Medicare Part B Extra Revenue With a Few Extra Codes! Physician Quality Reporting Initiative (PQRI)

Presented by
Denise Mohling, CPC
TrailBlazer Health Enterprises, LLC

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CMS CENTERS for MEDICARE & MEDICAID SERVICES

Important

The information contained in this presentation was current as of January 2010 and can be found on the TrailBlazer Health Enterprises® Web site under the Quality Initiatives specialty Web page. The PQRI manual is located on the TrailBlazer℠ Web site at:
http://www.trailblazerhealth.com

Additional resources can be found on the Centers for Medicare and Medicaid Services (CMS) Web site at:
http://www.cms.hhs.gov/pqri

Today's Objectives

- Introduction to the PQRI
- Reporting mechanisms:
  - Claims-based reporting
  - Registry-based reporting
  - Electronic Health Records- (EHR-) based reporting
  - Group Practice Reporting (GPRO) awareness
- Quality measures
- Measure groups
- Medicare claim submission guidelines
- PQRI online resources

Introduction to PQRI

On December 20, 2006, President Bush signed PL 109-432, the Tax Relief and Health Care Act of 2006 (TRHCA). Division B, Title I, Section 101 of Title I of TRHCA authorized the establishment of a physician quality reporting system by CMS.

CMS has titled the statutory program the PQRI.

This incentive began July 1, 2007.

Introduction to PQRI (Continued)

PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program.

Medicare Advantage plans are not eligible for this incentive; only Medicare Part B qualifies. Medicare Advantage plans may offer a similar program, but it is not part of this reporting process.

No Sign-Up or Preregistration

- There is no sign-up or preregistration for individual professionals to participate!
- Decision to participate requires careful review and consideration of the individual measures and/or group measures.
- Decide “how” to participate in PQRI; claim-based, registry-based, EHR, or group provider reporting options.
- Internal processes implemented to identify when PQRI was met include the Current Procedural Terminology (CPT) II codes/modifiers to all appropriate Medicare claims.

How Does PQRI Work?

1. CMS publishes a listing each year. This list comprises measures.
2. The physician/office must review the measures and select those that apply to the practice.
3. The physician then provides the service based on the measure specifications.
4. The physician reports the performance.
5. The physician waits until the next year to see if he/she was successful.

PQRI Reporting for 2010

- Eligible professionals may choose to report PQRI in the following ways:
  - Submitting quality measure(s) on their Medicare Part B claims:
    - Individual measures or measure groups
  - Reporting to a qualified registry.
  - Reporting through a qualified EHR. It must be through a CMS-approved EHR.
  - Group Practice Reporting–Large groups with 200 physicians or more.
- 2010 Measures List:
  - 175 individual quality measures
  - 13 measure groups

Who Is Eligible to Participate

Eligible professionals that may participate!

Medicare physicians:

- Doctor of medicine
- Doctor of osteopathy
- Doctor of podiatric medicine
- Doctor of optometry
- Doctor of oral surgery
- Doctor of dental medicine
- Doctor of chiropractic

Practitioners:

- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified registered nurse anesthetist (and anesthesiologist assistant)
- Certified nurse midwife
- Clinical social worker
- Clinical psychologist
- Registered dietitian
- Nutrition professional
- Audiologists (as of January 1, 2009)
- Physical Therapist (PT)/Occupational Therapist (OT)/Speech-Language Pathologist (SLP)

How to Report PQRI

Table 1: Criteria for Claims-based Reporting of Individual Measures

Reporting Criteria	Reporting Period
At least 3 PQRI measures, or 1-2 measures if less than 3, apply to the EP, for 80% of applicable Medicare Part B Fee-for-Service (FFS) patients of each EP.	January 1, 2010 – December 31, 2010
At least 3 PQRI measures, or 1-2 measures if less than 3, apply to the EP, for 80% of applicable Medicare Part B FFS patients of each EP.	July 1, 2010 – December 31, 2010

Table 2: Criteria for Claims-based Reporting of Measures Groups

Reporting Criteria	Reporting Period
One measures group for 30 Medicare Part B FFS patients of each EP. *	January 1, 2010 – December 31, 2010
One measures group for 80% of applicable Medicare Part B FFS patients of each EP (with a minimum of 15 patients during the reporting period). **	January 1, 2010 – December 31, 2010
One measures group for 80% of applicable Medicare Part B FFS patients of each EP (with a minimum of 8 patients during the reporting period). **	July 1, 2010 – December 31, 2010

* For 2010, EPs are no longer required to report on patients seen consecutively by date of service, but may report on any 30 patients seen during the reporting period.

** For 2010, the minimum patient sample requirement was reduced from 30 for the 12-month reporting period and 15 for the 6-month reporting period to 15 and 8, respectively.

Reporting Periods

Two separate PQRI claim-based reporting periods are available for 2010:

- January 1, 2010, through December 31, 2010
- July 1, 2010, through December 31, 2010

Denominators and Numerators

What is denominator coding?

- Describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator).
- PQRI measure denominators are identified by Internatinoal Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), CPT Category I, and Health Care Financing Administration Common Procedure Coding System (HCPCS) codes, as well as patient demographics (age, gender, etc.) and place of service (if applicable).

What is numerator coding?

- Describes the clinical action required by the measure for reporting and performance
- PQRI measure numerators are CPT Category II codes and "G" codes

Things to Consider During and After Measure Selection

- Select only those measures that apply to services most frequently provided to Medicare patients by the eligible professional/practice.
- Determine if you will submit individual measures or group measures.
- Review each measure (diagnoses and services) to determine which measure applies to each patient.
- Do not choose measures that do not or (or only infrequently) apply to the professional/practice.
- Determine if claims-based reporting, individual measure or group measures reporting, or registry reporting, EHR, or group reporting would be a better fit for the professional/practice.
- Implement steps to ensure the selected measures are performed, captured, and billed to Medicare.

