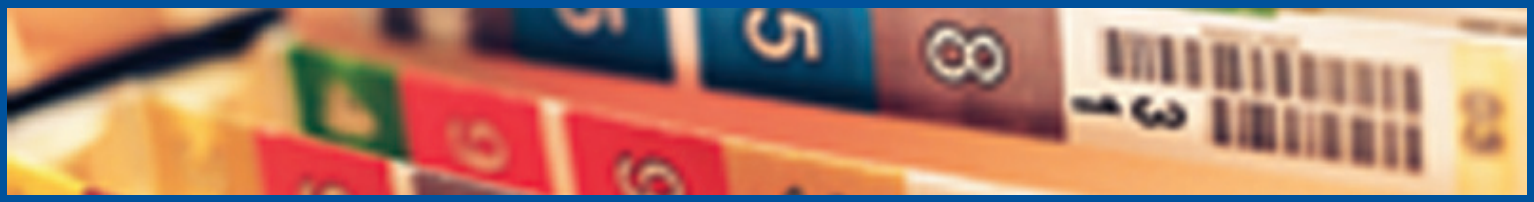

Medicare Physician Quality Reporting Initiative

June 2008

Getting Started with 2008 PQRI

Claims-Based Reporting of Measures Groups

http://www.cms.hhs.gov/PQRI

Introduction:

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) authorized CMS to establish for the 2008 PQRI program alternative reporting periods and criteria. This is in addition to reporting applicable individual measures up to three at or above 80% of the time for the entire calendar year. The alternative methods established include reporting on a group of clinically-related measures either through claims-based or registry-based data submission mechanisms. Four measures groups have been created for 2008 PQRI which include Diabetes Mellitus, End Stage Renal Disease (ESRD), Chronic Kidney Disease (CKD), and Preventive Care.

Eligible professionals can choose to participate under more than one 2008 PQRI reporting option. Professionals who successfully report under more than one reporting option will receive a maximum of one incentive payment, which will be equivalent to 1.5% of Medicare Physician Fee Schedule (PFS) allowed charges for all covered professional services furnished during the longest reporting period for which he or she has satisfied reporting criteria.

The 2008 PQRI Claims-Based Measures Groups reporting alternative is available for the six-month reporting period from July 1 through December 31, 2008. Eligible professionals who successfully report under the claims-based measures group method may, on that basis, receive an incentive payment equal to 1.5% of total allowed Physician Fee Schedule charges for covered professional services furnished to patients enrolled in Medicare Part B Fee-For-Service during the July through December, 2008 reporting period. Medicare Part C (e.g., Medicare Advantage) claims will not be utilized for 2008 PQRI analysis. This tip sheet provides strategies and information to facilitate successful reporting by eligible professionals who wish to pursue this alternative.

The *2008 PQRI Claims-Based Measures Groups Handbook*, posted on the CMS PQRI website, contains detailed descriptions for each quality measure within each measures group. Denominator coding has been modified from the original measure as specified by the measure developer to allow for implementation as a measures group. To get started, review the *2008 PQRI Claims-Based Measures Groups Handbook* to determine if a particular measures group is applicable to Medicare services your practice provides.

ICN# 900943

Measures Groups Participation Strategy:

1. Plan and implement processes within your practice to ensure successful reporting of measures groups per eligible professional.

2. Become familiar with the methods for successful claims-based reporting of measures groups. The two methods for claims-based measures groups are:

Consecutive Patient Sample Method: 15 consecutive Medicare Part B Fee-For-Service enrolled patients meeting patient sample criteria (see Patient Sample Criteria Table below) for the measures group for each eligible professional. **Counting will begin on the date of service that the measures group-specific G-code is submitted**. For example, an eligible professional can indicate intent to begin reporting the Diabetes Mellitus Measures Group by submitting G8485 on the first patient claim in the series of consecutive diabetic patients. All applicable measures within the group must be reported at least once during the reporting period for **each** of the 15 consecutive patients.

OR

80% Patient Sample Method: All Medicare Part B Fee-For-Service enrolled patients seen during the reporting period (July 1 through December 31, 2008) and meeting patient sample criteria (see Patient Sample Criteria Table below) for the measures group. Eligible professionals must report all applicable measures within the group at least once per beneficiary for a minimum of 80% of all eligible cases. (For example, 80% of all diabetes patients seen during the 6 month reporting period.)

3. Determine your patient sample based on the patient sample criteria, which is used for both the Consecutive Patient Sample Method and the 80% Patient Sample Method. The following table contains patient sample criteria (common codes) that will qualify a Medicare Part B beneficiary's professional services claim for inclusion in the measures group analysis. Claims must contain a specific line-item ICD-9 diagnosis code (where applicable) accompanied by a specific CPT patient encounter code.

