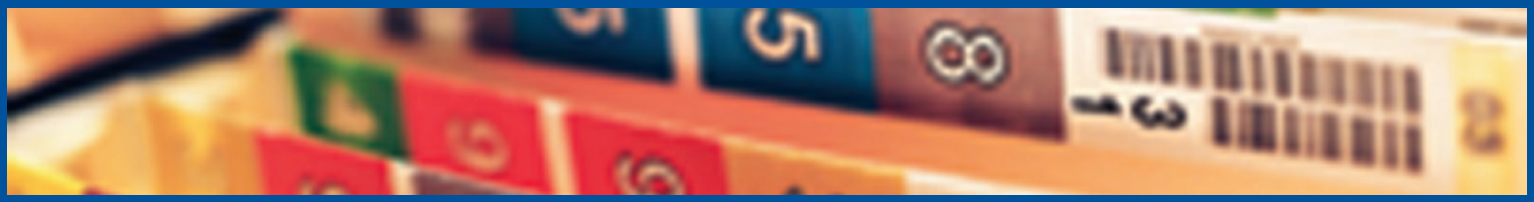

*Medicare Physician Quality Reporting Initiative*

April 2009

# Satisfactorily Reporting 2009 PQRI Measures

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

## Introduction

PQRI is a voluntary individual reporting program that provides an incentive payment to identified eligible professionals (EPs) who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (includes Railroad Retirement Board and Medicare Secondary Payer). Medicare Part C Medicare Advantage (MA) patients are not included in claims-based reporting of measures or measures groups but may be included in registry-based reporting in certain circumstances. Although there is no requirement to register prior to submitting the data, there are some preparatory steps that professionals should take prior to undertaking PQRI reporting. This tip sheet describes preparatory steps and helpful tips for professionals and their billing staff.

It is recommended that EPs and their office staff establish an office workflow that allows accurate identification of each denominator-eligible Part B Medicare claim (i.e., claims for services listed in the denominator coding section of each measure's specifications). The workflow process should also ensure these claims are accurately coded using PQRI quality-data codes (QDCs) found in the numerator section of the measure specification. The workflow process should also include discussing and coordinating with your billing software vendor/clearinghouse to ensure they can report all PQRI codes accurately on your behalf. Consider implementing an edit on your billing software to ensure all eligible claims are flagged for PQRI QDCs for each measure you select to report prior to submitting claims to the carrier/AB Medicare Administrative Contractor (MAC).

## How to Get Started

**STEP 1**

Determine if you are eligible to participate. A list of professionals who are eligible and able to participate in PQRI is available at http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp on the CMS website. Read this list carefully, as not all entities are considered EPs.

**STEP 2**

Determine which PQRI reporting option(s) best fits your practice (claims-based or registry-based for individual measures or measures groups) as well as the PQRI reporting period (6-months or 12-months), which varies with the reporting option. Refer to the *2009 PQRI Participation Decision Tree* in Appendix C of the *2009 PQRI Implementation Guide*, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI web page at http://www.cms.hhs.gov/PQRI on the CMS website.



**ICN: 901883**

**STEP 3**
Review the *2009 PQRI Measures List*, which is available as a downloadable document in the Measures/Codes section of the CMS PQRI web page at http://www.cms.hhs.gov/PQRI on the CMS website, and determine which PQRI measures apply.

EPs who choose to report on individual measures need to select at least three measures to report on to be able to qualify to earn a PQRI incentive payment.

EPs who choose to report measures groups need to select at least one measures group to report to be able to qualify to earn a PQRI incentive payment for 2009.

If you have already been participating in PQRI, there is no requirement to select new/different measures for PQRI 2009. Please note that all PQRI measure specifications are updated and posted prior to the beginning of each program year, so EPs will need to review them for any revisions.

**STEP 4**
*Individual PQRI Measures*
Once you have selected the measures (at least three), carefully review the following documents:

1) *2009 PQRI Quality Measures Specifications Manual and Release Notes* for claims-based or registry-based reporting of individual measures. You do not need to print the entire manual, just print the few pages that describe reporting and coding specifications for your three measures.

2) *2009 PQRI Implementation Guide,* which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in CMS-1500 format.

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

As you read through the specifications and reporting instructions, you will notice that each of the measures has a QDC (a CPT II code or G-code) associated with it and several CPT II modifiers: generally 1P, 2P, and 3P. To qualify for the incentive, the correct QDC will need to be reported on at least 80 percent of the claims that are eligible for each selected measure. A claim is "eligible" when the ICD-9-CM diagnosis and the CPT I service codes match the diagnosis and CPT I codes listed for the measure denominator.

