Getting Started with 2009 PQRI Reporting of Measures Groups

Introduction:

This document contains general guidance for reporting 2009 Physician Quality Reporting Initiative (PQRI) Measures Groups. Measures groups include reporting on a group of clinically-related measures either through claims-based or registry-based submission mechanisms. Seven (7) measures groups have been created for 2009 PQRI which include Diabetes Mellitus, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Bypass Graft (CABG), Rheumatoid Arthritis, Perioperative Care and Back Pain.

Eligible professionals (EPs) can choose to participate under more than one 2009 PQRI reporting option. Professionals who satisfactorily report under more than one reporting option will receive a maximum of one incentive payment, which will be equivalent to 2.0% 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 2009 PQRI Measures Groups reporting alternative is available for the 12-month reporting period from January 1 through December 31, 2009 or the six-month reporting period from July 1 through December 31, 2009. Individual participating EPs who satisfactorily report under measures groups may receive an incentive payment equivalent to 2.0% of total allowed PFS charges for covered professional services furnished to patients enrolled in Medicare Part B Fee-For-Service during either the January 1 through December 31, 2009 reporting period or the July 1 through December 31, 2009 reporting period. This document provides strategies and information to facilitate satisfactory reporting by each EP who wishes to pursue this alternative.

The *2009 PQRI Measures Groups Specifications Manual*, which can be found at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage, 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 *2009 PQRI Measures Groups Specifications Manual* to determine if a particular measures group is applicable to Medicare services the practice provides.

Measures Groups Participation Strategy:

1. Plan and implement processes within the practice to ensure satisfactory reporting of measures groups.
2. Become familiar with the methods for satisfactory reporting of measures groups. The two methods for measures groups are:

   Consecutive Patient Sample Method: For claims-based submissions, 30 consecutive Medicare Part B Fee-For-Service enrolled patients meeting patient sample criteria (see Patient Sample Criteria Table below) for the measures group. **Counting will begin on the date of service that the measures group-specific G-code is submitted**. For example, an EP 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. For registry-based submissions, EPs must report on all applicable measures within the selected measures group for a minimum of 30 consecutive patients (which may include non-Medicare Part B Fee-For-Service patients) who meet patient sample criteria for the measures group. For both claims-based and registry-based submissions, all *applicable* measures within the group must be reported at least once during the reporting period (January 1 through December 31, 2009) for each of the 30 consecutive patients.

OR

80% Patient Sample Method: All Medicare Part B Fee-For-Service enrolled patients seen during the reporting period (either January 1 through December 31, 2009 **OR** July 1 through December 31, 2009) and meeting patient sample criteria (see Patient Sample Criteria Table below) for the measures group. For claims-based submissions, PQRI analysis will be initiated when the measures group-specific G-code is submitted on a claim but all claims meeting patient sample criteria in the selected reporting period will be included regardless of the date of service the measures group-specific G-code is submitted. A minimum of 80% of this patient sample must be reported for all applicable measures within the group according to the individual measures group reporting instructions. For the 12-month reporting period, a minimum of 30 patients must meet the measures group patient sample criteria to report satisfactorily. For the six-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria to report satisfactorily.

3. Determine the 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 an EP's patient for inclusion in the measures group analysis. For claims-based submissions, claims must contain a line-item ICD-9-CM diagnosis code (where applicable) accompanied by a specific CPT patient encounter code. All diagnoses included on the base claim are considered in PQRI analysis.

Patient Sample Criteria Table		
Measures Group	**CPT Patient Encounter Codes**	**ICD-9-CM Diagnosis Codes**
Diabetes Mellitus 18–75 years	97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271	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, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
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	
Coronary Artery Bypass Graft (CABG) 18 years and older	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536	

Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Rheumatoid Arthritis 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456	714.0, 714.1, 714.2, 714.81
Perioperative Care 18 years and older	19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 44005, 44010, 44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49215, 50320, 50340, 50360, 50365, 50370, 50380, 60521, 60522, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276	

Patient Sample Criteria Table		
Measures Group	**CPT Patient Encounter Codes**	**ICD-9-CM Diagnosis Codes**
Back Pain 18-79 years	Diagnosis codes with CPT codes: 98940, 98941, 98942, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 OR 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103 , 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200	Diagnosis codes for CPT 9XXXX codes: 721.3 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2

4. For claims-based submissions, 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. It is not necessary to submit the measures group-specific G-code for registry-based submissions.

    G8485: I intend to report the Diabetes Mellitus Measures Group
    G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group
    G8486: I intend to report the Preventive Care Measures Group
    G8490: I intend to report the Rheumatoid Arthritis Measures Group
    G8492: I intend to report the Perioperative Care Measures Group
    G8493: I intend to report the Back Pain Measures Group

    Measures group-specific G-code line items on the claim must be complete, including accurate coding, date of service, diagnosis pointer, and individual National Provider Identifier (NPI) in the rendering provider field. The diagnosis pointer field on the claim links the patient diagnosis 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. EPs 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 the code passed through their local carrier 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. 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.

