

# 2015 Physician Quality Reporting System Measures Groups Flow Manual

## **Introduction:**

This document contains general implementation guidance for 2015 Physician Quality Reporting System (PQRS) Measures Groups Flows and Algorithms. The flows and associated algorithms are based on measures groups that include reporting on a group of clinically-related measures identified by CMS for use in Physician Quality Reporting, through Registry-based submission. Twenty-two measures groups have been established for 2015 Physician Quality Reporting: Diabetes, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Bypass Graft (CABG), Rheumatoid Arthritis (RA), Hepatitis C, Heart Failure (HF), Coronary Artery Disease (CAD), HIV/AIDS, Asthma, Chronic Obstructive Pulmonary Disease (COPD), Inflammatory Bowel Disease (IBD), Sleep Apnea, Dementia, Parkinson's Disease, Cataracts, Oncology, Total Knee Replacement (TKR), General Surgery, Optimizing Patient Exposure to Ionizing Radiation (OPEIR), Sinusitis, and Acute Otitis Externa (AOE). The Measures Groups Flows are a Registry resource for the application of logic for reporting and performance rates.

The 2015 Measures Group reporting method is a 20 patient sample method via the Registry reporting mechanism covering a 12-month reporting period (January 1, 2015 through December 31, 2015). A participating eligible professional must report on all applicable measures within the selected measures group for a minimum sample of 20 unique patients (or procedures as applicable), a majority of which must be Medicare Part B FFS patients, who meet patient sample criteria for the measures group. This document provides strategies and information to facilitate satisfactory submission by each Registry.

The 2015 Physician Quality Reporting System Measures Groups Specifications Manual, which can be found at [http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015\\_PQRS\\_MeasuresGroupsSpecs\\_SupportingDocs\\_111214.zip](http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2015_PQRS_MeasuresGroupsSpecs_SupportingDocs_111214.zip) contains detailed descriptions for each quality measure within each measures group. Denominator coding has been modified from the original individual measures, as specified by the measure developer, to allow for implementation as a measures group. To completely understand the Measures Groups Flows, please review the 2015 Physician Quality Reporting System Measures Groups Specification Manual.

## **Measures Groups Reporting Method:**

### **20 Patient Sample Method via Registry – 12-month reporting period:**

A participating eligible professional must report on all applicable measures within the selected measures group for a minimum sample of 20 unique patients (or procedures as applicable), a majority of which must be Medicare Part B FFS patients, who meet patient sample criteria for the measures group. If the eligible professional does not have at least 11 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group, the eligible professional will need to choose another measures group or choose another reporting option. Please refer to the 2015 Physician Quality Reporting System (PQRS) Implementation Guide to determine the proper reporting option.

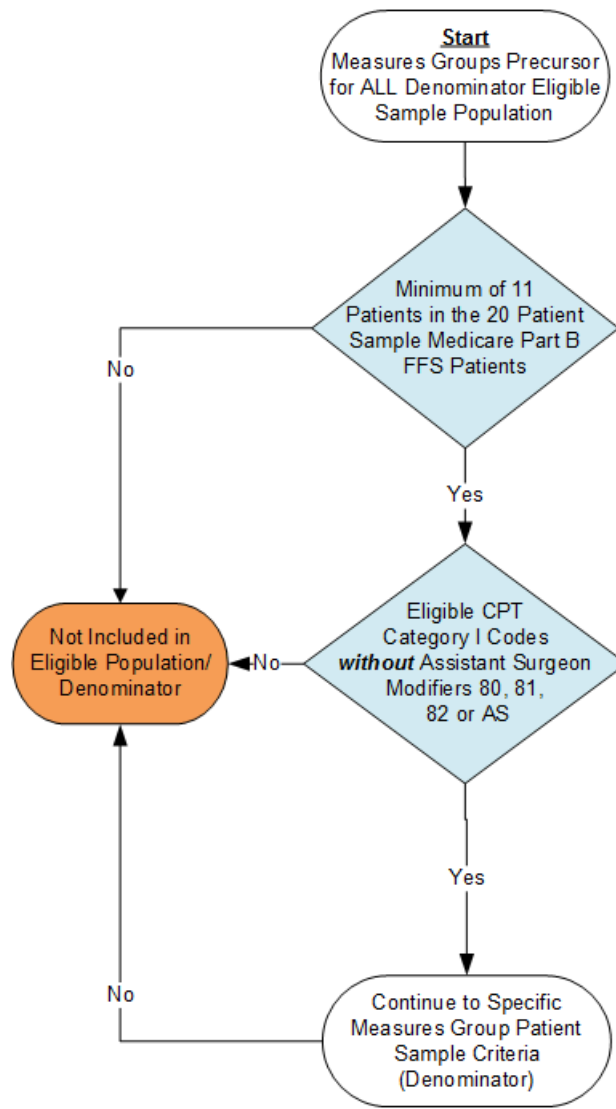
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## Interpretation of Measures Groups Flows:

