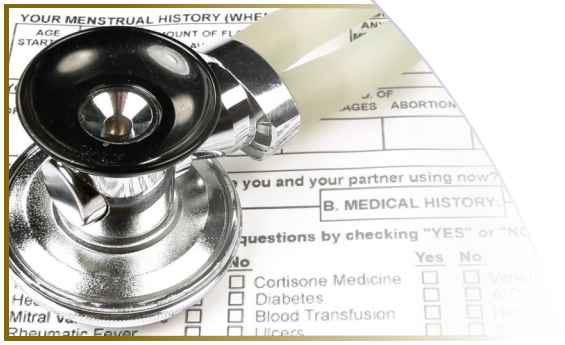
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers



2011 Physician Quality Reporting System

Made Simple for Reporting the Preventive Care Measures Group

FACT SHEET **http://www.cms.gov/PQRS**

The Physician Quality Reporting System (Physician Quality Reporting, formerly called the Physician Quality Reporting Initiative or PQRI) is a voluntary quality reporting program that provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-For-Service (FFS) beneficiaries. A web page dedicated to providing all the latest news on Physician Quality Reporting is available at http://www.cms.gov/PQRS on the Centers for Medicare & Medicaid Services (CMS) website.

Is This Your Situation?

- You have not yet begun to participate in the 2011 Physician Quality Reporting;
- You don't currently submit data to a registry; and
- You would like to participate in the 2011 Physician Quality Reporting using claims-based reporting.

Solution

- Report on the Preventive Care Measures Group for 30 **unique** Medicare Part B FFS patients between January 1, 2011, and December 31, 2011.

How to Start Using this Measures Group

- Select a start date to begin submitting quality data (e.g., February 15, 2011);
- Identify the next Medicare Part B FFS patient you will be seeing who is 50 years of age or older and for whom you will bill an Evaluation and Management (E/M) Current Procedural

Terminology (CPT) code in the ranges of 99201-99205 or 99212-99215. No specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis is required for this measures group;

- Report the measures group specific intent G-code (G8486) with your first patient; and
- Refer to the following table to see which measures apply to the patient based on the patient's age and gender.

Table 1: 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, 128, 173, 226	110, 112, 113, 128, 173, 226
65-69 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 112, 113, 128, 173, 226
70-75 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 113, 128, 173, 226
≥ 76 years	110, 111, 128, 173, 226	39, 48, 110, 111, 128, 173, 226

How to Report Using this Measures Group

- When you identify your first patient, place intent G-code G8486 on the claim submitted for that patient. This signals CMS that you plan to submit the Preventive Care Measures Group on 30 **unique** Medicare Part B FFS patients. (**NOTE**: the 30 patients do not have to be seen on consecutive dates.)
- Look at the **Data Collection Worksheet** (Appendix A) for a brief description of the measures in the Preventive Care Measures Group and the codes to report depending on the quality action or service you provide to the patient. The appropriate quality-data codes (QDCs) for the measures you are reporting for each patient will need to be included on the claim you submit for the patient during the 12-month reporting period. It is generally easier to report all of the applicable measures at one time on the same claim when the patient is seen. However, if a particular service has yet to be performed (e.g., a mammogram) you may report that measure at the time the patient returns post-procedure if that patient is seen again prior to the end of the reporting period (December 31, 2011). If all quality actions for the patient have been performed for the Preventive Care Measures Group, the composite G-code G8496 (i.e., all quality actions for the applicable measures in the Preventive Care Measures Group have been performed for this patient) may be reported in lieu of the individual QDCs for each of the measures within the group.
- Check the Measures Codes section of the Physician Quality Reporting web page for the full measures groups specifications at http://www.cms.gov/PQRS on the CMS website.
- Report **all** of the **applicable** measures (using the appropriate QDCs) on the claim you submit for each Medicare Part B FFS patient. To assist with tracking, consider photocopying the **Data Collection Worksheet** (Appendix A). Highlight or circle the appropriate measures and measures codes (QDCs) you intend to submit for that patient's visit and staple the worksheet to your superbill. Your billing staff or company can use this information to report the appropriate measures codes on the patient's claim.

- Use the worksheet following the **Data Collection Worksheet** (Appendix A) to track each of your 30 unique patients (**NOTE:** you may want to collect more than 30 as a safeguard). You can list the measures which still need to be reported to help guide you during the patient's next visit. This is a suggested informal worksheet intended for your office's internal use only and should **not** be sent to CMS or the Medicare Carrier/Medicare Administrative Contractor (MAC).

