



Provider Inquiry Assistance

2008 Physician Quality Reporting Initiative (PQRI) Establishment of Alternative Reporting Periods and Reporting Criteria – JA6104

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Contractors Affected

- Part A/B Medicare Administrative Contractors Medicare
- Carriers

Provider Types Affected Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) PQRI



Change Request (CR) 6104 announces the establishment of the Medicare, Medicaid, and State Children's Health Insurance Program Extension Act of 2007 (MMSEA – Public Law 110-173) mandated alternative reporting periods and alternative criteria for satisfactorily reporting 2008 PQRI quality measures.

Provider Needs to Know...

- The MMSEA authorizes CMS to make PQRI incentive payments for satisfactory reporting quality measures data for services furnished in 2008.
- For 2008, eligible professionals who meet the criteria for satisfactory submission of quality measures data on services furnished during the reporting period (January 1, 2008 – December 31, 2008) will earn an incentive payment of 1.5% of their total allowed charges for Medicare Physician Fee Schedule (MPFS) covered professional services furnished during that same period (the 2008 calendar year).
- MMSEA also requires (for 2008 and 2009) the Secretary of Health and Human Services establish alternative reporting periods and criteria for the satisfactory reporting of measure groups and for satisfactorily reporting quality measures data through registries.
- Therefore, in 2008, eligible professionals may earn the incentive payment based on data submitted through these alternative mechanisms.

- In addition, while the Tax Relief and Health Care Act (TRHCA) established a cap on incentive payments for 2007 (based on an average per measure payment amount) there is no cap on incentive payments under MMSEA for 2008 and 2009.
- TRHCA also required that CMS establish a PQRI measure set for 2008. The 2008 set:
 - Includes 119 measures that eligible professionals can select from (117 clinical quality measures, and 2 structural measures (use of electronic health records and electronic prescribing)); and
 - Addresses the submission of PQRI measures data through registries. In the 2008 MPFS Final Rule, CMS described plans to test two methods for submission of quality measures data through registries during 2008. The testing process for these registries is currently underway with test data submission slated to begin in July 2008 and to end by September 1, 2008.

Measures Groups

- There are four measures “groups” for the 2008 PQRI:
 - Diabetes Mellitus;
 - End Stage Renal Disease;
 - Chronic Kidney Disease (CKD); and
 - Preventive Care.
 - Each of the measure groups contains at least four PQRI measures.
 - **The individual Diabetes Mellitus Measures are:**
 - Measure 1 – Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus;
 - Measure 2 – Low Density Lipoprotein Control in type 1 or 2 Diabetes Mellitus;
 - Measure 3 – High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus;
 - Measure 117 – Dilated Eye Exam in Diabetic Patients; and
 - Measure 119 – Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.
 - **The individual ESRD Measures are:**
 - Measure 78 – Vascular Access for Patients Undergoing Hemodialysis;
 - Measure 79 – Influenza Vaccination in Patients with ESRD;
 - Measure 80 – Plan of Care for ESRD Patients with Anemia; and
 - Measure 81 – Plan of Care for Inadequate Hemodialysis in ESRD Patients.
 - **The individual CKD Measures are:**
 - Measure Number 120 – ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD;
 - Measure Number 121 – CKD: Laboratory Testing (Calcium, Phosphorus, Intact
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Parathyroid Hormone (iPTH) and Lipid Profile);

- Measure Number 122 – CKD: Blood Pressure Management ; and
- Measure Number 123 – CKD: Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).
- **The individual Preventive Care Measures are:**
 - Measure Number 39 – Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older;
 - Measure Number 48 – Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older;
 - Measure Number 110 – Influenza Vaccination for Patients > 50 Years Old;
 - Measure Number 111 – Pneumonia Vaccination for Patients 65 Years and Older;
 - Measure Number 112 – Screening Mammography ;
 - Measure Number 113 – Colorectal Cancer Screening;
 - Measure Number 114 – Inquiry Regarding Tobacco Use;
 - Measure Number 115 – Advising Smokers to Quit; and
 - Measure Number 128 – Universal Weight Screening and Follow-Up.

Note: If providers elect to report a group of measures, they must report all of the measures in the group that are applicable to the patient.

