

# Centers for Medicare & Medicaid Services

## 2008 Physician Quality Reporting Initiative (PQRI)

June 18, 2008

National Provider Call



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# 2007 PQRI Incentive Payments

- Incentive payments for satisfactory 2007 reporting issued mid-late July, 2008
- Payments for individual professionals billing under a Tax ID Number (TIN) rolled up to TIN
- Payments to TINs billing through multiple Carriers/MACs may be split among Carriers/MACs
- TINs will receive Remittance Advice
- Feedback Reports Available Separately

# 2007 PQRI Feedback Reports

- Reports will be accessible through a secure, on-line mechanism
- Availability planned for mid-July, 2008
- Will be in Adobe PDF format (readable by software available free online)
- Will include:
  - TIN-level reporting and financial information
  - Individual-Professional-level Reporting & Performance Information
  - National-average performance comparison information

# To Access Reports

- Each TIN will need to register as an “organization” in “IACS” – Individuals Authorized Access to CMS Computer Services
- Registration is free, but takes some time,  
So...

# Organizations Should Begin Registering Now!

- Registration in IACS is required for online system
  - Open now for Security Officials for Organizations (practices with multiple providers or individual professionals with staff who will access reports on their behalf)
  - Allow processing time
- Registration for individual professionals accessing own report on own behalf available June 30
  - Requires less time to approve, more automated

# Who're We Going to Call?

- General informational questions and inquiries about calculation methods and payments issues: -- Carrier/MAC
- IACS registration questions -- EUS Help Desk at 1-866-484-8049 or TTY (for hearing impaired) 1-866-523-4759
- PQRI Report Delivery System (RDS) questions -- PQRI RDS Help Desk
  - *RDS Help Desk available beginning July 10*

# 2008 PQRI: The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)

MMSEA authorized continuation of PQRI for 2008

- Eliminated cap on incentive payment
- Incentive payment remained 1.5% of total allowable charges for PFS covered professional services furnished during reporting period
- Required alternative reporting periods and alternative reporting criteria for 2008 and 2009.

# 2008 Reporting Options - Overview

- Two Reporting Periods
  - 12 months (January 1 - December 31, 2008)
  - 6 months (July 1 - December 31, 2008)
- Total of 9 PQRI Reporting Methods
  - 3 claims-based
  - 6 registry-based

# Current Participation

- If you are already reporting 3 measures on claims--GREAT!
- You do not need to make any changes for your PQRI participation.
- You do NOT need to switch to one of the options/methods we will now discuss.

# Physician Quality Reporting Initiative (PQRI) Participation Decision Tree

**I WANT TO PARTICIPATE IN 2008 PQRI  
FOR INCENTIVE PAYMENT**

(Select Reporting Method)

**CHOOSE  
CLAIMS-BASED REPORTING OPTIONS**

REGISTRY REPORTING



< 3 MEASURES  
APPLY

3 OR MORE  
MEASURES APPLY

ONLY OPTION IS TO  
REPORT CLAIMS FOR  
**12-MONTH** REPORTING  
PERIOD

1/1/08-12/31/08

REPORT EACH MEASURE  
≥ **80%** OF APPLICABLE  
PATIENTS

Subject to Measure-Applicability  
Validation (MAV)

CHOOSE TO REPORT ON  
≥ 3 MEASURES  
FOR

**12 MONTHS**

1/1/08-12/31/08

REPORT ≥ **80%** OF  
APPLICABLE PATIENTS  
ON AT LEAST 3  
MEASURES

CHOOSE TO REPORT  
**MEASURES GROUP**  
FOR

**6 MONTHS**

7/1/08-12/31/08

REPORT ≥ **80%** OF  
ELIGIBLE PATIENTS  
FOR A MEASURES  
GROUP THE FULL 6  
MONTHS

REPORT 100% OF  
**15 CONSECUTIVE**  
ELIGIBLE PATIENTS  
ANYTIME WITHIN 6  
MONTHS

# I WANT TO PARTICIPATE IN 2008 PQRI FOR INCENTIVE PAYMENT

(Select Reporting Method)