CMS Home > Medicare > Physician Quality Reporting Initiative > Measures Codes

Physician Quality Reporting Initiative

- Overview
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- Alternative Reporting Mechanisms
- Group Practice Reporting Option
- Analysis and Payment
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- 2007 PQRI Program
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- 2009 PQRI Program

Measures Codes

This page contains information about PQRI quality measures, including detailed specifications and related release notes for the individual PQRI quality measures and measures groups and other measures-related documentation needed by individual EPs for reporting the PQRI measures through claims or registry-based reporting.

Note: The PQRI measure documents for the current program year may be different from the PQRI measure documents for a prior year. EPs are responsible for ensuring that they are using the PQRI measure documents for the correct program year.

2010 PQRI

The following documents pertaining to the 2010 PQRI individual quality measures and measures groups are available in the **"Downloads"** section below:

- **2010 PQRI Measures List.** This document identifies the 179 quality measures (this includes 175 individual quality measures and the 4 measures in the Back Pain measures group, which are not reportable as individual PQRI quality measures) selected for the 2010 PQRI.
- **2010 PQRI QDC Categories.** A table that outlines, for each measure, each QDC that should be reported for a corresponding quality action performed by the individual EP as noted in the measures specification. This determines how each code will be used when calculating performance rates. This also clarifies those measures that require 2 or more QDCs to report satisfactorily. Insufficiently reporting the QDCs (as specified in the 2010 PQRI measure specifications) will result in invalid reporting.
- **Updated (12-17-09) - 2010 PQRI Single Source Code Master.** This file includes a numerical listing of all codes included in 2010 PQRI for incorporation into billing software.

2010 PQRI Individual Quality Measures

The following documents specific to the 2010 PQRI individual quality measures are available in the **"Downloads"** section below:

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- **2010 PQRI Implementation Guide.** Guidance about how to implement 2010 PQRI claims-based reporting of measures to facilitate satisfactory reporting of quality data codes by EPs.

2010 PQRI Measures Groups

PQRI measures can be reported for thirteen (13) measures groups that were created for specific conditions that are addressed by at least 4 measures that share a common denominator specification: Diabetes Mellitus, Chronic Kidney Disease, Preventive Care, Coronary Artery Bypass Graft Surgery, Rheumatoid Arthritis, Perioperative Care, Back Pain, Coronary Artery Disease, Heart Failure, Ischemic Vascular Disease, Hepatitis C, HIV/AIDS, and Community-Acquired Pneumonia.

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- **Getting Started with 2010 PQRI Reporting of Measures Groups.** A guide to implementing the 2010 PQRI measures groups.

2010 PQRI EHR Measure Specifications

The measure specifications and other related documents for the submission of ten (10) PQRI measures through a qualified an Electronic Health Record (EHR) system for the 2010 PQRI are available on the **"Alternative Reporting Mechanisms"** link at left.

Downloads

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2010 PQRI QDC Categories [PDF 189KB]

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2010 PQRI Measure Specifications Manual for Claims and Registry Reporting of Individual Measures and Release Notes [ZIP 3MB]

2010 PQRI Implementation Guide [PDF 437KB]

2010 PQRI Measures Groups Specifications Manual and Release Notes [ZIP 603KB]

Getting Started with 2010 PQRI Reporting of Measures Groups [PDF 720KB]

Understanding the *Individual* Measures

The measures address various aspects of quality of care:

- Prevention
- Chronic- and acute-care management
- Procedure-related care
- Resource utilization
- Care coordination

Factors to Consider When Selecting Measures

- Clinical conditions that are usually treated:
  - Diabetes, hypertension, preventive care, etc.
- Types of care typically provided:
  - Preventive, chronic, acute, etc.
- Settings where the care is usually delivered:
  - Office, emergency department, surgical suite, etc.
- Quality improvement goals for 2010

Understanding the Individual Measures

PQRI measures are formatted based on:

- Measure title
- Reporting option available (claims-based or registry)
- Measure description
- Instructions on reporting (frequency, time frames, and applicability)
- Numerator coding (CPT II procedure code based on the patient's condition/service provided)
- Definitions of terms
- Coding instructions
- Use of CPT II modifiers where applicable
- Denominator coding (patient's diagnosis/condition *and* the patient encounter (CPT/HCPCS) that was performed
- Rationale statement for measure
- Clinical recommendations or evidence supporting criteria for measure

Examples of Individual Measures Performed in IHS Facilities

Measure Number	Measure Title	Reporting	Denominator	Numerator
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus	Once per reporting period.	Ages 18–75. Diabetes diagnosis. E/M service.	3046F A1c >9.0 3044F A1c ≤9.0 3045F A1c 7.0 to 9.0 Append 8P to 3046F if not performed during performance period
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus	Once per reporting period.	Ages 18–75. Diabetes diagnosis. E/M service.	3048F LDL-C <100 mg/dL 3049F LDL-C ≥ 100 mg/dL 3050F LDL-C ≥ 130 mg/dL Append 8P to 3048F if LDL-C was not performed during performance period.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus	Once per reporting period.	Ages 18–75. Diabetes diagnosis. E/M service.	Two CPT II codes must be reported: Systolic – 3074F, 3075F, 3077F Diastolic – 3078F, 3079F, 3080F Append 8P to 2000F when no documentation of measurement.
163	Diabetes Mellitus: Foot Exam	Once per reporting period.	Ages 18–75. Diabetes diagnosis. E/M service.	2028F Foot exam performed; 2028F With 1P or 8P modifier indicating not performed.

