee schedule services though based on a unique methodology.

Other Part B services and items that may be billed by EPs but are not paid under or based upon the Medicare PFS are not included in the calculation of the eRx incentive payment amount.

In addition to the eRx incentive payment, under section 1848(a)(5)(A) of the Act, a PFS payment adjustment applies beginning in 2012 to those who are not successful electronic prescribers as defined in the 2011 Medicare PFS final rule with comment period then for 2012. The fee schedule amount for covered professional services furnished by such professionals during the year shall be less than the fee schedule amount that would otherwise apply by1.0 percent for 2012 criteria for 2013 and 2014 PFS adjustment, avoidance thereof will be addressed in subsequent year's rulemaking with comment period.

The potential Medicare PFS fee reductions for not successfully e-prescribing in the future are as follows:

- *1.5 percent for 2013 and*
- *2.0 percent for 2014.*

40 – Reporting Period

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

The reporting period for the eRx Incentive Program is the entire calendar year. For 2009, for example, the reporting period is January 1, 2009 – December 31, 2009.

50 – Form and Manner of Reporting

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Prior to the 2010 eRx Incentive Program, participation in the eRx Incentive Program was limited to the submission of quality data codes (QDCs) for the eRx measure through Medicare's claim processing system. Beginning with the 2010 eRx Incentive Program, EPs may choose to report the eRx measure to CMS using one of the following reporting mechanisms:

- *Claims-based reporting;*
- *Registry-based reporting; or*
- *EHR-based reporting.*

50.1 – Claims-based Reporting Mechanism

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Individual EPs (and beginning with the 2010 eRx Incentive Program, group practices) who choose to participate in the eRx Incentive Program via the claims-based reporting

mechanism do not have to enroll or register to begin claims-based reporting of the eRx measure to CMS.

Participating EPs (or group practices) who bill for the services or procedures included in the denominator of the eRx measure report the corresponding appropriate numerator G-code on their claim. Claims-based reporting may be via: (1) the paper-based CMS 1500 Claim form or (2) the equivalent electronic transaction claim, the 837-P. The specifications for the eRx measure are available on the eRx Measure section page of the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive.

The applicable G-code quality data must be reported on the same claim as the billable service or procedure to which the QDC applies. The eRx measure does not require a specific diagnosis to help determine the denominator; therefore, any diagnosis reported on the claim is sufficient. The analysis algorithms that are used to determine whether an EP is a "successful electronic prescriber" match the QDCs to the service and/or procedure codes on the claim. Thus, QDCs that are not submitted on the same claim as the applicable service and/or procedure codes do not count toward an EP meeting the requirements of being a "successful electronic prescriber."

50.1.1 - Coding and Reporting Principles for Claims-based Reporting
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

The following principles apply for claims-based reporting of the eRx measure:

- *For the 2009 eRx Incentive Program, report one of the three eRx codes listed below as the claim numerator, when applicable:*
    - *G8443 - "All prescriptions created during the encounter were generated using a qualified eRx system."*
    - *G8445 - "No prescriptions were generated during the encounter."*
    - *G8446 - "Provider does have access to a qualified eRx system and some or all of the prescriptions generated during the encounter were printed or phoned in as required by the State or Federal Law or regulations, patient request or pharmacy system being unable to receive electronic transmission; or because they were for narcotics or other controlled substances."*

  One of these codes must be reported on at least 50% of patients who meet the denominator criteria of the measure.

- *For 2010 the eRx measure's numerator includes only 1 G-code (CMS eliminated the 3 numerator G-codes used for 2009). To report the eRx measure for 2010, report the following eRx numerator G-code, when applicable:*
    - *G8553 – At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system.*

  The eRx G-code, which supplies the numerator, must be reported for 25 unique visits (for services in the denominator) to satisfactorily report:

- *on the same claims as the denominator billing code(s) for the same date of service (DOS)*
- *for the same beneficiary*
- *for the same date of service (DOS)*
- *by the same EP (individual NPI) who performed the covered service*

as the payment codes, CPT Category I or HCPCS codes, which supply the denominator.