### **Denominator/Numerator:**

The Measures Groups Flows are designed to provide interpretation of the measures contained in the measures group and the logic of calculating the reporting and performance rates. The flows start with identification of the patient population (denominator) for the applicable measures within the measures groups. Once the denominator is identified, the flow illustrates and stratifies the individual measures that comprise the measures group. When determining the denominator for all measures groups, please remember to include only those Medicare Part B FFS patients with CPT I Categories without modifiers 80, 81, 82 or AS.

Below is an illustration of additional prerequisite denominator criteria related to Medicare patients in the patient sample for all 2015 Physician Quality Reporting System measures groups.

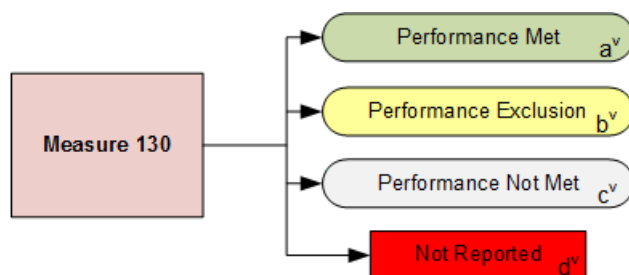


The Measures Groups Flows continue with the appropriate age group and denominator population for the

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measures group. Each individual measure then defines the quality action(s) (numerator option) available for reporting a measure in the group. Depending on the measure being reported, there are several outcomes that may be applicable for reporting the measures outcome: Performance Met = “a”/green, Performance Exclusion = “b”/yellow, Performance Not Met = “c”/gray, and Not Reported = “d”/red. The numerator options also include a roman numeral that correlates the quality action to a measure contained within the measures group (e.g. Measure 130 = v). On the flow, these outcomes are color-coded and labeled to identify the particular outcome of the measure represented. This is illustrated below:



If all the quality action(s) are Performance Met for each of the measures in the measures group, then it would be appropriate to report the composite Quality Data Code (QDC) or equivalent listed for the measures group in the 2015 Physician Quality Reporting System Measures Groups Specifications Manual. If the measure is an inverse measure, the appropriate quality action performed to be considered appropriate to report the composite QDC would be a Performance Not Met quality action.

### **Reporting and Performance Algorithms:**

#### **Reporting Algorithm:**

The algorithms are based on the eligible population and sample outcomes of the possible quality actions as described in the flows of the measures contained in the group. The Reporting Algorithm provides the calculation logic for patients who have been reported in the eligible professionals' appropriate denominator. In order to satisfactorily report, all applicable measures contained in the measures group must have been reported. Reporting satisfactorily may include the following categories provided in the numerator: Performance Met, Performance Exclusion, and Performance Not Met. Reporting on all measures in the measures group, per patient, equals one denominator instance and one numerator instance. However, if one measure in the measures group is missed and not reported, that patient would be included in the denominator but would count as a zero toward reporting the numerator for reporting calculations.