Measure No. 1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus

- **Reporting:** Reported either by claims-based or registry-based reporting
- **Description:** Lists age restrictions along with laboratory result requirements
- **Instruction:** Frequency of billing the measure

Measure #1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus

2010 PQRI REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

DESCRIPTION:
Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

INSTRUCTIONS:
This measure is to be reported a minimum of once per reporting period for patients with diabetes mellitus seen during the reporting period. The performance period for this measure is 12 months. The most recent quality-data code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

Measure No. 1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus (Continued)

Claims or registry reporting:

Measure Reporting via Claims:
Line-item ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, G-codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported ON THE SAME CLAIM.

Measure Reporting via Registry:
ICD-9-CM diagnosis codes, CPT codes, G-codes, and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure. The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

Measure No. 1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus (Continued)

Numerator reporting:

Utilizing the patient's laboratory results, select the CPT II code to bill from the measure specifications.

NUMERATOR:
Patients with most recent hemoglobin A1c level > 9.0%

Numerator Instructions: For performance, a lower rate indicates better performance/control.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:
Most Recent Hemoglobin A1c Level > 9.0%
CPT II 3046F: Most recent hemoglobin A1c level > 9.0%
OR

Hemoglobin A1c not Performed
Append a reporting modifier (**8P**) to CPT Category II code **3046F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.
3046F *with* 8P: Hemoglobin A1c level was not performed during the performance period (12 months)

OR

Most Recent Hemoglobin A1c Level ≤ 9.0%
CPT II 3044F: Most recent hemoglobin A1c (HbA1c) level < 7.0%
OR
CPT II 3045F: Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

Measure No. 1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus (Continued)

Denominator reporting:

The patient's diagnosis, along with the applicable Evaluation and Management (E/M) encounter, should be utilized for billing.

DENOMINATOR:
Patients aged 18 through 75 years with the diagnosis of diabetes

Denominator Criteria (Eligible Cases):
Patients aged 18 through 75 years on date of encounter
AND
Diagnosis for diabetes (line-item ICD-9-CM): 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
AND
Patient encounter during reporting period (CPT or HCPCS): 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

Measure No. 1: Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus (Continued)

Rationale:

The “logic” of maintaining A1c level used when determining the measure specifications.

RATIONALE:
Intensive therapy of glycosylated hemoglobin (A1c) reduces the risk of microvascular complications.

Performance Exclusions Modifiers

1P: Performance measure exclusion due to *medical* reasons

Includes:

- Not indicated (absence of organ/limb, already received/performed, other)
- Contraindicated (patient allergic history, potential adverse drug interaction, other)
- Other medical reasons

Instructions for using this modifier will be detailed in the individual measure.

Performance Exclusions Modifiers (Continued)

2P Performance measure exclusion modifier due to *patient* reasons

Includes:

- Patient declined
- Economic, social, or religious reasons
- Other patient reasons

Instructions for using this modifier will be detailed in the individual measure.

Performance Exclusions Modifiers (Continued)

3P Performance measure exclusion modifier due to *system* reasons

Includes:

- Resources to perform the service(s) not available (e.g. equipment, supplies)
- Insurance coverage or payer-related limitations
- Other reasons attributable to healthcare delivery system

Instructions for using this modifier will be detailed in the individual measure.

Performance Measure Reporting Modifier

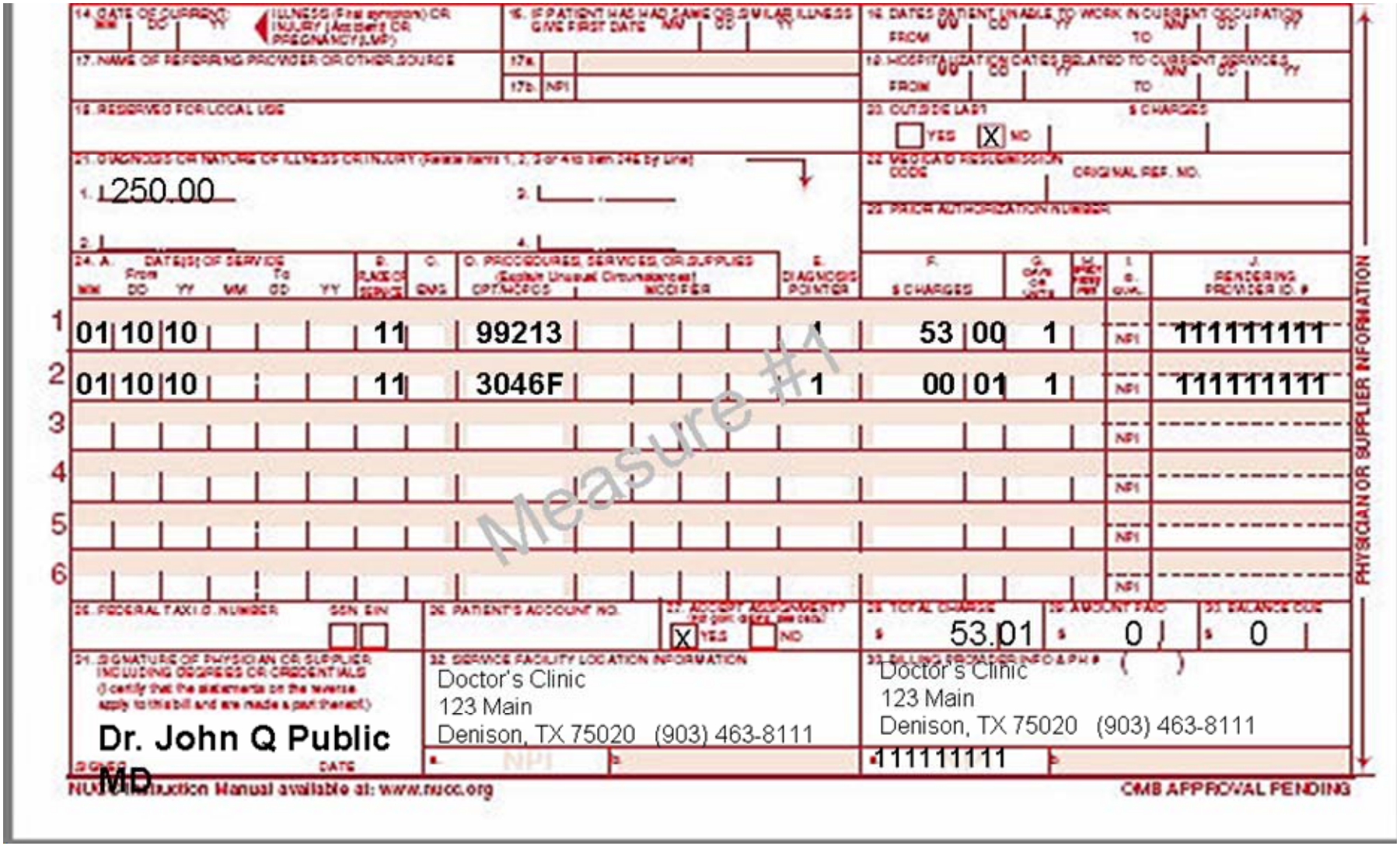
8P Performance measure reporting modifier

