



## **2009 Physician Quality Reporting Initiative Implementation Guide**

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## Introduction

This guide is provided to promote understanding about how to implement 2009 PQRI Physician Quality Reporting Initiative (PQRI) claims-based reporting of measures in clinical practice and to facilitate satisfactory reporting of quality data by eligible professionals (EPs) who wish to participate in PQRI. PQRI is a voluntary individual reporting program that provides an incentive payment to identified EPs who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Medicare Part C – Medicare Advantage patients are not included in claims-based reporting of individual measures or measures groups.

EPs, using their individual national provider identifier (NPI) to submit billable services on Part B claims for allowable PFS charges, may report the quality action for selected PQRI quality measure(s). Providers not defined as EPs in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRI. Services payable under fee schedules or methodologies other than the PFS are not included in PQRI (for example, services provided in federally qualified health centers, portable x-ray suppliers, independent laboratories including Place of Service Code “81”, independent diagnostic testing facilities, hospitals, rural health clinics, ambulance providers, and ambulatory surgery center facilities). Suppliers of durable medical equipment (DME) are not eligible for PQRI since DME is not paid under the PFS. A list of EPs can be found on the PQRI website at: [http://www.cms.hhs.gov/PQRI/10\\_EligibleProfessionals.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage).

In general, the quality measures consist of a unique denominator (eligible case) and numerator (clinical action) that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. It is important to review and understand each measure specification, which provides definitions and specific instructions for reporting a measure. The 2009 PQRI Measure Specifications Manual for Claims and Registry can be found at: [http://www.cms.hhs.gov/PQRI/15\\_MeasuresCodes.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage). Refer also to Appendix A, “Glossary of Terms,” which further defines the terms denominator and numerator as well as other terms commonly used in PQRI.

### PQRI Measure Selection Considerations

The 153 measures in 2009 PQRI address various aspects of care, such as prevention, chronic- and acute-care management, procedure-related care, resource utilization, and care coordination. Measure selection begins with a review of the 2009 PQRI measures. At a minimum, the following factors should be considered when selecting measures for reporting:

- Clinical conditions usually treated
- Types of care typically provided – e.g., preventive, chronic, acute
- Settings where care is usually delivered – e.g., office, ED, surgical suite
- Quality improvement goals for 2009

Review the specifications for each measure under consideration and select those measures that apply to services most frequently provided to Medicare patients by the EP/practice. Individual EPs should review each measure’s denominator coding (including all diagnoses and services submitted on a claim) to determine which PQRI measures are applicable to each patient. See **Appendix B**, “Sample 2009 PQRI Measure” to view the content included in a measure’s specification using PQRI measure #5 as an example.

2009 PQRI submission of quality data may be performed via claims or via a qualified registry, each of which include multiple reporting options for each method of submission. **Appendix C**, “2009 PQRI Participation

Decision Tree,” is a tool designed to help EPs/practices select among the multiple reporting options available. Select the reporting option (i.e., reporting individual measures or measures groups) best suited for the practice. Instructions for reporting measures groups are included in a separate document, “2009 PQRI Measures Groups Specifications Manual,” which can be found at:  
[http://www.cms.hhs.gov/PQRI/15\\_MeasuresCodes.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage).

Additional PQRI educational resources are available as downloads at: [www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri).

## **PQRI Denominators and Numerators**

Measures consist of two major components:

- 1) A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure’s numerator)
- 2) A numerator that describes the clinical action required by the measure for reporting and performance

Each component is defined by specific codes described in each measure specification along with reporting instructions and use of modifiers.

### **Use of CPT Category I Modifiers**

PQRI measure specifications include specific instructions regarding inclusion of the CPT Category I modifiers. Unless otherwise specified, CPT Category I codes may be reported with or without CPT modifiers. Refer to each individual measure specification for detailed instructions regarding CPT Category I modifiers that qualify or do not qualify a claim for denominator inclusion.

Note that surgical procedures billed by an assistant surgeon(s) will be excluded from the denominator population so their performance rates will not be negatively impacted for PQRI. PQRI analyses will exclude otherwise PQRI-eligible CPT Category I codes, when submitted with assistant surgeon modifiers 80, 81, or 82. The primary surgeon, not the assistant surgeon, is responsible for performing and reporting the quality action(s) in applicable PQRI measures.

PQRI-eligible CPT Category I procedure codes, billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population for applicable PQRI measure(s). Both surgeons participating in PQRI will be fully accountable for the clinical action(s) described in the PQRI measure(s).

### **Quality-Data Codes (QDCs)**

QDCs are non-payable HCPCS codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure’s numerator. Clinical actions can apply to more than one condition, and therefore can also apply to more than one measure. Where necessary, to avoid shared CPT Category II codes, G-codes are used to distinguish clinical actions across measures. Some measures require more than one clinical action and therefore have more than one CPT Category II code, G-code, or a combination associated with them. EPs should review numerator reporting instructions carefully.