The Reporting Algorithm is also color coded to help identify the outcome for a particular measure and apply that outcome to the calculation. The color definitions are as follows: Met =green, Exclusion Reported = blue, Not Met Reported =yellow/orange and Not Reported = Red. If a measure does not apply to a patient, for example due to age then Not Applicable is used. An example algorithm has been provided below based on a predetermined sample denominator for the Heart Failure Measures Group:

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	<u>Measure 5<sup>**</sup></u>	<u>Measure 8<sup>**</sup></u>	<u>Measure 47<sup>***</sup></u>	<u>Measure 110<sup>****</sup></u>	<u>Measure 130</u>	<u>Measure 226</u>
	(i)	(ii)	(iii)	(iv)	(v)	(vi)
Patient X Age 45 Visit 1/17/15	Met (a <sup>i</sup> )	Met (a <sup>ii</sup> )	Not Applicable (e <sup>iii</sup> )	Met (a <sup>iv</sup> )	Exclusion (b <sup>v</sup> )	Not Met (c <sup>vi</sup> )
Patient Y Age 70 Visit 08/10/15	Met (a <sup>i</sup> )	Exclusion (b <sup>ii</sup> )	Not Met (c <sup>iii</sup> )	Not applicable (e <sup>iv</sup> )	Met (a <sup>v</sup> )	Met (a <sup>vi</sup> )
Patient Z Age 68 Visit 11/20/15	Met (a <sup>i</sup> )	Met (a <sup>ii</sup> )	Met (a <sup>iii</sup> )	Not Reported (d <sup>iv</sup> )	Met (a <sup>v</sup> )	Met (a <sup>vi</sup> )

Patient X [a<sup>i</sup>,a<sup>ii</sup>,e<sup>iii</sup>,a<sup>iv</sup>,b<sup>v</sup>,c<sup>vi</sup>] + Patient Y [a<sup>i</sup>,b<sup>ii</sup>,c<sup>iii</sup>,e<sup>iv</sup>,a<sup>v</sup>,a<sup>vi</sup>] + Patient Z [a<sup>i</sup>,a<sup>ii</sup>,a<sup>iii</sup>,d<sup>iv</sup>,a<sup>v</sup>,a<sup>vi</sup>] = 1+1+0 = 2 of the Required 20 Patient Sample Reported

## Performance Algorithm:

The Performance Algorithm calculation is based on only those patients that were reported for the measure within the measures group. For those patients reported, the numerator is determined by completing the quality action as indicated by Performance Met. Meeting the quality action for a patient, as indicated in the 2015 Physician Quality Reporting System Measures Groups Specifications Manual, would add one patient to the denominator and one to the numerator. Patients reporting with Performance Exclusions are subtracted from the performance denominator when calculating the performance rate percentage. The performance rate is calculated per measure in the group and not for the entire measures group. Below is a sample algorithm that represents this calculation. In the scenario below, the patient sample equals 3 patients where 2 of these patients had the quality action performed (Performance Met), but one patient was reported as having a Performance Exclusion.

$$\frac{\text{Performance Met (2)}}{\text{Reported QDC for eligible patient (3) – Performance Exclusion (1)}} = \frac{2}{2} = 100\%$$

Please review the Measures Groups Flow Performance Algorithms for more examples.

## Measures Groups Analytic Tag Definitions:

Analytical “tags” are provided for each of the measures groups. The analytical tag defines the time period or event in which the measures groups should be reported. Once a unique patient has been added to the denominator sample, they may not be reported and counted again toward the denominator except in procedure or episode-based measures groups. Below are definitions of the analytical tags that are utilized for calculations of the measures groups:

- Patient-intermediate measures are reported a minimum of once per patient during the reporting period. The most recent quality-data code will be used, if the measure is reported more than once.

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- Patient-process measures are reported a minimum of once per patient during the reporting period. The most advantageous quality-data code will be used if the measure is reported more than once.
- Patient-periodic measures are reported a minimum of once per patient per timeframe specified by the measure during the reporting period. The most advantageous quality-data code will be used if the measure is reported more than once. If more than one quality-data code is reported during the episode time period, performance rates shall be calculated by the most advantageous quality-data code.
- Episode measures are reported once for each occurrence of a particular illness or condition during the reporting period.
- Procedure measures are reported each time a procedure is performed during the reporting period.

## **Other Resources:**

There are other resources that may be helpful for measures groups reporting. 2015 Physician Quality Reporting System Implementation Guide and Getting Started with 2015 Physician Quality Reporting Measures Groups are located in the Downloads section on the Measures Codes page of the Physician Quality Reporting website.

Disclaimer: Diagrams were created by CMS and may or may not have been reviewed by the measure steward. This diagram should not be used instead of the measure specification but may be used as an additional resource.