General Reporting Guidance for Professionals

- CR6104 also contains some general guidance about reporting PQRI measures that providers may find to be helpful before the alternative reporting periods and criteria are described:
 - “Patients” or “Medicare patients” means Part B Medicare Fee-For-Service (FFS) patients. Non-FFS Medicare (*e.g.*, Medicare Part C patients including those enrolled in Private FFS plans) and/or Non-Medicare patients may only be included in registry-based reporting under the consecutive patient criteria. “Non-Medicare patients” means persons not enrolled in Part B or Part C of Medicare.
 - “Consecutive” means next in order by date of service. Patients are considered consecutive without regard to gender even though some measures in a group (*e.g.*, preventive care measures) may apply only to males or only to females.
 - “Patients for whom the measures of one measures group apply” means patients to whom services are furnished during the reporting period and for whom the measures of a particular group apply as defined by the denominator of the measures.
 - Measures groups reporting requires that eligible professionals must report on each of the measures in the measures group that is applicable to the patient.
 - The alternative reporting criteria for the data required for measures groups reported

for the January 1, 2008 – December 31, 2008, reporting period through registry-based submission only, are:

- 30 consecutive patients for whom the measures of one measures group apply; or
- 80% of Medicare patients for whom the measures of the measures group apply, without regard to whether the patients are consecutive.
- The alternative reporting criteria for the data required for measures groups reported for the July 1, 2008 – December 31, 2008 reporting period are:
 - 15 consecutive patients for whom the measures of one measure group apply for measures groups reported through registry-based reporting;
 - 15 consecutive Medicare patients for whom the measures of one measures group apply for measures groups reported through the claims mechanism; or
 - 80% of Medicare patients for whom the measures of the measures group apply, without regard to the submission mechanism used or whether the patients are consecutive.
- Eligible professionals, who submit measures both through registries and through claims-based submission, will be eligible to receive an incentive payment, provided they meet the requirements for satisfactory reporting under either reporting mechanism.
- Qualification under both submission mechanisms will result in only one incentive bonus payment based on the longest reporting period for which the eligible professional satisfactorily reports.

Guidance for Registries

- In order to qualify to submit data under the registry-based reporting alternatives for 2008, a registry must have been in existence on January 1, 2008, and the registry also must meet certain technical and other requirements that CMS specifies. Those registry requirements will be available at <http://www.cms.hhs.gov/pqri> on the CMS website.
 - The requirements for qualified registries include, but are not limited to:
 - Submission of a self-nomination by a certain date. Registries that participated and/or self-nominated for the 2008 registry testing process will need to submit a new self-nomination specific to this new process in order to be considered for potential qualification; and
 - The registry having entered (or entering) into appropriate legal arrangements that provide for the registry's receipt of patient-specific data from eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program.
 - Each registry seeking to submit data for the PQRI program will be required to meet all technical and other requirements CMS identifies for registries to submit such
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information.

- CMS will post on the CMS website by August 31, 2008, the names of those registries that qualify to the CMS PQRI at <http://www.cms.hhs.gov/pqri> on the CMS website.
- Registry-based submissions under the 2008 registry-based reporting alternatives will begin after the completion of the 2008 registry testing process.
- Eligible professionals must comply with all applicable laws in establishing a relationship with a registry whereby the registry will report quality measures data to CMS on their behalf based on the data the eligible professional submits to the registry. The eligible professional will need to document and be able to demonstrate that this relationship has been established and must attest to the validity of the data submitted by the eligible professional to the registry.
- The registry-based submission must meet the criteria for satisfactory reporting for PQRI measure results and/or measures group results.
- Registries must submit to CMS all required data that will include reporting and performance rates on PQRI measures or PQRI measures groups and numerator and denominators for the performance rates.
- Registries must attest that the eligible professional has satisfactorily reported data for clinical quality measures or measures groups under the PQRI program. Registries must specify the reporting criteria and reporting periods for which the eligible professional satisfactorily reported.
- Registries must also attest that all applicable statutory, regulatory, and contractual requirements for reporting of information to CMS have been met.
- Registry reporting for each eligible professional must be on 2008 PQRI measures for patient services furnished during the applicable reporting period.

Alternative Reporting Periods and Reporting Options

- A description of the MMSEA-mandated alternative reporting periods and alternative criteria for satisfactorily reporting 2008 PQRI quality measures follows.
- There are two alternative reporting periods and nine options for the 2008 PQRI.

Reporting Periods

- January 1, 2008 – December 31, 2008; and
- July 1, 2008 – December 31, 2008.

Reporting Options

- Three of the nine reporting options from which providers may select, are **claims-based** and six are **registry-based**.
 - The **claims-based** reporting mechanism for measures groups will be first available July 1, 2008. Therefore, the July 1, 2008 – December 31, 2008, reporting period applies only when using the claims-based option to report measure groups.
 - Both reporting periods apply when using the **registry-based** option to report both
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measure groups and individual measures.