### **CPT Category II Codes**

CPT Category II or CPT II codes, developed through the CPT Editorial Panel for use in performance measurement, serve to encode the clinical action(s) described in a measure’s numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter “F.” CPT II codes are not modified or updated during the reporting period and remain valid for the entire program year as published in the measure specifications manuals and related documents for PQRI.

## Use of CPT II Modifiers

CPT II modifiers are unique to CPT II codes and may be used to report PQRI measures by appending the appropriate modifier to a CPT II code as specified for a given measure. The modifiers for a code are mutually exclusive and their use is guided by the measure's coding instructions, which are included in the numerator coding section of the measure specifications. Use of the modifiers is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. Descriptions of each modifier are provided below to help identify circumstances when the use of an exclusion modifier may be appropriate. Note that in a pay-for-reporting model, accurate reporting on all selected applicable measures counts the same, whether reporting that the clinical action was performed or not.

CPT II code modifiers fall into two categories, exclusion modifiers and the 8P reporting modifier.

- 1) Exclusion modifiers may be appended to a CPT II code to indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. These modifiers serve as denominator exclusions for the purpose of measuring performance. Some measures do not allow performance exclusions. Reasons for appending a performance measure exclusion modifier fall into one of three categories:
  - **1P Performance measure exclusion modifier 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
  - **2P Performance measure exclusion modifier due to *patient reasons***  
Includes:
    - Patient declined
    - Economic, social, or religious reasons
    - Other patient reasons
  - **3P Performance measure exclusion modifier due to *system reasons***  
Includes:
    - Resources to perform the services not available (eg, equipment, supplies)
    - Insurance coverage or payer-related limitations
    - Other reasons attributable to health care delivery system
- 2) The 8P reporting modifier is available for use only with CPT II codes to facilitate reporting an eligible case when an action described in a measure is not performed and the reason is not specified. Instructions for appending this reporting modifier to CPT Category II codes are included in applicable measures. Use of the 8P reporting modifier indicates that the patient is eligible for the measure; however, there is no indication in the record that the action described in the measure was performed, nor was there any documented reason attributable to the exclusion modifiers.
  - **8P Performance measure reporting modifier** - action not performed, reason not otherwise specified

The 8P reporting modifier facilitates reporting an eligible case on a given measure when the clinical action does not apply to a specific encounter. EPs can use the 8P modifier to receive credit for satisfactory reporting but will not receive credit for performance.

For example, a clinician has selected and submitted QDCs during the reporting period for 2009 PQRI Measure #6, Oral Antiplatelet Therapy. The clinician sees a patient at an encounter and the claim for services for that encounter contains ICD-9-CM and CPT codes that will draw the patient into the measures' denominator during analysis. The 8P modifier serves to include the patient in the numerator when reporting rates are calculated for PQRI.

### Claims-Based Reporting Principles

The following principles apply to the reporting of QDCs for PQRI measures:

- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
  - on the same claim as the denominator billing code(s)
  - for the same beneficiary
  - for the same date of service (DOS)
  - by the same EP (individual NPI) who performed the covered serviceas the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator.
- All diagnoses reported on the base claim will be included in PQRI analysis, as some PQRI measures require reporting more than one diagnosis on a claim. For line items containing a QDC, only a single reference number in the diagnosis pointer field will pass into the National Claims History File. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRI analysis.
- Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically.
- If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny, to one of the line items on that second claim for a total charge of one penny. PQRI analysis will subsequently join both claims based on the same beneficiary for the same date-of-service, for the same TIN/NPI and analyze as one claim. Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses or QDCs are not dropped.
- QDCs must be submitted with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed.
  - The submitted charge field cannot be blank.
  - The line item charge should be \$0.00.
  - If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted - the beneficiary is not liable for this nominal amount.
  - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be \$0.00.)
  - Whether a \$0.00 charge or a nominal amount is submitted to the carrier/contractor, the PQRI code line is denied and tracked.
  - QDC line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis. EPs will receive a Remittance Advice (RA) associated with the claim which will contain the PQRI quality-data code line-item and will include a standard remark code (N365) and a message that confirms that the QDCs passed into the National Claims History (NCH) file. N365 reads: "This procedure code is not payable. It is for reporting/information

purposes only.” The N365 remark code does **NOT** indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.

- Multiple EPs’ QDCs can be reported on the same claim using their individual NPI. Therefore, when a group is billing, they should follow their normal billing practice of placing the NPI of the individual EP who rendered the service on each line item on the claim including the QDC line(s).
- Some measures require the submission of more than one QDC in order to properly report the measure. Report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.
- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).
- EPs may submit multiple codes for more than one measure on a single claim.
- Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.
- If a denied claim is subsequently corrected through the appeals process to the Carrier/AB MAC, with accurate codes that also correspond to the measure’s denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.
- Claims may **NOT** be resubmitted for the sole purpose of adding or correcting QDCs.

#### **Submission through Carriers/Medicare Administrative Contractors (MACs)**

QDCs shall be submitted to carriers/MACs either through:

**Electronic submission**, which is accomplished using the **ASC X 12N Health Care Claim Transaction (Version 4010A1)**.

CPT Category II and/or temporary G-codes should be submitted in the **SV101-2** “Product/Service ID” Data Element on the **SV1** “Professional Service” Segment of the **2400 “Service Line” Loop**.