Appendix A: Data Collection Worksheet

Data Collection Worksheet: Physician Quality Reporting System Preventive Care Measures Group **Measures in the Preventive Care Measures Group (G8486) and the Quality-Data Codes to be Reported on Patient Claim Depending on Action/Service Performed**			
Patient Name:	**Date of Service:**	**Physician:**	**Physician:**
Measure number and title*	**Action performed**	**Action not performed/ Reason documented**	**Action not performed/ Reason not documented**
39: Screening or Therapy for Osteoporosis (females only)	**G8399** DXA ordered, documented or patient on Rx treatment	**G8401** DXA not ordered or patient not on meds for documented reasons	**G8400** DXA not ordered, no Rx treatment, reason not specified
48: Assessment of Presence or Absence of Urinary Incontinence (females only)	**1090F** Incontinence assessed within past 12 months	**1090F-1P** Medical reason for not assessing incontinence	**1090F-8P** Incontinence not assessed, reason not specified
110: Influenza Immunization	**G8482** Influenza immunization ordered or administered	**G8483** Influenza immunization not ordered or administered for reasons documented by clinician	**G8484** Influenza immunization not ordered or administered, reason not specified
111: Pneumonia Vaccination	**4040F** Pneumococcal vaccine administered or previously received	**4040F-1P** Pneumococcal vaccine not administered or previously received for medical reasons	**4040F-8P** Pneumococcal vaccine not administered or previously received, reason not specified
112: Screening Mammography (females only)	**3014F** Screening mammography results documented and reviewed	**3014F-1P** Mammogram not performed for medical reasons (e.g., mastectomy)	**3014F-8P** Screening mammography results were not documented and reviewed, reason not specified

Data Collection Worksheet: Physician Quality Reporting System Preventive Care Measures Group Measures in the Preventive Care Measures Group (G8486) and the Quality-Data Codes to be Reported on Patient Claim Depending on Action/Service Performed			
Patient Name:	**Date of Service:**	**Physician:**	**Physician:**
Measure number and title*	**Action performed**	**Action not performed/ Reason documented**	**Action not performed/ Reason not documented**
113: Colorectal Cancer Screening	**3017F** Colorectal cancer screening results documented and reviewed	**3017F-1P** Colorectal cancer screening not performed for medical reasons	**3017F-8P** Colorectal cancer screening results not documented and reviewed, reason not specified
128: Body Mass Index (BMI) Screening and Follow-Up	**G8420** Calculated BMI within normal parameters and documented **OR** **G8417** Calculated BMI above the upper parameter and a follow-up plan was documented **OR** **G8418** Calculated BMI below the lower parameter and a follow-up plan was documented	**G8422** Patient not eligible for BMI calculation for documented reasons	**G8421** BMI not calculated **OR** **G8419** Calculated BMI outside normal parameters, no follow-up plan documented
173: Unhealthy Alcohol Use – Screening	**3016F** Screened for unhealthy alcohol use using a systematic screening method	**3016F-1P** Medical reason(s) for not screening for unhealthy alcohol use	**3016F-8P** Not screened, reason not specified
226: Tobacco Use: Screening and Cessation Intervention	**4004F** Patient screened for tobacco use AND received tobacco cessation counseling, if identified as a tobacco user **OR** **1036F** Current tobacco non-user	**4004F-1P** Medical reason(s) for not screening for tobacco use (e.g., limited life expectancy)	**4004F-8P** Tobacco Screening not performed, reason not otherwise specified