Descriptions of Claims-based Reporting Options

- **Option 1** – Reporting individual measures using the claims-based option (reporting period January 1, 2008 – December 31, 2008)
 - If providers elect the claims-based option to report individual measures, they must report 3 measures (or 1 -2 measures if less than 3 measures apply to them) on 80% of applicable patient claims for 1 – 3 measures).
- **Option 2** – Reporting measure groups using the claims-based option (reporting period July 1, 2008 – December 31, 2008)
 - If providers elect the claims-based option to report measure groups, they must report all of the measures in one measure group that apply to each of 15 consecutive patients. To start the count of the 15 consecutive patients, providers should report the measure group specific “G code” on the claim for the first of these patients.
- **Option 3** – Reporting measure groups using the claims-based option (reporting period July 1, 2008 – December 31, 2008)
 - If providers elect the claims-based option to report measures groups, they must report all measures in one measures group on 80% of patients for the applicable measures group during the reporting period. They should report the measures group specific “G code” or the claim to indicate the intent to report the measures group.

Descriptions of Registry-based Reporting Options

- **Option 4** – Reporting individual measures using the registry-based option (reporting period January 1, 2008 – December 31, 2008)
 - If providers elect the registry-based option to report individual measures, they must report at least 3 measures on 80% of applicable Medicare FFS patients.
 - **Option 5** – Reporting individual measures using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)
 - If providers elect the registry-based option to report individual measures, they must report at least 3 PQRI measures on 80% of applicable Medicare FFS patients
 - **Option 6** – Reporting measure groups using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)
 - If providers elect to use the registry-based option to report measure groups, they must report all of the measures in one measure group that apply to each of 15 consecutive patients. The consecutive patients may include (but not be exclusively) non-Medicare patients. The reporting of a measures group specific “G-code” is not required for registry-based reporting.
 - **Option 7** – Reporting measure groups using the registry-based reporting option (reporting period January 1, 2008 – December 31, 2008)
 - If providers elect to use the registry-based option to report measure groups, they
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must report all of the measures in one measure group that apply to each of 30 consecutive patients. The consecutive patients may include (but not be exclusively) non-Medicare patients. The reporting of a measures group specific "G-code" is not required for registry-based reporting.

- **Option 8** – Reporting measure groups using the registry-based reporting option (reporting period July 1, 2008 – December 31, 2008)
 - If providers elect to use the registry-based option to report measure groups, they must report all of the measures in one measure group on 80% of Medicare FFS patients for the applicable measures group on services provided during the reporting period. The reporting of a measures group specific "G-code" is not required for registry-based reporting.
- **Option 9** – Reporting measure groups using the registry-based option (reporting period January 1, 2008 – December 31, 2008)

If providers elect to use the registry-based option to report measure groups, they must report all of the measures in one measure group on 80% of Medicare FFS patients for the applicable measures group for services provided during the reporting period. The reporting of a measures group specific "G-code" is not required for registry-based reporting.

Healthcare Common Procedure Coding System (HCPCS) Codes

- Effective for dates of service on or after July 1, 2008, Medicare Carriers and A/B MACs will recognize the following HCPCS codes, which will be included in the July Update to the 2008 MPFS Database. These codes are required for claims-submission of measures groups:
 - G8485 (Clinician intends to report the Diabetes measure) for intent to report the Diabetes measure group;
 - G8486 (Clinician intends to report the Preventive Care measure group) for intent to report the Preventive Care measure group;
 - G8487 (Clinician intends to report the Chronic Kidney Disease (CKD) measure group) for intent to report the Chronic Kidney Disease measure group; and
 - G8488 (Clinician intends to report the End Stage Renal Disease (ESRD) measure group) for intent to report the End Stage Renal Disease measure group.

Note: The alternative reporting criteria for measure groups apply regardless of whether the measures are reported through claims-based submission or through registry-based reporting. However, these G-codes that are required for claims-submission of measures groups will not be implemented until July 1, 2008. Therefore, the July 1, 2008 – December 31, 2008, reporting period is the only available reporting period for measure groups data that providers submit on claims.

Background

- TRCHA required the CMS to establish the PQRI that included an incentive payment for eligible professionals who satisfactorily reported data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period).
- Under this program, CMS paid eligible professionals, who satisfactorily reported such data, an incentive payment equivalent to 1.5% of their total allowed charges for MPFS-covered professional services (referred to as total allowed charges) furnished during the 2007 reporting period (July 1, 2007 – December 31, 2007). The statute defines satisfactory reporting to be reporting of up to 3 applicable measures in at least 80% of the cases in which such measures are reportable. A total of 74 clinical quality measures were available for reporting for 2007, which occurred only via claims.

Operational Impact

N/A

Reference Materials

The related MLN Matters article can be found at <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6104.pdf> on the CMS website.

The official instruction issued regarding this change may be found at <http://www.cms.hhs.gov/Transmittals/downloads/R355OTN.pdf> on the CMS website.