- It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 “Professional Service” Segment.
- Diagnosis codes are submitted at the claim level, **Loop 2300, in data element HI01**, and if there are multiple diagnosis codes, in **HI02 through HI08** as needed with a single reference number in the diagnosis pointer.
- In general for group billing, report the NPI for the rendering provider in **Loop 2310B** (Rendering Provider Name, claim level) or **2420A** (Rendering Provider Name, line level), using data element **NM109 (NM108=XX)**.

**OR**

**Paper-based submission**, which is accomplished by using the **CMS-1500 claim form (version 08-05)**.

Relevant ICD-9-CM diagnosis codes are entered in **Field 21**. **Service codes** (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in **Field 24D** with a single reference number in the diagnosis pointer **Field 24E** that corresponds with the diagnosis number in Field 21.

- For group billing, the **National Provider Identifier (NPI)** of the rendering provider is entered in **Field 24J**.
- The **Tax Identification Number (TIN)** of the employer is entered in **Field 25**.

### **Group NPI Submission**

When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

### **Solo NPI Submission**

The individual NPI of the solo practitioner must be included on the claim line as is the normal billing process for submitting Medicare claims. For PQRI, the QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in PQRI analysis.

### **CMS-1500 Claim Example**

An example of a claim in CMS-1500 format that illustrates how to report several PQRI measures is provided. See **Appendix D**.

## **Timeliness of Quality Data Submission**

Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 28, 2010 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly. Claims that are resubmitted only to add QDCs will not be included in the analysis.

## **Analysis of PQRI Data Reporting Frequency and Performance Timeframes**

Instructions for some measures limit the frequency of reporting necessary in certain circumstances, such as for patients with chronic illness for whom a particular process of care is provided only periodically. Some measures, due to their complexity, are reportable as registry only or measures group only.

Each measure specification includes a reporting frequency for each denominator-eligible patient seen during the reporting period. The reporting frequency described in the instructions applies to each individual EP participating in PQRI. PQRI uses the reporting frequency to analyze each measure for determination of satisfactory reporting:

- Patient-Process: Report a minimum of once per reporting period per individual EP (NPI).
- Patient-Intermediate: Report a minimum of once per reporting period per individual EP (NPI).
- Patient-Periodic: Report once per timeframe specified in the measure for each individual EP (NPI) during the reporting period.
- Episode: Report once for each occurrence of a particular illness/condition by each individual EP (NPI) during the reporting period.
- Procedure: Report each time a procedure is performed by the individual EP (NPI) during the reporting period.
- Visit: Report each time the patient is seen by the individual EP (NPI) during the reporting period.

A measure's performance timeframe is defined in the measure's description and is distinct from the reporting frequency requirement. The performance timeframe, unique to each measure, delineates the timeframe in which the clinical action described in the numerator may be accomplished. See **Appendix A**.

## Appendix A: Glossary of Terms

<b>Base Claim Diagnosis</b>	<p>PQRI refers to all diagnoses listed (Item 21 of the CMS-1500 claim form) associated with physician office, outpatient, and inpatient visits for reporting in PQRI.</p>
<b>CPT Category II Codes</b>	<p>A set of supplemental CPT codes intended to be used for performance measurement. These codes may be used to facilitate data collection about the quality of care rendered by coding certain services, test results or clinical actions that support nationally established performance measures and that the evidence has demonstrated contribute to quality patient care.<sup>2</sup></p> <p>For PQRI, CPT Category II codes are used to report quality measures on a claim for measurement calculation.</p>
<b>Denominator (Eligible Cases)</b>	<p>The lower part of a fraction used to calculate a rate, proportion, or ratio.</p> <p>The denominator is associated with a given patient population that may be counted as eligible to meet a measure’s inclusion requirements.</p> <p>PQRI measure denominators are identified by ICD-9-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc), and place of service (if applicable).</p>
<b>Denominator Statement</b>	<p>A statement that describes the population eligible for the performance measure. For example, “Patients aged 18 through 75 years with a diagnosis of diabetes.”</p>
<b>Diagnosis Pointer</b>	<p>Item 24E of the CMS-1500 claim form or electronic equivalent. For PQRI, the line item containing the quality-data code (QDC) for the measure should point to one diagnosis (from Item 21) per measure-specific denominator coding.</p> <p>To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure’s diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRI analysis.</p>
<b>Eligible Professional</b>	<p>Refer to <a href="http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage">http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage</a> for a list of EPs eligible to participate in 2009 PQRI.</p> <p>Providers not defined as EPs in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRI and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the Medicare Physician Fee Schedule (PFS) are not included in PQRI (for example, services provided in federally qualified health centers, portable x-ray suppliers, independent laboratories, independent diagnostic testing facilities, hospitals, rural health clinics, ambulance providers, and ambulatory surgery center</p>

	facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRI since DME is not paid under the PFS.
<b>Encounter</b>	Encounters with patients during the reporting period which include: CPT Category I E/M service codes, CPT Category I procedure codes, or HCPCS codes found in a PQRI measure's denominator. These codes count as eligible to meet a measure's inclusion requirements when occurring during the reporting period.
<b>G-codes for PQRI</b>	A set of CMS-defined temporary HCPCS codes used to report quality measures on a claim. G-codes are maintained by CMS.
<b>ICD-9-CM Diagnosis Codes</b>	The International Classification of Diseases, 9th Revision, Clinical Modification <sup>5</sup> is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office visits for reporting in PQRI.
<b>Line-Item Diagnosis</b>	Six service lines in Section 24 of the CMS-1500 claim form to accommodate submission of the rendering NPI and supplemental information to support the billed service, including the pointed diagnosis from Item 21.  QDCs are submitted on the line item in section 24 for PQRI reporting.
<b>Measure</b>	<p>Performance Measure</p> <ul style="list-style-type: none"> <li>• A quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process or outcome.</li> <li>• See also process measure and outcome measure. <sup>1, 6</sup></li> </ul> <p>Types of Measures</p> <ul style="list-style-type: none"> <li>• Process measure: A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome. <sup>6</sup></li> <li>• Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function(s) or process(es). <sup>6</sup></li> <li>• Structure measure: A measure that assesses whether organizational resources and arrangements are in place to deliver health care, such as the number, type, and distribution of medical personnel, equipment, and facilities. <sup>6</sup></li> </ul>
<b>Measure Reporting Timeframes (Frequency)</b>	<ul style="list-style-type: none"> <li>• <b>Patient-Process:</b> Report a minimum of once per reporting period per individual eligible professional (NPI). <ul style="list-style-type: none"> <li>○ If the measure is reported more than once during the reporting period, performance rates are calculated using the most advantageous QDC submitted.</li> <li>○ Reflect quality actions performed throughout the reporting period or other timeframe.</li> </ul> </li> </ul>

	<ul style="list-style-type: none"> <li>• <b>Patient-Intermediate:</b> Report a minimum of once per reporting period per individual eligible professional (NPI). <ul style="list-style-type: none"> <li>○ If the measure is reported more than once during the reporting period, performance rates are calculated using the most recent QDC submitted.</li> <li>○ Often reflect lab or other test value, so the most recent measurement is desired.</li> </ul> </li> <li>• <b>Patient-Periodic:</b> Report once per timeframe specified in the measure for each individual eligible professional (NPI) during the reporting period. <ul style="list-style-type: none"> <li>○ Examples include once per month and three times per year.</li> </ul> </li> <li>• <b>Episode:</b> Report once for each occurrence of a particular illness/condition by each individual eligible professional (NPI) during the reporting period. <ul style="list-style-type: none"> <li>○ Usually reflect a clinical episode, difficult to determine from a single Part B claim.</li> <li>○ Require specialized analytics to determine the episode.</li> </ul> </li> <li>• <b>Procedure:</b> Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period.</li> <li>• <b>Visit:</b> Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period.</li> </ul>
<b>MIPPA</b>	Medicare Improvements for Patients and Providers Act of 2008.
<b>MMSEA</b>	Medicare, Medicaid, and SCHIP Extension Act of 2007.
<b>NPI</b>	National Provider Identifier of the individual eligible professional billing under the Tax ID (“NPI within the Tax ID”).
<b>Numerator</b>	<p>The upper portion of a fraction used to calculate a rate, proportion, or ratio.</p> <p>A clinical action to be counted as meeting a measure’s requirements (i.e., patients who received the particular service or obtained a particular outcome that is being measured).<sup>6</sup></p> <p>PQRI measure numerators are CPT Category II codes and G-codes.</p>
<b>Numerator Statement</b>	<p>A statement that describes the clinical action that satisfies the conditions of the performance measure.</p> <p>For example, “Patients who were assessed for the presence or absence of urinary incontinence.”</p>
<b>Performance Timeframe</b>	A designated timeframe within which the action described in a performance measure should be completed. This timeframe is generally included in the measure description and may or may not coincide with the measure’s data reporting frequency requirement.

<b>Performance Measure Exclusion Modifiers</b>	Modifiers developed exclusively for use with CPT Category II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure's denominator. <sup>2</sup>
<b>Performance Measure Reporting Modifier 8P</b>	The 8P reporting modifier is intended to be used as a "reporting modifier" to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.  8P Performance measure reporting modifier - action not performed, reason not otherwise specified (AMA)
<b>Place of Service</b>	References Place of Service Codes (POS) from the list provided in section 10.5 of the Medicare Claims Processing Manual.
<b>Quality-Data Code (QDC)</b>	Specified CPT Category II codes with or without modifiers and G-codes used for submission of PQRI data. The 2009 PQRI Measure Specifications Manual for Claims and Registry contains all codes associated with each PQRI measure and instructions for data submission through the administrative claims system.
<b>Rationale</b>	A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results. <sup>4</sup>
<b>Remittance Advice (RA)</b>	Means utilized by Medicare contractors to communicate to providers' claims processing decisions such as payments, adjustments, and denials. <sup>7</sup>
<b>Reporting Frequency</b>	The number of times QDCs specified for a quality measure must be submitted on claims during the reporting period. The reporting frequency for each measure is described in the 2009 PQRI Measure Specifications Manual for Claims and Registry posted on the CMS Web site, <a href="http://www.cms.hhs.gov/PQRI">www.cms.hhs.gov/PQRI</a> .
<b>Reporting Options</b>	2009 PQRI reporting methods available for incentive payment: claims-based; registry-based; or measures group. Refer to the 2009 PQRI Participation Decision Tree (Appendix C).
<b>Reporting Period</b>	The period during which PQRI measures are to be reported for covered professional services provided.  6-month (July 1, 2009 through December 31, 2009) or 12-month (January 1, 2009 through December 31, 2009) time periods are available depending upon the 2009 PQRI reporting option the eligible professional selects for submitting PQRI quality data.
<b>TRHCA</b>	Tax Relief and Health Care Act of 2006.