CLAIMS-BASED REPORTING

**CHOOSE  
REGISTRY-BASED REPORTING  
OPTIONS**

CHOOSE TO SUBMIT  
DATA ON **80%** OF  
ELIGIBLE PATIENTS  
ON AT LEAST 3  
MEASURES

CHOOSE TO  
REPORT

**12 MONTHS**

1/1/08-12/31/08

CHOOSE TO  
REPORT

**6 MONTHS**

7/1/08-12/31/08

SUBMIT DATA ON  
100% OF **30**  
**CONSECUTIVE**  
ELIGIBLE  
PATIENTS WITHIN  
12 MONTHS

SUBMIT DATA  
ON **80%** OF  
APPLICABLE  
PATIENTS FOR  
THE MEASURES  
GROUP

SUBMIT DATA ON  
100% OF **15**  
**CONSECUTIVE**  
ELIGIBLE  
PATIENTS WITHIN  
6 MONTHS

SUBMIT DATA  
ON **80%** OF  
ELIGIBLE  
PATIENTS FOR  
A MEASURES  
GROUP

SUBMIT  
**12 MONTHS**

1/1/08-12/31/08

SUBMIT  
**6 MONTHS**

7/1/08-12/31/08

# I WANT TO PARTICIPATE IN 2008 PQRI FOR INCENTIVE PAYMENT

(Select Reporting Period)

**12-MONTH  
REPORTING PERIOD**  
1/1/08-12/31/08

**6-MONTH  
REPORTING PERIOD**  
7/1/08-12/31/08

CLAIMS

REGISTRY

CLAIMS

REGISTRY

≥ 80% OF  
ELIGIBLE  
PATIENTS ON AT  
LEAST 3  
MEASURES **OR**  
ON EACH  
MEASURE IF < 3  
MEASURES

≥ 80% OF  
ELIGIBLE  
PATIENTS  
ON AT  
LEAST 3  
MEASURES

**MEASURES  
GROUPS**

100% of **15  
CONSECUTIVE**  
ELIGIBLE  
PATIENTS FOR  
THE MEASURES  
GROUP  
ANYTIME  
WITHIN 6  
MONTHS

≥ 80% OF  
ELIGIBLE  
PATIENTS IN  
MEASURES  
GROUP

≥ 80% OF  
ELIGIBLE  
PATIENTS ON  
AT LEAST 3  
MEASURES

**MEASURES  
GROUPS**

100% OF  
**30 CONSECUTIVE**  
ELIGIBLE  
PATIENTS  
ANYTIME WITHIN  
12 MONTHS

≥ 80% OF  
ELIGIBLE  
PATIENTS FOR  
THE FULL 12  
MONTHS

≥ 80% OF  
ELIGIBLE  
PATIENTS FOR  
THE FULL 6  
MONTHS

100% OF  
**15  
CONSECUTIVE**  
ELIGIBLE  
PATIENTS  
ANYTIME  
WITHIN 6  
MONTHS

# 3 Claims-Based Options

## January 1, 2008 –December 31, 2008 (full-year)

1. Claims-based reporting of Individual PQRI Measures
  - if  $<3$ , report each for  $\geq 80\%$  of eligible patients (this is the only way to report less than 3 measures)
  - if  $\geq 3$ , report at least 3 for  $\geq 80\%$  of eligible patients

## July 1, 2008 –December 31, 2008 (half-year)

2. Claims-Based Reporting of 1 Measures Group
- OR**
3. for 80% of eligible patients for the Measures Group

*Note: Claims-based reporting for 6-month reporting period only available for reporting of Measures Groups*

# Measures Groups

- A measures group is a group of measures covering patients with a particular condition or preventive services.
- Each of the applicable measures in a measures group must be reported for each patient in the measures group.

# Measure Group Denominators

- A single set of codes (CPT I and/or ICD9) as well as **specific age ranges** make up the denominator for each measures group.
- The measure group specifications can be viewed on the PQRI website at [www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri). Click on the Measures/Codes tab on the left side of the page.

# How to Determine if Patient Fits into a Measures Group

- Step 1—Does the Measures Group apply?
  - Does the patient have the required denominator codes (CPT I and/or ICD-9 codes) on the claim?
  - Does the patient fit into the listed age range?
- Step 2—Does the individual measure apply?
  - If the patient fits into the group but a particular measure does not apply due to age, gender, or diagnosis you can choose not to report the measure OR report the measure with an exclusion modifier.

# How is Age Calculated?

- Age is determined based on the date of service (DOS).
- If the patient is of the proper age for a measure **anytime** during the reporting period AND you are reporting using the 80% of a measures group option, that patient **would** count in the 80% cohort for the measures group.
- If you are reporting using the consecutive patient option, the patient's age at the time they appear in the consecutive patient sequence is the age used to determine if they should count as one of the consecutive patients.