*** Note: Medicare coverage may differ from Physician Quality Reporting System measures specification.**

Worksheet to Track Unique Medicare Part B FFS Patients for Reporting Preventive Care Measures Group				
Unique Patient #	**Date of Service**	**Patient Identifier**	**All Applicable Measures Submitted for this Patient?**	**Measure Numbers that still need to be submitted for this Patient** (if any)
Example A	02/15/2011	MS	No	112
Example B	02/16/2011	PF	Yes	None
1				
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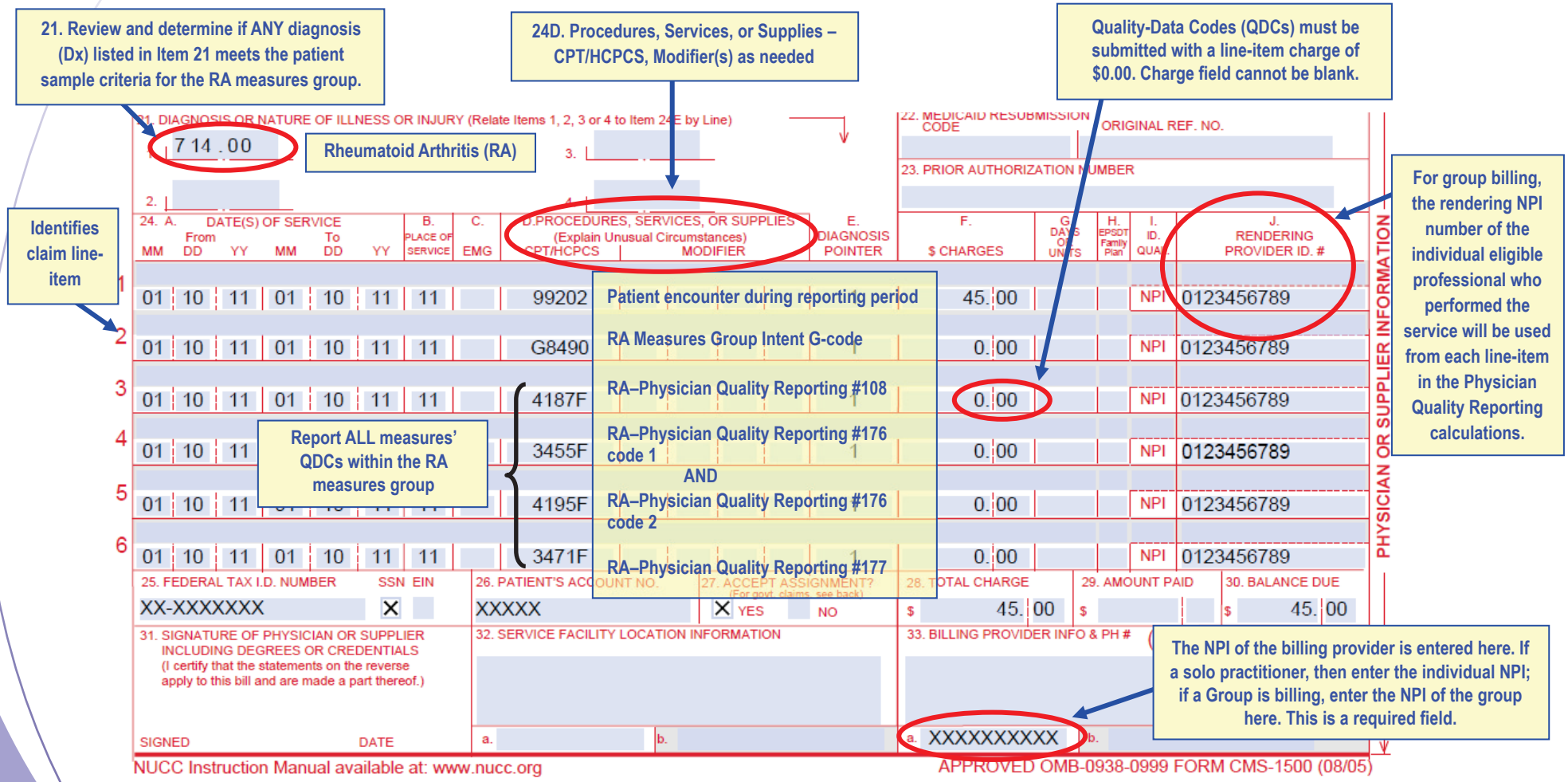
Appendix B: Form CMS-1500 Claim [Detailed Measures Group] – Sample 1 (continues on the next page)

The following is a claim sample for reporting the Rheumatoid Arthritis (RA) Measures Group on a Form CMS-1500 claim, and it continues on the next page. Two samples are included: one is for reporting of individual measures for the RA measures group; the second sample shows reporting performance of all measures in the group using a composite G-code. For more information, visit http://www.cms.gov/PQRS/15_MeasuresCodes.asp on the CMS website.