## **Sources:**

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## Appendix B: Sample 2009 PQRI Measure

The following is a sample 2009 PQRI quality measure which includes text boxes to assist eligible professionals with PQRI reporting.

The official measure title follows the symbol.

This symbol (triangle) represents the Measure Developer (as noted in the Symbol and Copyright Information section following the 2009 PQRI Measure Specifications Manual for Claims and Registry).

### **Measure #5: Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)**

#### **2009 PQRI REPORTING OPTIONS: CLAIMS-BASED, REGISTRY**

Each measure specification identifies the reporting options available for the 2009 PQRI incentive.

This segment includes a high-level description of the measure.

#### **DESCRIPTION:**

Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD who were prescribed ACE inhibitor or ARB therapy

Details when the measure should be reported and who should report.

#### **INSTRUCTIONS:**

This measure is to be reported a minimum of once per reporting period for all heart failure patients seen during the reporting period. This measure is intended to reflect the quality of services provided for patients with heart failure and decreased left ventricular systolic function. The left ventricular systolic dysfunction may be determined by quantitative or qualitative assessment, which may be current or historical. Examples of a quantitative or qualitative assessment may include an echocardiogram: 1) that provides a numerical value of left ventricular systolic dysfunction or 2) that uses descriptive terms such as moderately or severely depressed left ventricular systolic dysfunction. The most recent ejection fraction study should be used. 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.

Sample measure #5 is in claims-based format.

Refer to PQRI measure specification #166 to view a "registry only" formatted specification.

#### **Measure Reporting via Claims:**

Line-item ICD-9-CM diagnosis codes, CPT 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.

To ensure satisfactory PQRI reporting, submit all measure-specific coding for the beneficiary on the **SAME CLAIM** for the **SAME DATE of SERVICE** for the **NPI/TIN** reporting the measures.

Refer to the Glossary of Terms "line-item diagnosis" and the introduction of the 2009 PQRI Measure Specifications Manual for Claims and Registry for additional information.

When reporting the measure via claims, submit the listed ICD-9-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) **OR** the CPT Category II code(s) **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported ON THE SAME CLAIM.

#### **NUMERATOR:**

Patients who were prescribed ACE inhibitor or ARB therapy

A clinical action to be counted as meeting a measure's requirements (i.e., patients who received the particular service or obtained a particular outcome that is being measured).