# Measures Groups Using Claims

- For claims, you must submit the measures group specific G-code for the measures group with the first patient of the 15 consecutive patients you intend to report on for the group.
- A measure group specific G-code is also necessary to signal your intention to report a measures group even if you plan to use the 80% of the measures group option.
- A Quality Data Code (G-code or CPT II code) must be submitted for each applicable measure included in the measures group for each patient within that group.

# G codes for Measures Groups (using claims)

- Submission of a measures group specific G-code signals CMS that the provider has selected the measures group option.
- CMS will begin the consecutive patient count starting with the patient with whom the measures group G-code was submitted.
- For the consecutive patient option, it **MUST** be submitted with the first such patient in the measure group.
- You **CAN** submit it with each patient in the group but this is not necessary.
- You **CANNOT** restart the consecutive patient count if you miss a patient.
  - You may still qualify for reporting the group on 80% of your measure group eligible patients.

# Diabetes Measure Group Common Denominators

<b>Measures Group</b>	<b>CPT Patient Encounter Codes</b>	<b>ICD-9 Codes</b>
Diabetes Mellitus  <b>Ages 18-75</b>	99201-99205, 99212-99215	250.00-250.03, 250.10-250.13, 250.2- 250.23, 250.3-250.33, 250.4-250.43, 250.5- 250.53, 250.6-250.63, 250.7-250.73, 250.8- 250.83, 250.9-250.93, 648.0-648.04

# DM Measures Group (cont)

## Diabetes Mellitus:

(report measure group specific G-code **G8485** on first patient to signal intent to report a measures group if submitting via claims)

- 1 – Hgb A1c Poor Control
- 2 – LDL Control
- 3 – High Blood Pressure Control
- 117 – Dilated Eye Exam
- 119 – Urine Screening for Microalbumin

Note: All 5 measures apply to any patient who meets the denominator criteria (age, CPT I and ICD-9 code) for the measures group.

# ESRD Measure Group Common Denominators

Measures Group	CPT Patient Encounter Codes	IcD-9 Diagnosis Codes
End Stage Renal Disease  <b>Ages: 18 years and older</b>	90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319	585.6

# ESRD Measures Group (cont)

## End Stage Renal Disease (ESRD):

(report measure group specific G-code **G8488** on first patient to signal intent to report a measures group if submitting via claims)

78 - Vascular Access for hemodialysis (HD) patients

79 - Influenza Vaccination

80 - Plan of Care for patients with anemia

81 - Plan of Care for inadequate HD

**Note:** All 4 measures apply to any patient who meets the denominator criteria (age, CPT I and ICD-9 code) for the measures group.

# CKD Measure Group Common Denominators

Measures Group	CPT Patient Encounter Codes	ICD-9 Diagnosis Codes
Chronic Kidney Disease  <b>Ages: 18 years and older</b>	99201-99205, 99212-99215, 99241-99245	585.4, 585.5

# CKD Measures Group (cont)

## Chronic Kidney Disease (CKD):

(report measure group specific G-code **G8487** on first patient to signal intent to report a measures group if submitting via claims)

120 – ACE or ARB

121 – Testing for Ca, Phos, IPTH, Lipids

122 – Blood Pressure Management

123 – Plan of Care: Elevated Hgb for patients on ESA

# CKD Measures Group (cont)

- Measures 121-123 apply to all patients who meet the CKD denominator criteria (age, CPT I codes, and ICD-9 codes)
- For measure 120 to apply, the patient must meet the above criteria AND have a diagnosis of hypertension and proteinuria (by ICD-9 code) on the claim. If the measure does not apply to the patient, the professional does not need to report this measure for the group OR the professional can report G8480 (no treatment for documented reason).

# Preventive Care Measure Group Common Denominators

Measures Group	CPT Patient Encounter Codes	ICD-9 Diagnosis Codes
Preventive Care  <b>Ages: 50 years and older</b>	99201-99205, 99212-99215	None

# Measures Groups (cont)

## Preventive Care:

(report measure group specific G-code **G8486** on first patient to signal intent to report a measures group if submitting via claims)

- 39 -Screening/Therapy for Osteoporosis in Women aged 65 and Older\*
- 48 -Assessment of Urinary Incontinence in Women aged 65 and Older\*
- 110 - Influenza Vaccination for Patients  $\geq$  50 years old
- 111- Pneumonia Vaccination for Patients 65 Years and Older
- 112 - Screening Mammography\*
- 113 - Colorectal Cancer Screening
- 114 - Inquiry Regarding Tobacco Use
- 115 - Advising Smokers to Quit
- 128 - Weight Screening and Follow-up

\*Apply to female patients only

# Preventive Care Measures Group (continued)

AGE (in years)	Male Patients (Measures)	Female Patients (Measures)
<50	Patient does not qualify for group	Patient does not qualify for group
50 - 64	110, 113, 114, 115	110, 112, 113, 114, 115
65 - 69	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 112, 113, 114, 115, 128
70 - 80	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 113, 114, 115, 128
81 +	110, 111, 114, 115, 128	39, 48, 110, 111, 114, 115, 128

# If a Measure in a Group is Not Applicable to a Specific Patient

- For measures in the measures group that do not apply to a particular patient (due to age or gender requirements of the specific measure) the professional may choose not to report the measure for the group OR may report the measure with an exclusion modifier.