- *The eRx G-code 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 an EP's illing software 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 charge will be rejected. (Total charge for the claim cannot be $0.00.)*
  - *Whether a $0.00 charge or a nominal amount is submitted to the carrier/ MAC, the eRx G-code line is denied and tracked.*
  - *eRx line items will be denied for payment, but are passed through the claims processing system to the NCH database and used for eRx claims analysis. EPs will receive a Remittance Advice (RA) which includes a standard remark code (N365). N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does **NOT** indicate whether the eRx G-code is accurate for that claim or for the measure the EP is attempting to report. N365 only indicates that the eRx G-code passed into NCH.*

- *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).*

- *Claims may **NOT** be resubmitted for the sole purpose of adding or correcting an eRx code.*

Submission Through Carriers/MACs

eRx G-codes shall be submitted to carriers/MACs either through:
Electronic submission using the ASC X 12N Health Care Claim Transaction (Version 4010A1), or via paper-based submission, using the CMS-1500 claim form.

- ***Electronic Submission:***

*The eRx G-codes should be submitted in the **SV101-2** "Product/Service ID" Data Element on the **SV1** "Professional Service" Segment of the **2400 "Service Line" Loop**.*

  - *It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 "Professional Service" Segment.*

- *Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI08** as needed with a single reference number in the diagnosis pointer.*
- *In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data element **NM109 (NM108=XX)**.*

- ***Paper-based Submission:***
  *Paper-based submissions are accomplished using the CMS-1500 claim form (version 08-05). Relevant ICD-9-CM diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D** with a single reference number in the diagnosis pointer **Field 24E** that corresponds with the diagnosis number in Field 21.*

- *For group billing, the NPI of the rendering/performing provider is entered in **Field 24J** and the TIN of the employer is entered in **Field 25**.*

Timeliness of Quality Data Submission
Claims processed by the Carrier/MAC must reach the National Claims History (NCH) file by no later than 2 months after the end of the reporting period to be included in the analysis. For the 2010 eRx Incentive Program, for example, claims processed by the Carrier/MAC must reach the NCH file by no later than February 28, 2011 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.

50.2 – Registry-based Reporting Mechanism
(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Individual EPs (and beginning with the 2010 eRx Incentive Program, group practices) may choose to participate in the eRx Incentive Program via the registry-based reporting mechanism beginning with the 2010 eRx Incentive Program. EPs and group practices that choose to participate in the eRx Incentive Program via the registry-based reporting mechanism do not have to enroll or register to begin registry-based reporting of the eRx measure to CMS. However, to report eRx measure data via the registry-based reporting mechanism, an EP or group practice must select a qualified clinical data registry and must enter into and maintain an appropriate legal arrangement with a qualified clinical data registry. Such arrangements should provide for the registry's receipt of patient-specific data from the EP and the registry's disclosure of eRx measure results and numerator and denominator data on behalf of the EP or group practice to CMS. An EP or group practice choosing the registry-based reporting mechanism must submit information on the eRx measure to their selected registry in the form and manner and by the deadline specified by the registry. Thus the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as "data submission vendors." The "data submission vendors" would have the requisite legal authority to provide information on eRx measure results and numerator and denominator data on the eRx measure on behalf of the eligible professional for the eRx,

Only a registry that is qualified to submit PQRI quality measures information to CMS on behalf of EPs is eligible to become a qualified registry for the purpose of submitting eRx measure information to CMS on behalf of EPs or group practices. CMS qualifies registries for PQRI for each program year through a self-nomination process (see Chapter 1, §50.2). The list of qualified registries for a specific program year are made available on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive. For a specific program year, this list usually is made available in the summer of that same year. For example, we anticipate the list of qualified registries for the 2010 eRx Incentive Program would be made available in the summer of 2010.