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

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

*PQRI Measures Groups*
Once you have selected the measures group(s), carefully review the following documents:

1) *2009 PQRI Measures Groups Specifications Manual* for claims-based or registry-based reporting of measures groups. You do not need to print the entire manual, just print the few pages that have to do with the detailed coding specifications for your selected measures group(s). Note that the specifications for a measures group are different from those for individual measures. Be sure you use the correct specifications.

2) *Getting Started with 2009 PQRI Reporting of Measures Groups* – This is the implementation guide for reporting measures groups.

3) *2009 PQRI Tip Sheet: PQRI Made Simple – Reporting the Preventive Care Measures Group* – This tip sheet provides a useful worksheet to keep track of each patient reported when using the 30 consecutive patient sample method for a measures group.

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

## Tips for PQRI Reporting

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

### Claims-based Reporting of Individual Measures

- Ensure all staff understand the measures you have selected to report. The primary authoritative sources for measure specifications are those posted on the CMS PQRI website.

- It is important to review *all* the denominator codes that can affect *claims-based* reporting, particularly for broadly applicable measures or measures that do not have an associated diagnosis (for example, #110 influenza immunization, #154 Falls Risk Assessment, #47 Advance Care Plan, etc.) because you will need to report on each eligible claim as instructed in the measure specifications.

- Ensure you identify and capture *all* eligible claims per the measure denominator for each measure selected. Note that several measures apply broadly across various settings of care, (not only office practices but also hospitals, nursing homes, and home health agencies). For example, the table below shows some measures that include only CPT I service codes in the denominator; an ICD-9-CM diagnosis code is not required for denominator inclusion. Therefore, each individual EP who chooses to report these broadly applicable measures will need to report the QDC on each eligible claim that falls into the denominator. Failure to submit a QDC on claims for these Medicare patients will result in a "missed" PQRI reporting opportunity that can impact incentive eligibility.

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

- For measures that require capturing clinical values for coding, make sure that these clinical values are available to those who are coding claims for PQRI reporting.

- Some measures have specified patient demographics, such as age parameters and sex, for denominator inclusion.

- For measures that you have selected to report, carefully review all ICD-9-CM diagnoses (if applicable) and CPT service (encounter) codes that will qualify claims for inclusion in PQRI measurement calculations (i.e., claims that are denominator-eligible) to ensure that each claim includes the appropriate QDC(s) or QDC with the allowable CPT II modifier with the individual EP's NPI. Refer to the *2009 PQRI Implementation Guide*. If the diagnosis or encounter code is different than those listed in the PQRI denominator, then that measure will not apply.

- For measures that require more than one QDC (CPT II or G-code), please ensure that all codes are captured on the claim. For example, when submitting codes for Measure #3 - High Blood Pressure Control in Diabetes Mellitus, be sure to include codes for both the systolic and diastolic blood pressure. Refer to the *CMS-1500 Claim Sample* in Appendix D of the *2009 PQRI Implementation Guide*.

- If all billable services on the claim are denied for payment by the carrier/AB MAC, the QDCs will not be included in PQRI analysis. The claim, as a whole, must include the payment codes, usually ICD-9-CM and CPT I or HCPCS codes, which supply the denominator as well as the QDCs, which supply the numerator in order for the measure's QDCs to be included in PQRI analysis. If the denied claim is subsequently corrected and paid through an adjustment, reopening, **or** the appeals process by the carrier/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 that corrected claim as instructed in the measure specifications. Note that claims may not be resubmitted only to add or correct QDCs, and claims with only QDCs on them with a zero total dollar amount may not be resubmitted to the carrier. Remember that claim adjustments, reopenings, **or** appeals processed by the carrier/AB MAC must reach the national Medicare claims system data warehouse (National Claims History [NCH] file) by February 28, 2010, to be included in the analysis.

- QDCs should be submitted on the line item of the claim as a zero charge or nominal amount such as a penny. The submitted charge field ($Charges) cannot be left blank. Since there is no allowed charge for the PQRI QDC line items, all PQRI QDC line items will be denied by the carrier claims processing system and passed onto the NCH file for PQRI analysis and incentive payment eligibility calculation. The Remittance Advice (RA) with denial code N365 is your indication that the PQRI codes were passed into the NCH file for use in calculating incentive eligibility. Note: Claims may NOT be resubmitted solely to add QDCs. Review the measure specification to determine the appropriate numerator codes to place on the claim. When applicable, utilize the 8P reporting modifier (or G-code equivalent) when the action required is not performed and the reason is not otherwise specified so that the claim will count toward satisfactory reporting.

- Check your RA regularly to ensure you receive a remark code N365 for each QDC submitted to ensure QDCs for individual measures as well as measures groups were passed into the NCH. This remark does not confirm QDC accuracy.