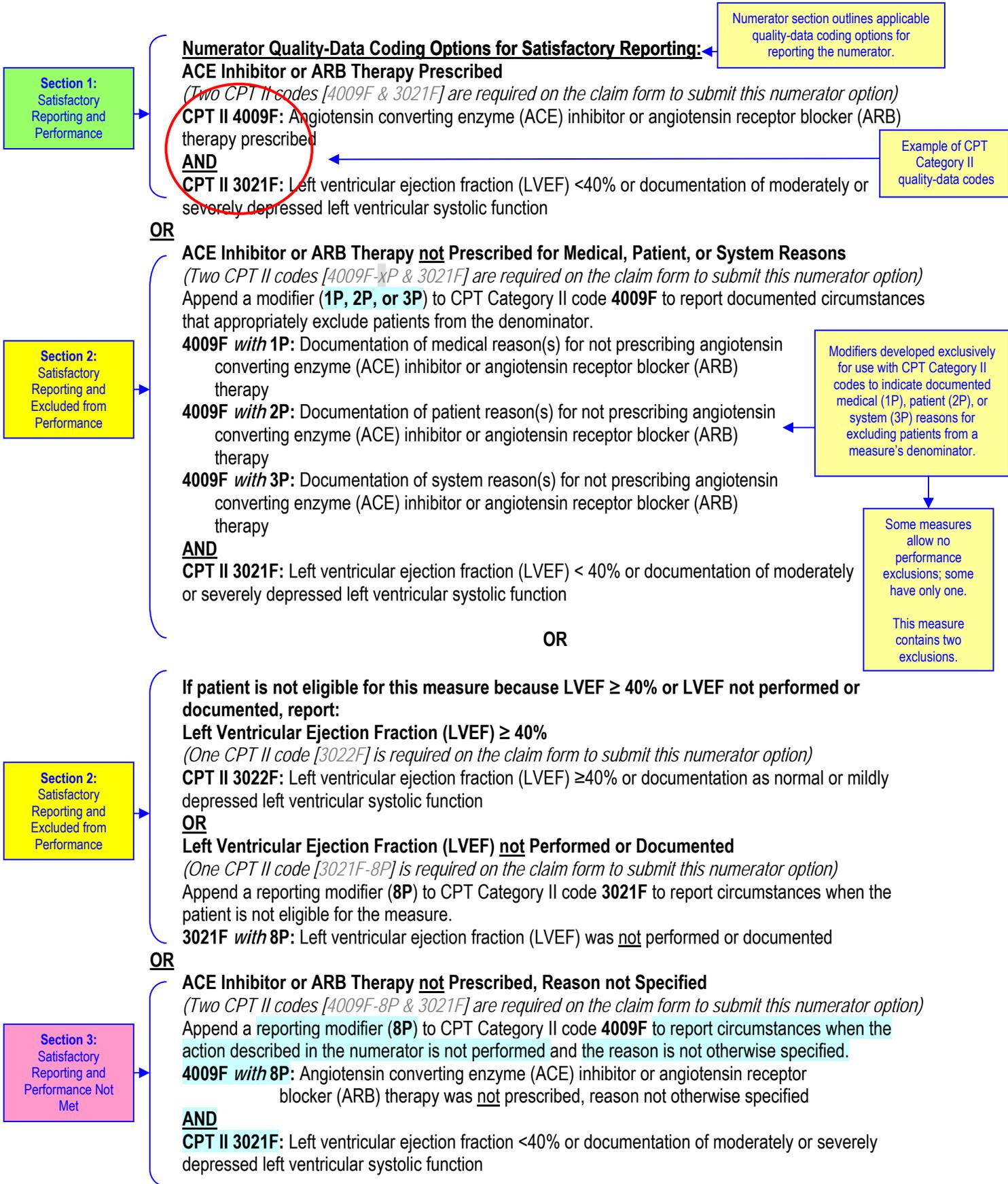
Measures may or may not contain definitions.

#### **Definition:**

**Prescribed** – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter.

Measure #5 is an example of a complex measure. Review carefully to submit the quality-data codes that meet the quality action being reported.

**NUMERATOR NOTE:** *The correct combination of numerator code(s) must be reported on the claim form in order to properly report this measure. The "correct combination" of codes may require the submission of multiple numerator codes.*



Denominator statement describes the population evaluated by the performance measure.

**DENOMINATOR:**

Heart failure patients aged 18 years and older with LVEF < 40% or with moderately or severely depressed left ventricular systolic function

Review patient demographics, DX, and encounter codes to determine if the patient meets denominator criteria.

Review other PQRI measures for which the patient meets denominator inclusion.

Enter the correct combination of codes on the claim.

**Denominator Criteria (Eligible Cases):**

Patients aged ≥ 18 years on date of encounter

Patient population that may be counted as eligible to meet a measure's inclusion requirements.

**AND**

**Diagnosis for heart failure (line-item ICD-9-CM):** 402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9

**AND**

**Patient encounter during reporting period (CPT):** 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99238, 99239, 99241, 99242, 99243, 99244, 99245, 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

Identified by ICD-9-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc), and place of service (if applicable).

**RATIONALE:**

In the absence of contraindications, ACE Inhibitors or ARBs are recommended for all patients with symptoms of heart failure and reduced left ventricular systolic function, as measured by left ventricular ejection fraction (LVEF). Both drugs have been shown to decrease mortality and hospitalizations.

A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.

Questions or comments regarding how the measure is constructed or suggestions for changes to a measure should be submitted to the measure's developer/owner. (see PQRI FAQ #8515)

**CLINICAL RECOMMENDATION STATEMENTS:**

Angiotensin converting enzyme inhibitors are recommended for all patients with current or prior symptoms of HF and reduced LVEF, unless contraindicated. (Class I Recommendation, Level of Evidence: A)(ACC/AHA)

Summary of clinical recommendations based on best practices.

Angiotensin II receptor blockers approved for the treatment of HF are recommended in patients with current or prior symptoms of HF and reduced LVEF who are ACEI-intolerant. (Class I Recommendation, Level of Evidence: A) (ACC/AHA)

Angiotensin II receptor blockers are reasonable to use as alternatives to ACEIs as first-line therapy for patients with mild to moderate HF and reduced LVEF, especially for patients already taking ARBs for other indications. (Class IIa Recommendation, Level of Evidence: A) (ACC/AHA)

# I WANT TO PARTICIPATE IN 2009 PQRI FOR INCENTIVE PAYMENT

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2009 PQRI)

## CHOOSE CLAIMS-BASED REPORTING OPTIONS

REGISTRY  
REPORTING



< 3 INDIVIDUAL  
MEASURES APPLY

**1**  
ONLY OPTION IS TO  
REPORT CLAIMS FOR  
**12-MONTH** REPORTING  
PERIOD  
  
1/1/09-12/31/09  
  
REPORT EACH MEASURE  
≥ **80%** OF APPLICABLE  
PATIENTS

Subject to Measure-Applicability  
Validation (MAV)