# CMS 1500 – Claims-Based Example: Initiating Measures Group Reporting

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)											22. MEDICAID RESUBMISSION CODE				ORIGINAL REF. NO.									
1. 250 00																								
2. [ ] [ ]																								
3. [ ] [ ]																								
4. [ ] [ ]																								
23. PRIOR AUTHORIZATION NUMBER																								
24. A. DATE(S) OF SERVICE											B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)				E. DIAGNOSIS POINTER	F. \$ CHARGES		G. DAYS OR UNITS	H. ERSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #	
mm	DD	YY	mm	DD	YY			CPT/HCPCS	MODIFIER															
07	01	08	07	01	08	11		99213				1	50	00			NPI	0123456789						
07	01	08	07	01	08	11		3048F				1	0				NPI	0123456789						
07	01	08	07	01	08	11		G8XXX				1	0				NPI	0123456789						
																	NPI							
																	NPI							
																	NPI							
25. FEDERAL TAX I.D. NUMBER						SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For govt. claims, see back)		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE						
XX-01234567						<input type="checkbox"/> <input type="checkbox"/>		987654321				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 50 00		\$		\$ 50 00						

**Note:** Measures group-specific G-code submitted on first diabetic patient (meeting the denominator for one or more measures within the Diabetes Mellitus measures group). Submitting G8485 (circled above) starts counting consecutive patients for Diabetes measures group.

Review remaining DM measures within group and report QDCs for each applicable measure.

# 6 Registry-Based Options

<b>Reporting Period:</b> January 1, 2008 - December 31, 2008	<b>Reporting Period:</b> July 1, 2008 - December 31, 2008
<b>Individual Measures:</b> •80% of applicable cases Minimum <b>3</b> measures	<b>Individual Measures:</b> •80% of applicable cases Minimum <b>3</b> measures
<b>One Measures Group:</b> • <b>30</b> consecutive patients OR •80% of applicable cases	<b>One Measures Group:</b> • <b>15</b> consecutive patients OR •80% of applicable cases

# Registry-Based Options (cont)

- Individual Measures
  - (all Medicare FFS patients)
  - At least **3** measures on 80% of eligible patients for either the **6 month** or **12 month** reporting period.
- Measure Groups (no measure group specific G-code required to be submitted)
  - **30 consecutive\*** patients for **12 months** or 80% of eligible pts for measure group
  - **15 consecutive\*** patients for **6 months** or 80% of eligible pts for measure group
    - \*Must contain some Medicare FFS patients

# How to Submit Via a Registry

- Contact the registry you will be using to **ensure they will be self-nominating** to participate in 2008.
- Inquire as to whether the registry believes it can meet the technical requirements?
- If both answers are yes, ask the registry how data is collected from their professionals?
- CMS will, by 8/31/08, post on the website the registries who become “qualified.”
- **It is preferable to have only 1 registry submit data on behalf of a given TIN/NPI.**

