Getting Started with 2008 PQRI
Claims-Based Reporting of Measures Groups

Errata Sheet (Release Date: August 2008)

Please note that since the June 2008 version of the *Getting Started with 2008 Claims-Based Reporting of Measures Groups* tip sheet was produced, the following corrections or changes have been identified. Please keep the latest version of the errata sheet with your copy of the tip sheet.

Page 3:

The following sentences have been revised in Section 4 to read:

- The diagnosis pointer field on the claim links a patient diagnosis to a service line.

- Eligible professionals should check their Remittance Advice for a denial code (e.g., N365) for the measures-group-specific G-code, confirming that the code passed through their local carrier/Medicare Administrative Contractor (MAC) to the National Claims History file.

Page 5:

The entry in the Diagnosis Pointer column for CKD Measure 120 in the first table should include only the numeral “1”. Note that this example is for illustrative purposes only. CKD measure 120 requires 3 diagnoses to be reported for this measure, but only one diagnosis may be pointed to in the diagnosis pointer field.