3 OR MORE  
INDIVIDUAL  
MEASURES APPLY

**1**  
CHOOSE TO REPORT  
ON ≥ 3 INDIVIDUAL  
MEASURES  
FOR  
**12 MONTHS**  
  
1/1/09-12/31/09

REPORT ≥ **80%** OF  
APPLICABLE PATIENTS  
ON AT LEAST 3  
MEASURES

**2**  
CHOOSE TO REPORT  
**MEASURES GROUP**  
FOR 30 CONSECUTIVE  
PATIENTS  
  
**12 MONTHS**  
  
1/1/09-12/31/09

**3**  
CHOOSE TO REPORT  
**MEASURES GROUP**  
FOR  
**12 MONTHS**  
  
1/1/09-12/31/09

REPORT ≥ **80%** OF  
ELIGIBLE PATIENTS  
(minimum 30 patients)  
FOR A MEASURES  
GROUP THE FULL 12  
MONTHS

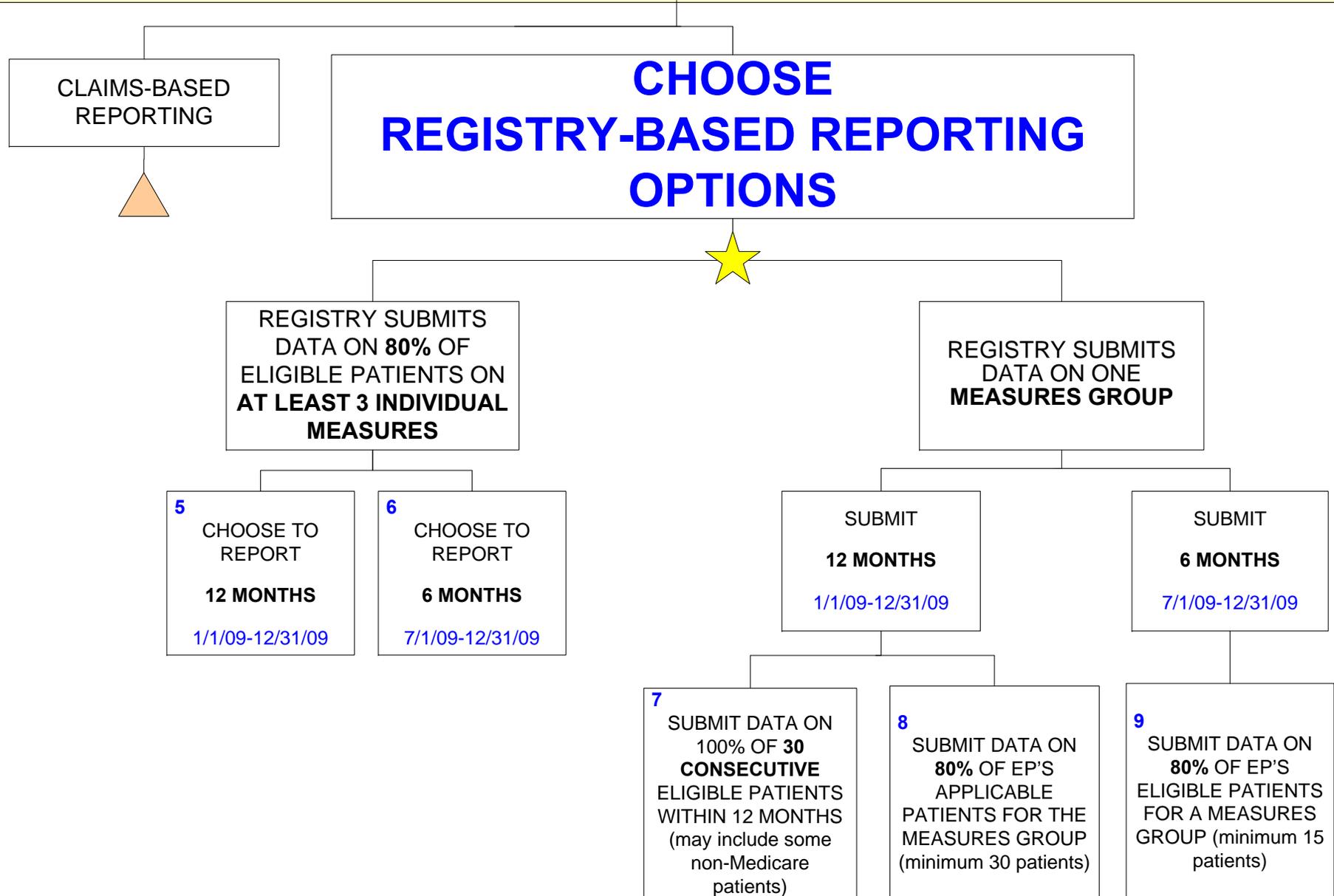
**4**  
CHOOSE TO REPORT  
**MEASURES GROUP**  
FOR  
**6 MONTHS**  
  