Includes:

- *Action not performed*, reason not specified.

Instructions for using this modifier will be detailed in the individual measure.

Individual Measure Reported on Claim



Individual Measure Claim-Based Successful Reporting

- The CPT II code (measure code) must be reported on the same claim as the payment CPT (E/M) code and diagnosis code.
- Multiple CPT II codes can be reported on the same claim.
- Providers should report on at least three measures during the reporting period.
- Providers reporting fewer than three measures will receive a validation prior to the incentive payment calculation to determine the reason for reporting fewer than three measures.

Measures Groups

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

Measures Groups Reporting

Thirteen measures groups have been established for 2010 PQRI:

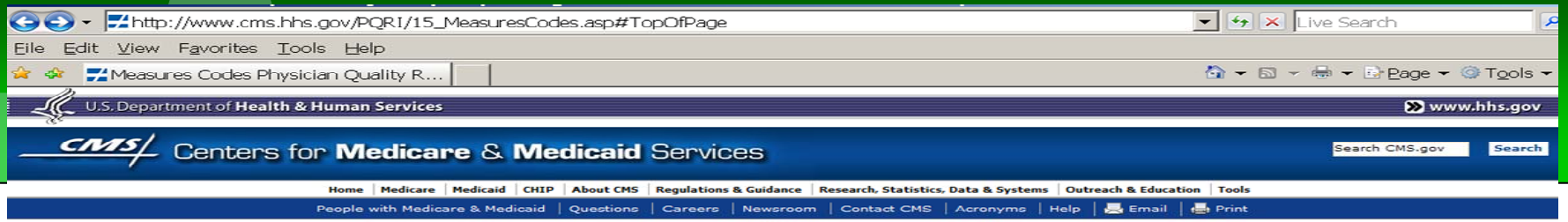
- Diabetes Mellitus
- Chronic Kidney Disease (CKD)
- Preventive Care
- Coronary Artery Bypass Graft (CABG)
- Rheumatoid Arthritis
- Perioperative Care
- Back Pain
- Hepatitis C
- Heart Failure
- Coronary Artery Disease (CAD)
- Ischemic Vascular Disease (IVD)
- HIV/AIDS
- Community-Acquired Pneumonia (CAP)

Two Methods for Satisfactory Measures Groups-Based Reporting

- Thirty-patient sample method–12-month reporting only:
  - Thirty unique Medicare patients who meet patient sample criteria:
    - CMS removed the “30 consecutive” requirement for 2010
  - Claim-based analysis will begin when the measure group specific “intent” procedure code is submitted on a claim (“G” code).
  - All applicable measures within the measure group must be reported at least once for each patient within the sample population during the reporting period of January 1, 2010–December 31, 2010.
  - Can be reported either claim-based or registry-based.

Two Methods for Satisfactory Measures Groups-Based Reporting (Continued)

- 80% patient sample method:
  - All Medicare patients seen during the reporting period: January 1, 2010–December 31, 2010, or July 1, 2010–December 31, 2010.
  - Claim-based analysis will begin when the measure group-specific “intent” procedure code is submitted on a claim (“G” code).
  - A minimum of 80% of the patient sample must be reported for all applicable measures within the measure group according to the measure instructions.
  - For the 12-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria.
  - For the six-month reporting period, a minimum of eight patients must meet the measures group patient sample.



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Getting Started with 2010 PQRI Reporting of Measures Groups [PDF 720KB]

Measures Groups-Based Reporting

Measure Number	Measure Title
	Diabetes Mellitus Measures Group
	Diabetes Mellitus Measures Group Overview
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
2	Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
163	Diabetes Mellitus: Foot Exam

Reminder: An initial claim for this measure group would require the intent CPT II code to initiate the claim analysis process.

Example

Diabetes Mellitus Measures Group:

- Made up of six individual measures that all relate to the diagnosis of diabetes.
- If the Medicare patient meets the sample criteria and all the elements of each measure within the group are met, the claim would be filed to include the measure group CPT II code.
- The group measure will identify the appropriate CPT II composite code to report based on the patient's criteria.
- Composite code **G8494** identifies *all* quality actions for the diabetes measure were performed.

G8485 "I intend to report the Diabetes Mellitus Measures Group."

Diabetes Measures Group Codes

Diabetes Mellitus Measures Group

This measures group is to be reported for patients aged 18 through 75 years with diabetes mellitus receiving office or other outpatient services, nursing facility care, domiciliary/rest home/custodial care services, or medical nutrition therapy.