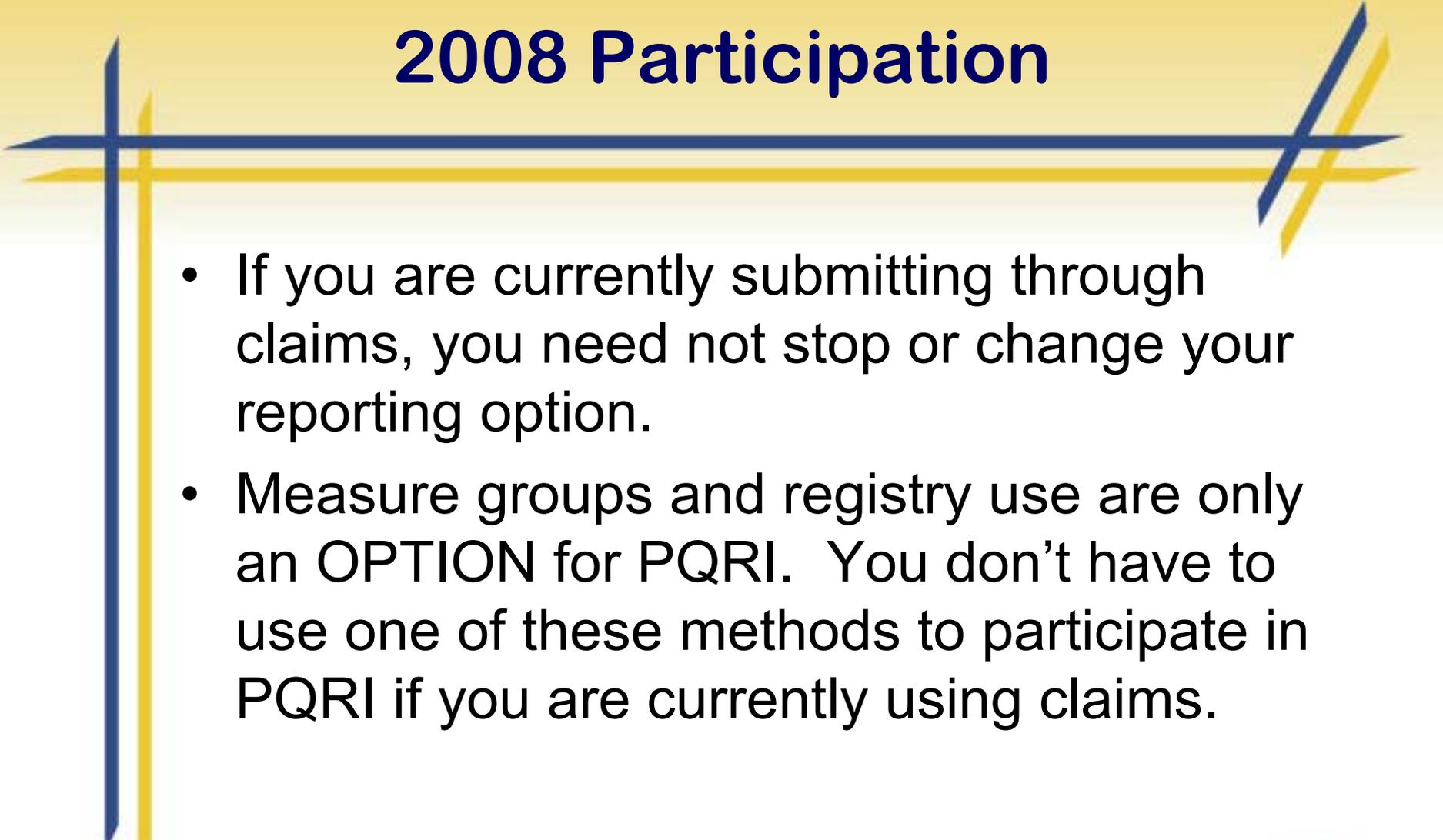
# Payment

- EP must satisfactorily report under one method to qualify for 1.5% incentive
- CMS will review data submitted via all methods to determine satisfactory reporting and eligibility
  - Maximum incentive payment = 1.5% of total allowed PFS charges for Part B covered services for the applicable reporting period
- If qualify for more than one 2008 PQRI reporting method -- receive incentive for longest reporting period

# 2008 Participation Consideration

- Not Too Late to Begin Reporting
  - Alternative half-year reporting period  
(July 1, 2008 – December 31, 2008)
  - 60 measures can be reported only once per patient per reporting period (patient-level measures).
    - This list will be available on the PQRI website.
  - Registry-based reporting options

# 2008 Participation



- If you are currently submitting through claims, you need not stop or change your reporting option.
- Measure groups and registry use are only an OPTION for PQRI. You don't have to use one of these methods to participate in PQRI if you are currently using claims.

# Resources

- CMS PQRI website
  - [www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri)
  - FAQs and other support materials available
  - MLN articles
    - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0747.pdf>
    - <http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0753.pdf>
- CMS IACS website
  - [http://www.cms.hhs.gov/MMAHelp/07\\_IACS.asp](http://www.cms.hhs.gov/MMAHelp/07_IACS.asp)
- Provider Call Center Toll-Free Numbers Directory at:  
[http://www.cms.hhs.gov/MLNGenInfo/01\\_Overview.asp](http://www.cms.hhs.gov/MLNGenInfo/01_Overview.asp)

# Additional PQRI Resources

For more information on PQRI you may contact your Regional Office, Carrier, or visit <http://www.cms.hhs.gov/pqri>

Thank you!