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 *2009 PQRI Measures Groups Specifications Manual* on all applicable measures within the measures group for each patient included in the sample population for each individual EP. For claims-based submissions, EPs 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.

   If all quality actions for the applicable measures in the measures group have been performed for the patient, one G-code may be reported in lieu of the individual quality-data codes for each of the measures within the group. Refer to the *2009 PQRI Measures Groups Specifications Manual* for detailed instructions to report quality-data codes for each of the measures group at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

   An EP is only required to report QDCs on those individual measures in the measures group that meet the criteria (age or gender) according to the *2009 PQRI Measures Groups Specifications Manual*. For example, if an EP is reporting the Preventive Care Measures Group for a 52 year old female patient, only six 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, 128	110, 112, 113, 114, 115, 128
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

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 and 3079F); referred to eye care professional (optometrist or ophthalmologist) for dilated eye exam (2022F-8P); urine protein screening performed = negative (3061F); foot exam performed (2028F)

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
163	07/01/2008	2028F		1	$0.00	0123456789

The above is an example of satisfactory reporting in PQRI. The EP included G-code G8485 on the claim form to initiate reporting of the Diabetes Measures Group. In this example, the EP 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 EP 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.

CKD Example

Stage 5 CKD patient, not receiving RRT, office visit: lab tests ordered on last visit and results documented in the chart (3278F); known hypertensive with documented plan of care for hypertension (G8477 and 0513F); Hgb = 14 and patient is receiving ESA and has a plan of care documented for elevated hemoglobin level (3279F and 0514F and 4171F); record indicates influenza immunization at a previous visit in January of this year (4037F); referred for AV fistula (4051F)

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
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
135	07/01/2008	4037F		1	$0.00	0123456789
153	07/01/2008	4051F		1	$0.00	0123456789

Preventive Care Example

Primary care office visit for a 67 year old female, established patient presenting 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 and 1036F and 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

Rheumatoid Arthritis Example

Rheumatoid arthritis patient, office visit: prescribed DMARD therapy (4187F); documentation of TB screen performed and results interpreted 2 months ago (3455F and 4195F); disease activity assessed and documented as moderate (3471F); functional status assessed (1170F); disease prognosis assessed and documented as good (3476F); documented glucocorticoid use is for less than 6 months (4193F)

Dx 1: 714.0

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
	07/01/2008	99213		1	$50.00	0123456789
	07/01/2008	G8490		1	$0.00	0123456789
108	07/01/2008	4187F		1	$0.00	0123456789
176	07/01/2008	3455F		1	$0.00	0123456789
176	07/01/2008	4195F		1	$0.00	0123456789
177	07/01/2008	3471F		1	$0.00	0123456789
178	07/01/2008	1170F		1	$0.00	0123456789
179	07/01/2008	3476F		1	$0.00	0123456789
180	07/01/2008	4193F		1	$0.00	0123456789

Perioperative Care Example

Patient has surgery for resection of small intestine (Enterectomy): documentation of order for prophylactic antibiotic to be given within one hour prior to surgical incision (4047F); the order for the prophylactic antibiotic was for cefazolin (4041F); prophylactic antibiotics were given one hour prior to surgical incision and there is an order to discontinue within 24 hours of surgery end time (4049F and 4046F); documentation there was an order to give VTE prophylaxis within 24 hours of surgery end time (4044F)

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	44120		1	$1500.00	0123456789
	07/01/2008	G8492		1	$0.00	0123456789
20	07/01/2008	4047F		1	$0.00	0123456789
21	07/01/2008	4041F		1	$0.00	0123456789
22	07/01/2008	4049F		1	$0.00	0123456789
22	07/01/2008	4046F		1	$0.00	0123456789
23	07/01/2008	4044F		1	$0.00	0123456789

Back Pain Example

Initial office visit for a new patient with newly diagnosed back pain: back pain and function assessed including pain assessment, functional status, patient history with notation of no “red flags”, prior treatment and response assessment and employment status (1130F); physical exam performed (2040F); patient counseled to resume normal activities (4245F); patient advised against bed rest lasting four days or longer (4248F)

Dx 1: 724.2

Measure No.	Date of Service	CPT/HCPCS	Modifier	Diagnosis Pointer	Charges	NPI
	07/01/2008	99203		1	$60.00	0123456789
	07/01/2008	G8493		1	$0.00	0123456789
148	07/01/2008	1130F		1	$0.00	0123456789
149	07/01/2008	2040F		1	$0.00	0123456789
150	07/01/2008	4245F		1	$0.00	0123456789
151	07/01/2008	4248F		1	$0.00	0123456789