You will need to report G-code G8485 once to indicate your intent to report on the Diabetes Mellitus Measures Group. Once you have reported the G-code, you should begin reporting using one of the patient sample methods listed below.

The following 2010 PQRI measures are included in the Diabetes Mellitus Measures Group:

#1. Hemoglobin A1c Poor Control in Diabetes Mellitus

Measure Description

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%

#2. Low Density Lipoprotein Cholesterol (LDL-C) Control in Diabetes Mellitus

Measure Description

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dL)

#3. High Blood Pressure Control in Diabetes Mellitus

Measure Description

Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)

#117. Dilated Eye Exam in Diabetic Patient

Measure Description

Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam

#119. Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

Measure Description

Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months

#163. Foot Exam

Measure Description

Percentage of patients aged 18 through 75 years with diabetes mellitus who had a foot examination

This measures group can be reported by one of the following patient sample methods:

- ***30 Patient Sample Method*** — 30 unique patients meeting patient sample criteria for the measures group.
- ***80% Patient Sample Method*** — All patients meeting patient sample criteria for the measures group during the entire reporting period (January 1 through December 31, 2010 OR July 1 through December 31, 2010). For the 12-month reporting period, a minimum of 15 patients must meet the measures group patient sample criteria to report satisfactorily. For the six-month reporting period, a minimum of 8 patients must meet the measures group patient sample criteria to report satisfactorily.

Diabetes Measures Group Criteria

Patient Age	CPT Encounter Codes	ICD-9-CM Codes
18–75	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, 250.7–250.73, 2508–250.83, 250.9–250.93, 648.0–648.04

Steps to Reporting the Diabetes Measure Group

- Reporting period July 1–December 31, 2010.
- Plan and implement processes to ensure successful reporting.
- Become familiar with method of reporting:
  - 80% of all diabetes patients seen at least once during reporting period, with a minimum of 8 patients seen.
    - Example: 100 in clinic with diabetes diagnoses. Eighty of those patients must be submitted with measure group code(s).
- Initiate reporting of the diabetes measure group by indicating G8485 on the first claim reporting these measures.
- Report G8494 if all applicable measures for the measure group were performed.
- If any measure was not performed, report all measures and use the 8P modifier to indicate which measure was not performed.

Diabetes Clinic Visits

IHS has a great opportunity to receive PQRI initiatives for 2010 by reporting the diabetes quality measures group.

Monthly diabetes clinic visits are your chance to begin PQRI reporting.

First Patient Data Sheet

Diabetes Mellitus Measures Group

PQRI Data Collection Sheet*

Patient's Name	Practice Medical Record Number (MRN)	Birth Date (mm/dd/yyyy)	
Jane Doe	DOE123	06/10/1941	☐ Male ☒ Female
National Provider Identifier (NPI)		Date of Encounter	
XXXXXXXXXX		1/12/2010	

Step 1 Preliminary reporting requirements

You must identify your intent to report the Diabetes Mellitus Measures Group by submitting the G-code specified for this measures group on the first patient claim (G8485: I intend to report the Diabetes Mellitus Measures Group). You do not need to resubmit the measures group-specific G-code on more than one claim.

Step 2 Determine patient eligibility

*(Codes determining a patient's eligibility must be reported on the **same claim** as the quality code(s) identified in Step 3 below.)*

	Yes	No	
Patient is aged 18 through 75 years on date of encounter.	X	☐	Refer to date of birth listed above or on claim form.
Patient has a line item diagnosis of diabetes mellitus.	X	☐	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
There is a CPT Service Code for a visit in the office, nursing facility, domiciliary, or home OR a code for medical nutrition therapy.	X	☐	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

If **No** is checked for any of the above, STOP. This patient is not eligible for reporting on this measures group. Do not report a CPT category II code or G-code.

Step 3 Complete individual measures

Blood Pressure (BP) Management		Report one code for systolic BP AND one code for diastolic BP OR one code for NOT assessed.	
PQRI Measure #3 • *measure target: <140/80 mmHg* • *reporting frequency: BP must be assessed and reported once during the calendar year* • *most recent BP should be reported*	Systolic BP	< 130 mmHg	☐ 3074F
		130–139 mmHg	☒ 3075F
		≥ 140 mmHg	☐ 3077F
	Diastolic BP	< 80 mmHg	☐ 3078F
		80–89 mmHg	☒ 3079F
		≥ 90 mmHg	☐ 3080F
		OR	
		Blood pressure NOT assessed	☐ 2000F–8P

First Patient Data Sheet (Continued)

Hemoglobin A1c Management (poor control)		Report one code for A1c level OR one code for NOT assessed.	
PQRI Measure #1 • *poor control: >9.0%* • *reporting frequency: A1c must be assessed and reported once during the calendar year* • *most recent A1c should be reported*	A1c level	< 7.0 %	☐ 3044F
		7.0 to 9.0 %	☒ 3045F
		> 9.0 %	☐ 3046F
		OR	
		HbA1c NOT assessed	☐ 3046F-8P
Lipid Profile		Report one code for LDL-C level OR one code for NOT assessed.	
PQRI Measure #2 • *measure target: < 100 mg/dL (lower is better)* • *reporting frequency: LDL-C level must be assessed and reported once during the calendar year* • *most recent LDL-C level should be reported*	LDL-C level	< 100 mg/dL	☐ 3048F
		100–129 mg/dL	☒ 3049F
		≥ 130 mg/dL	☐ 3050F
		OR	
		LDL-C level NOT assessed	☐ 3048F-8P
Nephropathy Screening or Treatment		Report one code for nephropathy screening OR one code for nephropathy treatment OR one code for NOT performed.	
PQRI Measure #119 • *reporting frequency: nephropathy screening (or documentation of treatment for nephropathy) must be performed and reported once during the calendar year*	Screened for nephropathy	Microalbuminuria positive test result	☐ 3060F
		Microalbuminuria negative test result	☒ 3061F
		Macroalbuminuria positive test result	☐ 3062F
		OR	
	Receiving treatment for nephropathy	Documentation of treatment for nephropathy (eg, patient receiving dialysis, patient being treated for ESRD, CRF, ARF, or renal insufficiency, any visit to a nephrologist)	☐ 3066F
		Patient prescribed ACE inhibitor or ARB therapy	☐ G8506
		OR	
		Nephropathy screening NOT performed	☐ 3060F-8P OR 3061F-8P OR 3062F-8P
Comprehensive Foot Exam *(visual inspection, sensory exam with monofilament, or pulse exam)*		Report one of the following comprehensive foot exam codes OR one code for NOT completed.	
PQRI Measure #163 • *reporting frequency: comprehensive foot exam must be completed and reported once during the calendar year*		Completed	☐ 2028F
		Not Completed for medical reasons *(eg, patient has bilateral foot amputation)* • Document reason in medical chart	☐ 2028F-1P
		OR	
		Comprehensive foot exam NOT completed	☒ 2028F-8P