7/1/09-12/31/09

REPORT ≥ **80%** OF  
ELIGIBLE PATIENTS  
(minimum 15 patients)  
FOR A MEASURES  
GROUP THE FULL 6  
MONTHS

# I WANT TO PARTICIPATE IN 2009 PQRI FOR INCENTIVE PAYMENT

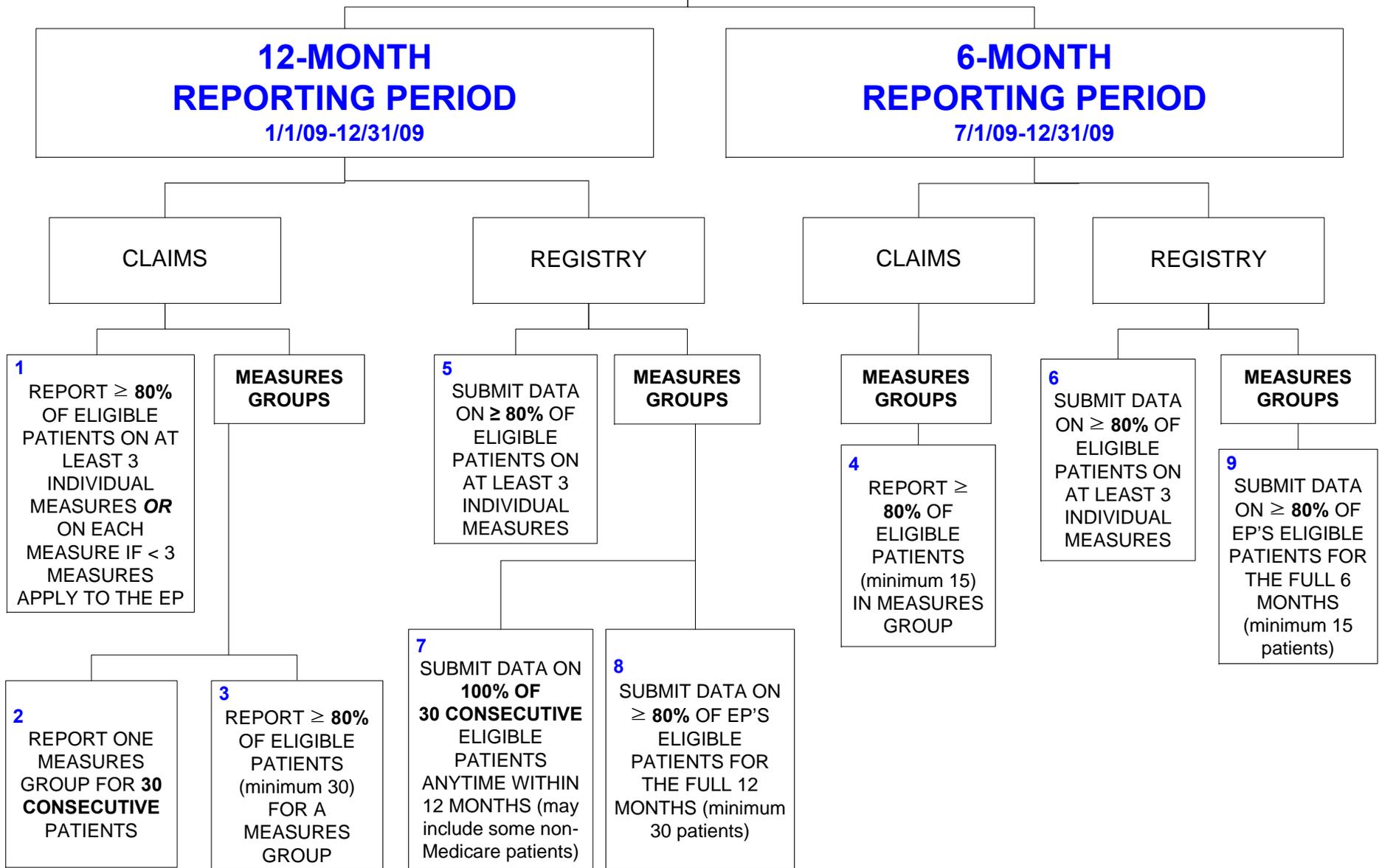
Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2009 PQRI)



# I WANT TO PARTICIPATE IN 2009 PQRI FOR INCENTIVE PAYMENT

(Select Reporting Period)



## Appendix C: 2009 Participation Decision Tree

### 2009 PQRI Reporting Options

1. Claims-based reporting of individual measures (12 months)
2. Claims-based reporting of one measures group for 30 consecutive Medicare Part B FFS patients (12 months)
3. Claims-based reporting of one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 30 patients during the reporting period) (12 months)
4. Claims-based reporting of one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period) (6 months)
5. Registry-based reporting of at least 3 individual PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (12 months)
6. Registry-based reporting of at least 3 individual PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (6 months)
7. Registry-based reporting of one measures group for 30 consecutive patients (patients may include, but may not be exclusively non-Medicare patients) (12 months)
8. Registry-based reporting of one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 30 patients during the reporting period) (12 months)
9. Registry-based reporting of one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients during the reporting period) (6 months)