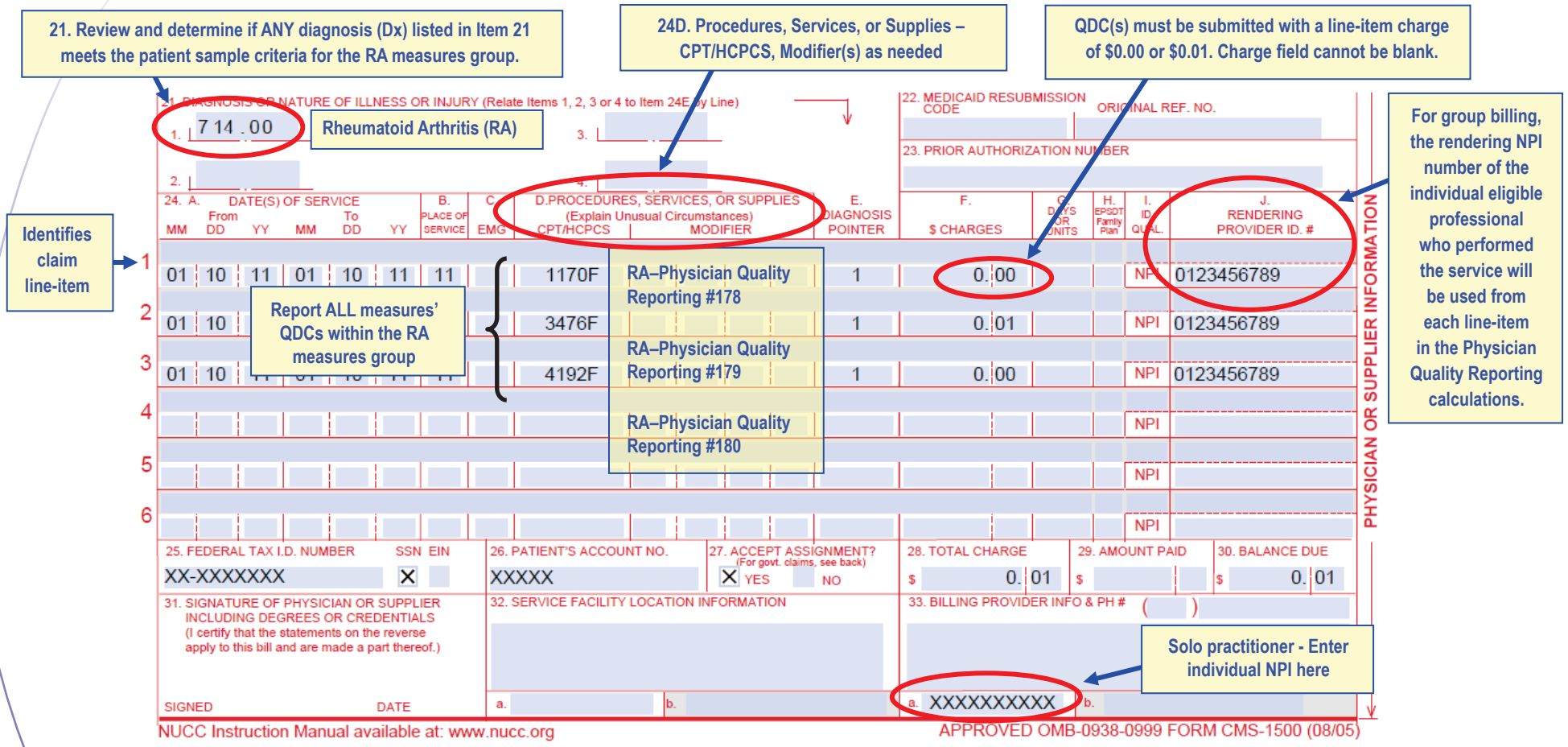
The patient was seen for an **office visit (99202)**. The provider reports **all measures (#108, #176, #177, #178, #179, and #180) in the RA Measures Group:**

- Intent **G-code (G8490)** was submitted to initiate the eligible professional's submission of the RA Measures Group.
- Measure **#108** (RA-DMARD Therapy) with **QDC 4187F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);
- Measure **#176** (RA-Tuberculosis Screening) with **QDCs 3455F + 4195F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);
- Measure **#177** (RA-Periodic Assessment of Disease Activity) with **QDC 3471F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);

RA Measures Group Sample 1 continues on the next page.

Appendix B: Form CMS-1500 Claim [Detailed Measures Group] – Sample 1 (cont.)