First Patient Data Sheet (Continued)

Diabetes Mellitus Measures Group

continued from previous page

Eye Exam *(including interpretation by an ophthalmologist or optometrist)*		Report one of the following eye exam codes OR one code for NOT performed.	
PQRI Measure #117 • *reporting frequency: eye exam (or evidence that patient is at low risk for retinopathy) must be performed and reported once during the calendar year*	Eye exam completed by an eye care professional and results reviewed	Dilated retinal eye exam results reviewed	☐ 2022F
		Seven standard field stereoscopic photo results reviewed	☐ 2024F
		Eye imaging validated to match diagnosis from seven standard field stereoscopic photos results	☐ 2026F
	Eye exam not required	Low risk for retinopathy: in the year prior to the reporting period, patient's retinal eye exam had no evidence of retinopathy	☐ 3072F
		OR	
		Eye exam NOT performed	☒ 2022F-8P OR 2024F-8P OR 2026F-8P

First Patient's Claim

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: **Mary Smith, MD**

17a.

17b. NPI **##########**

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. **25080** 3.

2. **4019** 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01	12	10				22		99213		1	100 00	1		NPI	##########
01	12	10				22		G8485		1	0	1		NPI	##########
01	12	10				22		3075F		1	0	1		NPI	##########
01	12	10				22		3079F		1	0	1		NPI	##########
01	12	10				22		3045F		1	0	1		NPI	##########
01	12	10				22		3049F		1	0	1		NPI	##########

Start of measure group reporting

25. FEDERAL TAX I.D. NUMBER SSN EIN: ######### ☐ ☒

26. PATIENT'S ACCOUNT NO.: **XXX######**

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ **Continued**

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Smith, MD 01/12/10

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Indian Health Clinic
123 Main St.
Anytown, USA 12345-6789

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Indian Health Clinic
123 Main St.
Anytown, USA 12345-6789

a. ########## b.

First Patient's Claim (Continued)

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: **Mary Smith, MD**

17a.

17b. NPI ##########

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 25080 3.

2. 4019 4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01	12	10				22		3061F		1	0	1		NPI	##########
01	12	10				22		2028F	8P	1	0	1		NPI	##########
01	12	10				22		2022F	8P	1	0	1		NPI	##########
														NPI	
														NPI	
														NPI	

25. FEDERAL TAX I.D. NUMBER: ######### SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: XXX######

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE $ 100 00

29. AMOUNT PAID $

30. BALANCE DUE $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Smith, MD 01/12/10

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Indian Health Clinic
123 Main St.
Anytown, USA 12345-6789

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Indian Health Clinic
123 Main St.
Anytown, USA 12345-6789

a. ########## b.

Second Patient's Claim

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM — TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: **Mary Smith, MD**

17a.

17b. NPI ##########

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM — TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☒ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 25080
2. 4019
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
01	12	10				22		99213		1	100 00	1		NPI	##########
01	12	10				22		G8494		1	0	1		NPI	##########
														NPI	
														NPI	
														NPI	
														NPI	

Indicates all measures in group performed

25. FEDERAL TAX I.D. NUMBER: ######### SSN ☐ EIN ☒

26. PATIENT'S ACCOUNT NO.: XXX######

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO

28. TOTAL CHARGE: $ 100 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 100 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Mary Smith, MD 01/12/10

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

Indian Health Clinic
123 Main St.
Anytown, USA 12345-6789

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

Indian Health Clinic
123 Main St.
Anytown, USA 12345-6789

a. ########## b.

Advise On PQRI?

Neither CMS nor TrailBlazer can tell a provider which measure codes are appropriate for their practice. Nor can an office be advised of the method in which to bill (claim-based, EHR, registry, or individual measures versus measure groups).

Eligible professionals are encouraged to contact their professional organizations for measure code information if they cannot make a selection on their own.

PQRI and the American Medical Association (AMA)

The AMA provides excellent tools for collecting PQRI data.

The AMA also provides data collection sheets to assist offices in selecting the correct CPT II code to report the PQRI measure.