Patient Sample Criteria Table

Measures Group	CPT Patient Encounter Codes	ICD-9 Diagnosis Codes
Diabetes Mellitus *18–75 years*	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 648.00, 648.01, 648.02, 648.03, 648.04
End Stage Renal Disease (ESRD) *18 years and older*	90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319	585.6
Chronic Kidney Disease (CKD) *18 years and older*	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245	585.4, 585.5
Preventive Care *50 years and older*	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	Applicable codes

4. Initiate reporting of measures groups by using measures group-specific G-codes. Indicate your intention to begin reporting a measures group by submitting a measures group-specific G-code on a patient claim. It is not necessary to submit the measures group-specific G-code on more than one claim. If the 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.

G8485: I intend to report the Diabetes measure grouping
G8488: I intend to report the End Stage Renal Disease (ESRD) measure grouping
G8487: I intend to report the Chronic Kidney Disease (CKD) measure grouping
G8486: I intend to report the Preventive Care measure grouping

Measures group-specific G-code line items on the claim must be complete, including accurate coding, date of service and diagnosis pointer. The diagnosis pointer field on the claim links one or more patient diagnoses to the service line. A G-code specific to a condition-specific measures group (e.g. Diabetes Mellitus Measures Group) should be linked to the diagnosis for the condition to which it pertains; a G-code for the Preventive Care Measures Group may be linked to any diagnosis on the claim.

Measures group-specific G-code line items should be submitted with a charge of zero dollars ($0.00). Measures group-specific G-code line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. Eligible professionals should check their Remittance Advice ("Explanation of Benefits" or "EOB") 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. The N365 denial indicates that the code is not payable and is used for reporting/informational purposes only. Other services/codes on the claim will not be affected by the addition of measures group-specific G-codes.

5. For patients to whom measures groups apply, report all applicable individual measures for the measure group. Report quality-data codes (QDCs) as instructed in the *2008 PQRI Claims-Based Measures Groups Handbook* on all applicable measures within the measures group for each patient included in the sample population. Eligible professionals may choose to submit QDCs either on a current claim or on a claim representing a subsequent visit, particularly if the quality action has changed. For example, a new laboratory value may be available at a subsequent visit. Only one instance of reporting for each patient included in the sample population will be used when calculating reporting and performance rates for each measure within a group.

An eligible professional is only required to report QDCs on those individual measures in the measures group that meet the criteria (age, gender, or additional diagnosis) according to the *2008 PQRI Measures Groups Handbook*. For example, if an eligible professional is reporting the Preventive Care Measures Group for a 52 year old female patient, only five measures out of nine apply. See the Preventive Measures Group Demographic Criteria table below:

Preventive Measures Group Demographic Criteria

Age	Measures for Male Patients	Measures for Female Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 114, 115	110, 112, 113, 114, 115
65-69 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 112, 113, 114, 115, 128
70-80 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 113, 114, 115, 128
≥81 years	110, 111, 114, 115, 128	39, 48, 110, 111, 114, 115, 128

Another example would be: if an eligible professional is reporting on the CKD Measures Group, he or she would not be expected to report measure 120 *(ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD)* for a CKD patient who does not also have hypertension and proteinuria.

There are two types of patients that can be reported in the ESRD (End Stage Renal Disease) measures group; those that have ESRD and are undergoing hemodialysis, and those that have ESRD and are undergoing peritoneal dialysis. If an eligible professional chooses to report this measures group he or she should report the appropriate quality data code for all 4 measures if the patient is receiving hemodialysis. However, if the patient is receiving peritoneal dialysis, only measures #79 and #80 should be reported as measures #78 and #81 do not apply to patients undergoing peritoneal dialysis.

Reporting Measures Groups - Common Clinical Scenarios:

The following clinical scenarios are offered as examples describing the quality data that should be reported on claims using a measures groups method:

Diabetes Mellitus Example

Primary care office visit for a new patient with newly diagnosed diabetes mellitus: A1c = lab drawn, result unknown, prior result not available (3046F-8P); LDL-C=110 (3049F); today's BP = 140/80 (3077F, 3079F); referred to ophthalmologist for dilated eye exam (2022F-8P); urine protein screening performed = negative (3061F)