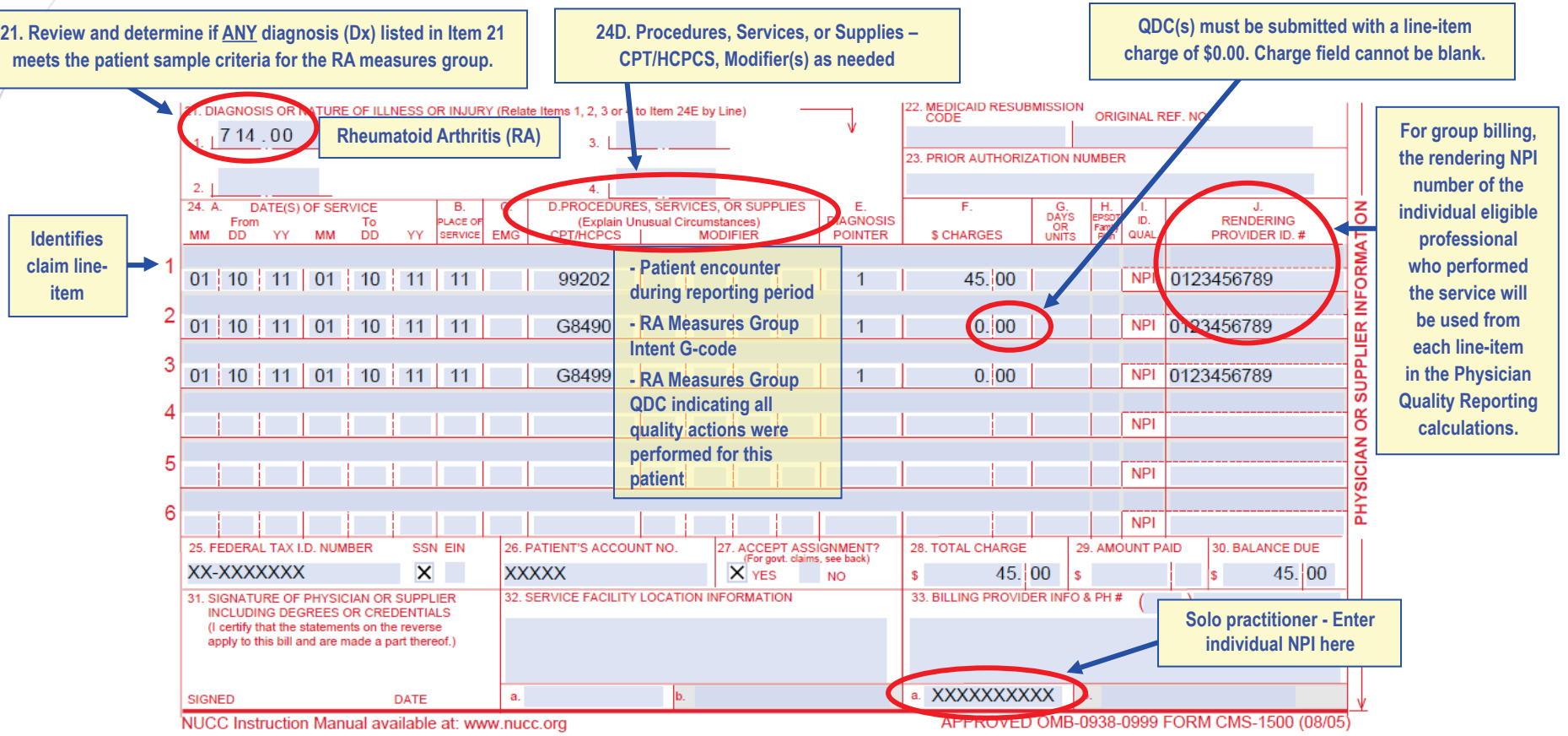
If billing software limits the line items on a claim, you may add a nominal amount, such as a penny, to one of the QDC line items on that second claim for a total charge of $0.01.



- Measure **#178** (RA-Functional Status Assessment) with **QDC 1170F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);
- Measure **#179** (RA-Assessment & Classification) with **QDC 3476F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**); and
- Measure **#180** (RA-Glucocorticoid Management) with **QDC 4192F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**).
- **NOTE:** All diagnoses listed in **Item 21** will be used for Physician Quality Reporting System analysis. (Measures that require the reporting of two or more diagnoses on a claim will be analyzed as submitted in Item 21.)
- **NPI placement: Item 24J** must contain the NPI of the individual provider that rendered the service when a group is billing.

Appendix B: Form CMS-1500 Claim [Sample Measures Group] – Sample 2

A detailed sample of an individual NPI reporting the RA Measures Group on a related Form CMS-1500 claim is shown below. This sample shows reporting performance of all measures in the group using a composite G-code. For more information, visit http://www.cms.gov/PQRS/15_MeasuresCodes.asp on the CMS website.



The patient was seen for an **office visit (99202)**. The provider reports **all measures (#108, #176, #177, #178, #179, and #180) in the RA Measures Group:**

- Intent **G-code (G8490)** was submitted to initiate the eligible professional's submission of the RA Measures Group.
- Measures Group **QDC Composite G-code G8499** (indicating all quality actions related to the RA Measures Group were performed for this patient) + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**). The composite G-code G8499 may not be used if performance modifiers (1P, 2P, 3P, or G-code equivalent) or the 8P reporting modifier apply.
- **NOTE:** All diagnoses listed in **Item 21** will be used for Physician Quality Reporting System analysis. (Measures that require the reporting of two or more diagnoses on claim will be analyzed as submitted in Item 21.)
- **NPI placement: Item 24J** must contain the NPI of the individual provider that rendered the service when a group is billing.

This fact sheet was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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