The additional tools can be obtained at:

http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/participation-tools-individual-2010.shtml

AMA Data Collection Tool Example

AMA Data Collection Tool Example (Continued)

Diabetes Mellitus

Hemoglobin A1c Poor Control in Diabetes Mellitus

PQRI Data Collection Sheet

Patient's Name | Practice Medical Record Number (MRN) | Birth Date (mm/dd/yyyy) / / | ☐ Male ☐ Female Gender

National Provider Identifier (NPI) | Date of Service

Clinical Information			Billing Information
Step 1 Is patient eligible for this measure?			
	Yes	**No**	**Code Required on Claim Form**
Patient is aged 18 through 75 years on date of encounter.	☐	☐	Verify date of birth on claim form.
Patient has a line item diagnosis of diabetes mellitus.	☐	☐	Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.
There is a CPT Code or G-code for this visit.	☐	☐	
If **No** is checked for any of the above, STOP. Do not report a CPT category II code.			
Step 2 Does patient meet the measure?			
Most Recent Hemoglobin A1c Level[1]	**Yes**	**No**	**Code to be Reported on Line 24D of Paper Claim Form, if *Yes* (or Service Line 24 of Electronic Claim Form)**
Hemoglobin A1c level > 9.0%	☐	☐	3046F
Hemoglobin A1c level 7.0% to 9.0%	☐	☐	3045F
Hemoglobin A1c level < 7.0%	☐	☐	3044F
			If **No** is checked for **all** of the above, report 3046F–8P (Hemoglobin A1c level was not performed during the performance period [12 months], reason not otherwise specified.)

PQRI Reports

- Each year, the PQRI incentive payment and the PQRI feedback reports are issued. (These are handled through a separate process.)
- The feedback reports are issued whether an incentive payment was earned or not.
- Reports are available for every Taxpayer Identification Number (TIN) under which at least one eligible professional submitting Medicare Part B claims reported at least one valid PQRI measure a minimum of once during the reporting period.
- The reporting/analysis information can be found on the CMS PQRI Web site at: http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage

Example of 2008 PQRI Report

2008 PHYSICIAN QUALITY REPORTING INITIATIVE FEEDBACK REPORT

Participation in PQRI is at the individual National Provider Identifier level within a Tax ID (TIN/NPI). 2008 PQRI included three claims-based reporting methods, six registry-based reporting methods and two alternate reporting periods. All Medicare Part B claims submitted with PQRI quality-data codes (QDCs) and all registry data received for services furnished from July 1, 2008 to December 31, 2008 (for the six month reporting period) and for services furnished from January 1, 2008 to December 31, 2008 (for the twelve month reporting period) were analyzed to determine whether the Eligible Professional (EP) earned a PQRI incentive payment. Each TIN/NPI had the opportunity to participate in PQRI via multiple reporting methods. Participation is defined as Eligible Professionals (EPs) submitting at least one valid QDC via claims or submitting data via a qualified registry. Valid submissions are where a QDC is submitted and all measure-eligibility criteria is met (i.e. correct age, gender, diagnosis and CPT). For those NPIs satisfactorily reporting multiple reporting methods, the method associated with the most advantageous reporting period satisfied was used to determine their PQRI incentive. The methods reported and amounts earned for each TIN/NPI are summarized below. More information regarding the PQRI program is available on the CMS website, www.cms.hhs.gov/pqri.

Table 1: Earned Incentive Summary for Taxpayer Identification Number (Tax ID)
Sorted by Earned Incentive Yes/No and sub-sorted by NPI Number

Tax ID Name«: John Q. Public Clinic
Tax ID Number: XXXXX6789

Total Tax ID Earned Incentive Amount for NPIs (listed below): $14,150.00	Distribution of Total Incentive Earned Among Carriers and/or A/B MACs That Processed Payments		
	Carrier and/or A/B MAC Identification #	Proportion of Incentive« per Carrier and/or A/B MAC	Tax ID Earned Incentive Amount Under Carrier and/or A/B MAC
	12345	90.0%	$12,735.00
	6789	10.0%	$1,415.00

NPIs that did not earn an incentive will still appear in the report along with the reason they were not incentive eligible.

NPI	NPI Name«	Earned Incentive•				Total # Measures with QDCs Submitted^	Total # Measures Denominator Eligible with QDCs~	Total # Measures Satisfactorily Reported‡	Total Estimated Allowed Medicare Part B PFS Charges□	NPI Total Earned Incentive Amount*
		Method of Reporting	Reporting Period	Yes/No	Rationale					
1000000002	Smith, Susie	Individual measure(s) reporting via registry	6 months	Yes	Sufficient # of measures reported at 80%	10	8	5	$100,000.00	$1,500.00
1000000003	Not Available	Individual measure(s) reporting via registry	12 months	Yes	Sufficient # of measures reported at 80%	6	4	3	$133,333.33	$2,000.00
1000000004	Not Available	80% Measures Groups beneficiaries via claims	6 months	Yes	Sufficient # of beneficiaries reported at 80%	8	6	4	$63,333.33	$950.00
1000000006	Not Available	80% Measures Groups patients via registry	12 months	Yes	Sufficient # of patients reported at 80%	8	5	4	$166,666.66	$2,500.00
1000000008	Beans, John	Consecutive Measures Groups patients via registry	6 months	Yes	Sufficient # of consecutive patients reported	7	6	4	$53,333.33	$800.00
1000000009	Smithson, Steve	Consecutive Measures Groups patients via registry	12 months	Yes	Sufficient # of consecutive patients reported	12	10	9	$166,666.66	$2,500.00
1000000011	Jones, Josie	80% Measures Groups patients via registry	6 months	Yes	Sufficient # of patients reported at 80%	7	5	4	$93,333.33	$1,400.00
1000000012	Doe, John	Individual measure(s) reporting via claims	12 months	Yes	Sufficient # of measures reported at 80%	6	4	3	$80,000.00	$1,200.00
1000000013	Not Available	Consecutive Measures Groups beneficiaries via claims	6 months	Yes	Sufficient # of consecutive beneficiaries reported	9	8	5	$86,666.66	$1,300.00

Obtaining the Feedback Reports

TIN Feedback Report Registration

- This report will be a “total” of the PQRI check received, along with a detailed breakdown of all providers individually reporting under the group TIN.
- Provider must be in the Provider Enrollment, Chain and Ownership System (PECOS) to obtain reports.
- Providers must use the CMS portal to gain access to the Individuals Authorized Access to the CMS Computer Services (IACS).