Dx 1: 250.00						
Measure No.	**Date of Service**	**CPT/HCPCS**	**Modifier**	**Diagnosis Pointer**	**Charges**	**NPI**
	07/01/2008	99201		1	$60.00	0123456789
	07/01/2008	G8485		1	$0.00	0123456789
	07/01/2008	83036		1	$15.00	0123456789
	07/01/2008	81000		1	$6.00	0123456789
1	07/01/2008	3046F	8P	1	$0.00	0123456789
2	07/01/2008	3049F		1	$0.00	0123456789
3	07/01/2008	3077F		1	$0.00	0123456789
3	07/01/2008	3079F		1	$0.00	0123456789
117	07/01/2008	2022F	8P	1	$0.00	0123456789
119	07/01/2008	3061F		1	$0.00	0123456789

The above is an example of successful reporting in PQRI. In this example, the eligible professional has chosen to report measures 1 and 117 with an 8P modifier indicating that performance of the measure was not met on this visit. An eligible professional may choose whether to report these two measures on the current claim or wait to report them on a claim for a subsequent visit during the reporting period after the results of the test/exam are available.

ESRD Example

Hemodialysis visit for a patient with ESRD: AV Fistula = functioning (4052F); documentation of flu vaccination received on January 1, 2008 (4037F); Hgb = 10 with a plan of care documented (3281F, 0516F); Ktv = 1.3 (3083F)

Dx 1: 585.6						
Measure No.	**Date of Service**	**CPT/HCPCS**	**Modifier**	**Diagnosis Pointer**	**Charges**	**NPI**
	07/01/2008	90935		1	$500.00	0123456789
	07/01/2008	G8488		1	$0.00	0123456789
78	07/01/2008	4052F		1	$0.00	0123456789
79	07/01/2008	4037F		1	$0.00	0123456789
80	07/01/2008	3281F		1	$0.00	0123456789
80	07/01/2008	0516F		1	$0.00	0123456789
81	07/01/2008	3083F		1	$0.00	0123456789

CKD Example

Stage 5 CKD patient, not receiving RRT, office visit: known hypertensive with documented plan of care for hypertension (G8477, 0513F); urinalysis indicates proteinuria, documentation of current prescription for ACE inhibitor (G8479); lab tests ordered on last visit and results documented in the chart (3278F); Hgb = 14 and patient is receiving ESA and has a plan of care documented for elevated hemoglobin level (3279F, 0514F, 4171F)

Dx 1: 585.5; Dx 2: 401.0; Dx 3: 791.0						
Measure No.	**Date of Service**	**CPT/HCPCS**	**Modifier**	**Diagnosis Pointer**	**Charges**	**NPI**
	07/01/2008	99213		1	$50.00	0123456789
	07/01/2008	G8487		1	$0.00	0123456789
120	07/01/2008	G8479		1, 2 or 3	$0.00	0123456789
121	07/01/2008	3278F		1	$0.00	0123456789
122	07/01/2008	G8477		1	$0.00	0123456789
122	07/01/2008	0513F		1	$0.00	0123456789
123	07/01/2008	3279F		1	$0.00	0123456789
123	07/01/2008	0514F		1	$0.00	0123456789
123	07/01/2008	4171F		1	$0.00	0123456789

Preventive Care Example

Primary care office visit for a 67 year old female, established patient. Presents with mild cold symptoms. Record indicates patient had a DXA done at age 62, with results documented as within normal limits (G8399); denies urinary incontinence (1090F); record indicates influenza vaccination at a previous visit in January of this year (G8482); pneumonia vaccination administered last year (4040F); results of last month's mammogram (3014F) and last week's FOBT (3017F) reviewed with patient; denies tobacco use (1000F, 1036F, G8457); today's BMI measurement = 24 (G8420)

Dx 1: Use any visit-specific diagnosis for the measures in this group						
Measure No.	**Date of Service**	**CPT/HCPCS**	**Modifier**	**Diagnosis Pointer**	**Charges**	**NPI**
	07/01/2008	99212		1	$45.00	0123456789
	07/01/2008	G8486		1	$0.00	0123456789
39	07/01/2008	G8399		1	$0.00	0123456789
48	07/01/2008	1090F		1	$0.00	0123456789
110	07/01/2008	G8482		1	$0.00	0123456789
111	07/01/2008	4040F		1	$0.00	0123456789
112	07/01/2008	3014F		1	$0.00	0123456789
113	07/01/2008	3017F		1	$0.00	0123456789
114	07/01/2008	1000F		1	$0.00	0123456789
114	07/01/2008	1036F		1	$0.00	0123456789
115	07/01/2008	G8457		1	$0.00	0123456789
128	07/01/2008	G8420		1	$0.00	0123456789