50.3 – Electronic Health Record-based (EHR-based) Reporting Mechanism

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

Individual EPs and group practices may choose to participate in the eRx Incentive Program via the EHR-based reporting mechanism beginning with the 2010 eRx Incentive Program. EPs and group practices that choose to participate in the eRx Incentive Program via the EHR-based reporting mechanism do not have to enroll or register to begin EHR-based reporting of the eRx measure to CMS. However, to report eRx measure data via the EHR-based reporting mechanism, an EP or group practice must select a qualified EHR product. An EP or group practice choosing the EHR-based reporting mechanism must:

- *Have an active Individuals Authorized Access to CMS Systems (IACS) user account that will be used to submit the eRx measure data extracted from the EHR to CMS;*
- *Submit a test file containing real or dummy clinical quality data extracted from the EHR to a CMS clinical data warehouse; and*
- *Submit a file containing the EP's or group practice's eRx measure data extracted from the EHR for the entire reporting period via IACS by no later than 2 months after the end of the reporting period. (For the 2010 reporting period the submission period will be 02/0/11 – 03/31/11)*

Only an EHR product that is qualified for use by EPs to submit PQRI quality measures information to CMS is eligible to become a qualified EHR product for the purpose of an EP or group practice using the product to submit eRx measure information to CMS. CMS qualifies EHR vendors and their specific product(s) for use by EPs to submit PQRI quality measures data to CMS (see Chapter 1, §50.3). The list of qualified EHR vendors and products for a specific program year are made available on the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive. A list of 2010 qualified EHR vendors and their products are currently posted on the CMS website.

60 – Criteria for Determination of Successful Electronic Prescriber

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

In order to qualify to earn an eRx incentive payment for a particular program year, EPs and group practices must be considered a "successful electronic prescriber." The criteria that will be used to determine whether an EP or group practice is a successful electronic prescriber differ depending on whether participation is at the individual EP level or at the group practice level and may differ from one program year to another.

60.1 – Criteria for Determination of Successful Electronic Prescriber for Individual Eligible Professionals

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For purposes of qualifying for the eRx incentive payment for the 2009 program year, an individual EP was considered a "successful electronic prescriber" if he/she reported the eRx measure (as specified for 2009) on at least 50% of the cases in which the measure is reportable by the EP during the 2009 reporting period.

For purposes of qualifying for the eRx incentive payment for the 2010 program year, an individual EP is considered a "successful electronic prescriber" if he/she reports the eRx measure (as specified for 2010) for at least 25 unique denominator-eligible events during the 2010 reporting period.

60.2 – Criteria for Determination of Successful Electronic Prescriber for Group Practices

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

For purposes of qualifying for the eRx incentive payment for the 2010 program year, a group practice selected to participate in the eRx GPRO is considered a "successful electronic prescriber" if the practice reports the eRx measure (as specified for 2010) for at least 2,500 unique denominator-eligible events during the 2010 reporting period.

70 – Confidential Feedback Reports

(Rev. 1, Issued: 06-11-10, Effective/Implementation: 09-13-10)

CMS provides confidential feedback reports to participating EPs for a particular program year at or near the time that the lump sum incentive payments are made for the program year. For example, EPs who participate in the 2009 eRx Incentive Program can expect to receive confidential feedback reports with respect to the 2009 program year after the 2009 incentive payments are made in 2010. Access to confidential feedback reports may require EPs to complete an identity-verification process. Receipt of a report is not a requirement for participation in the eRx Incentive Program or to receive an incentive payment.

To receive a feedback report the EP must have had at least one valid eRx measure submission. A valid submission is defined as receipt by CMS of the correct numerator, denominator, age and gender (where applicable) as listed in the eRx measure specifications. The eRx measure specifications are subject to change for each program year. The eRx measure specifications for the current or an upcoming program year, as well as those for prior program years are posted or archived on the appropriate eRx Program page of the CMS eRx Incentive Program website at http://www.cms.gov/ERXincentive.

In addition, section 1848(m)(5)(G) of the Act requires CMS to post on the CMS website, in an easily understandable format, a list of the names of the EPs (or group practices) who are successful electronic prescribers. Therefore, beginning with the 2009 eRx Incentive Program the names of EPs (and beginning with the 2010 eRx Incentive Program, group practices) who are determined to be successful electronic prescribers for the eRx Incentive Program are required to be posted on http://www.medicare.gov. The names of EPs (and group practices) who are successful electronic prescribers for a particular year will be publicly posted after the lump sum incentive payments for that program year are made in the following year.