IACS Registration (assistance only)

IACS Help Desk:

Telephone:
(866) 484-8049
(866) 523-4759 TTY/TDD

E-mail:
EUSSupport@cgi.com

Web site:
http://www.cms.hhs.gov/IACS/

Obtaining the Feedback Reports (Continued)

Feedback Report Access

- After IACS registration is complete, the actual reports are housed by QualityNet.
- Reports will be accessed by using passwords/IDs issued via e-mails during the registration process.

QualityNet Help Desk:

Telephone:

(866) 288-8912

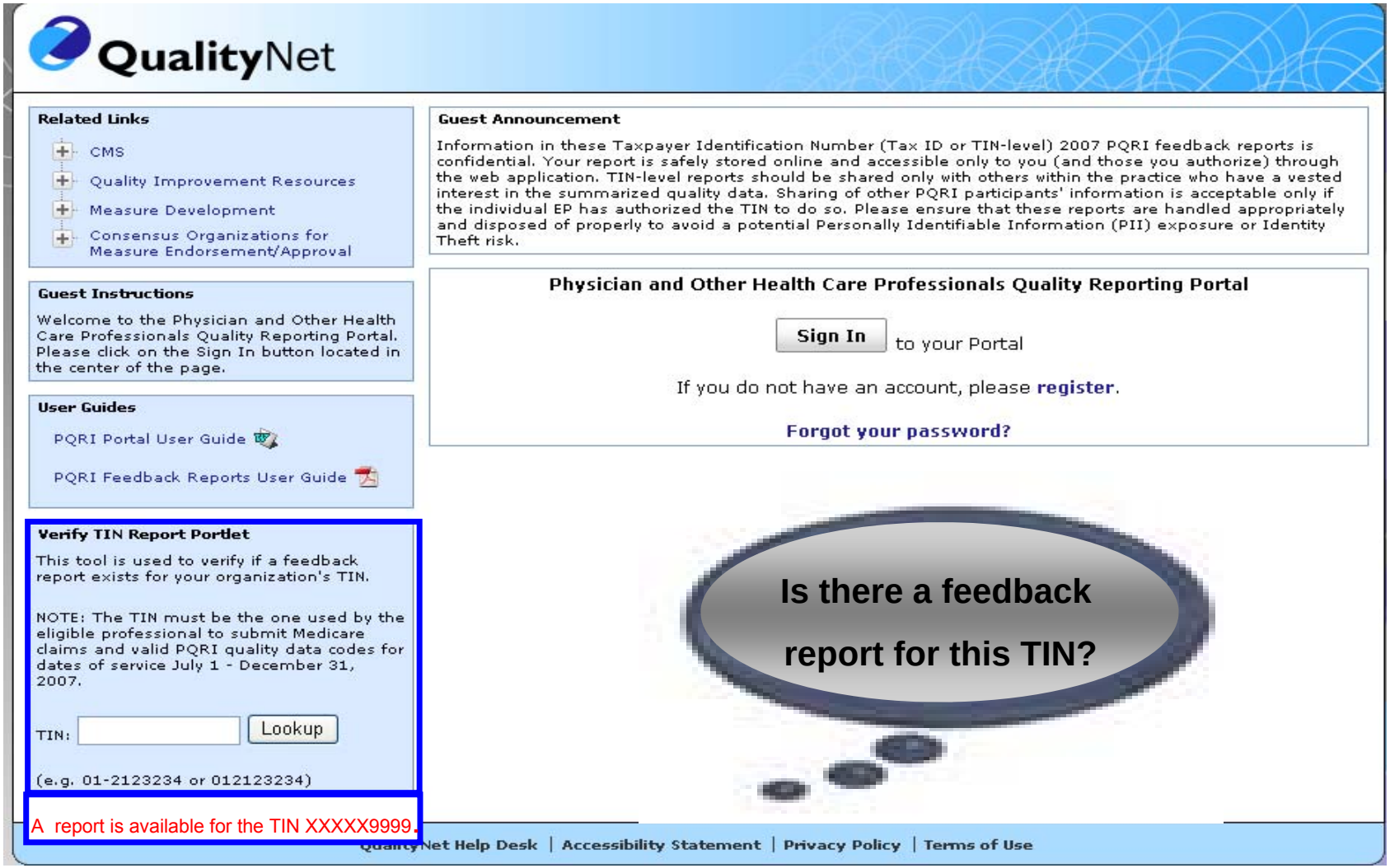
E-mail:

Qnetsupport@ifmc.sdps.org

Web site:

https://www.qualitynet.org/portal/server.pt

https://www.qualitynet.org/portal/server.pt



Four Steps to Access PQRI Reports

There is no registration deadline, but registration must be completed before reports can be accessed (TIN reports only).

Step 1: Individuals IACS registration.

Step 2: Request access to PQRI application via IACS.

Step 3: Enter the PQRI application.

Step 4: Access QualityNet using password/ID information and obtain/print reports.

PQRI Resources

CMS PQRI Web site: http://www.cms.hhs.gov/pqri

- Information provided includes but is not limited to:
  - Measures and codes
  - Frequently Asked Questions (FAQs)
  - Other support materials available

CMS IACS Web site: http://www.cms.hhs.gov/IACS

CMS Quality Net Web site: http://www.qualitynet.org

AMA Web site: http://www.ama-assn.org

TrailBlazer Web site:
http://www.trailblazerhealth.com/Quality%20Initiatives/default.aspx?DomainID=1

Questions and Answers

PQRI …
Will You Pass or Fail?

Medicare Part B Extra Revenue With a Few Extra Codes! PQRI

Thank you for attending.