**Claims-based Reporting of Measures Groups**

There are two reporting methods for submission of measures groups that involve a patient sample selection: either the Consecutive Patient Sample Method or the 80% Patient Sample Method. An "intent G-code" must be submitted for either method to initiate your intent to report measures groups via claims.

- When reporting quality actions for the PQRI measures groups, the individual EP may report QDCs on each individual measure within the measures group OR report one (composite) G-code, which indicates that all quality actions for all the measures in the group were performed (for example, G8494, indicates all quality actions for the applicable measures in the diabetes mellitus measures group have been performed for the patient).

  If all of the quality actions for the measures within the measures group were performed at an encounter during the reporting period, the EP could report the composite G-code instead of reporting QDCs for each measure individually. Note that performance exclusion modifiers (i.e., 1P, 2P, 3P, or G-code equivalent) and the 8P reporting modifier cannot apply to the reporting of any measure within the measures group if the composite G-code is used for reporting because all of the quality actions for each measure must have been performed and documented. Refer to the *CMS-1500 Claim Examples-Measures Groups* posted on the Measures/Codes section of the CMS PQRI website.

- For the consecutive patient sample method, "consecutive" refers to how you select the sample or cohort of patients eligible for a measures group and consists of patients who were seen on consecutive dates of service by the EP who has selected to report a measures group. If the patient selected in the sample returns at a subsequent encounter, a QDC may be added to that subsequent claim to indicate that the clinical action was performed during the reporting period. PQRI analysis will consider all QDCs submitted across multiple claims for patients in the consecutive sample.

- EPs need to only report the applicable measures for each patient that meets denominator inclusion in the consecutive patient sample. Denominator inclusion of the patient sample for both the Consecutive Patient Sample Method and the 80% Patient Sample Method is determined by diagnosis and/or encounter parameters common to all measures within a selected measures group. For example, if patient #3 in the sample does not meet the age requirements for all of the measures within the measures group, report those measures that ARE applicable to patient #3. All patients may not meet all of the measure criteria within the measures group.

- EPs who have contracted with MA Plans should not include their MA patients in *claims-based* reporting of measures groups using the Consecutive Patient Sample method. Only Medicare Part B FFS patients should be included in claims-based reporting of measures groups using the Consecutive Patient Sample Method.

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

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

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

Submission of at least three individual measures or at least one measures group via registry is governed by the *2009 PQRI Quality Measures Specifications Manual and Release Notes* and *2009 PQRI Measures Groups Specifications Manual,* respectively. The qualified registry is responsible for providing their clients with instructions on how to submit the selected measures or measures group through the registry. Information regarding qualified registries can be found on the Reporting section of the CMS PQRI website. Note: 18 PQRI measures and 1 measures group are reportable through the registry-based reporting option only.

Registry-based reporting for measures groups may include Medicare Part B FFS patients as well as non-Medicare patients when reporting using the Consecutive Patient Sample Method.

EPs reporting measures groups via the Consecutive Patient Sample Method via *registry* must report on all patients within the sample, regardless of payer.

**Medical Record Documentation**

EPs should document fulifllment of measure requirements in the medical record.

| CMS PQRI Tip Sheet References | CMS/PQRI Website Location |
|---|---|
| *2009 PQRI Fact Sheet: What's New for the 2009 PQRI* | Educational Resources Download |
| *Eligible Professionals List* | Eligible Professionals section |
| *2009 PQRI Implementation Guide*<br>*Appendix A: Glossary of Terms*<br>*Appendix B: Sample 2009 PQRI Measure*<br>*Appendix C: 2009 PQRI Participation Decision Tree*<br>*Appendix D: CMS-1500 Claim Example* | Measures/Codes Download |
| *2009 PQRI Quality Measures List* | Measures/Codes Download |
| *2009 PQRI Quality Measures Specifications Manual and Release Notes* | Measures/Codes Download |
| *2009 PQRI Measures Groups Specifications Manual* | Measures/Codes Download |
| *Getting Started with 2009 PQRI Reporting of Measures Group* | Measures/Codes Download |
| *CMS 1500 Claim Examples-Measures Groups* | CMS Educational Resources Download |
| *2009 PQRI Tip Sheet: PQRI Made Simple-Reporting Preventive Care Measures Group* | CMS Educational Resources Download |
| *2009 PQRI Patient-Level Measures List* | CMS Educational Resources Download |
| *Information and Materials for National Provider Calls & Open Door Forums* | CMS Sponsored Calls web page |
| *FAQs* | PQRI FAQs - Related Links Inside CMS, bottom of PQRI web page |