



2010 Physician Quality Reporting Initiative Implementation Guide

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Introduction

This guide is provided to promote understanding about how to implement 2010 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 beneficiaries 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 [including critical access], 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.

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 2010 PQRI Measure Specifications Manual for Claims and Registry Reporting of Individual Measures can be found at:

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 179 measures in 2010 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 2010 PQRI Measures List to determine which measures may be of interest to the practice. The list is available as a downloadable document from the Measures Codes section of the CMS PQRI website. 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 2010

After making a selection of potential measures, 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 2010 PQRI Measure” to view the content included in a measure’s specification, using PQRI measure #19 as an example.

2010 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. 2010 PQRI submission of quality data may also be performed via an electronic health record. **Appendix C**, “2010 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. EPs should not choose individual measures

that do not or infrequently apply to services provided to Medicare patients by the EP/practice. EPs may choose to report on measures groups if all of the measures within the group are applicable to services provided to Medicare patients by the EP. Instructions for reporting measures groups are included in a separate document, "2010 PQRI Measures Groups Specifications Manual," which can be found at: http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

Ensure that the practice identifies and reports on all eligible cases for the measures selected by the practice. Consider implementing an edit on the billing software that will flag each claim every time that a combination of codes listed in a measure's denominator is billed so that the entry of PQRI QDCs is required prior to final posting. Additional PQRI educational resources are available as downloads at: <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 analysis 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 allergy 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. EPs should use the 8P reporting modifier judiciously for applicable measures they have selected to report. The 8P modifier may not be used indiscriminately in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

For example, a clinician has selected and submitted QDCs during the reporting period for 2010 PQRI Measure #6, Oral Antiplatelet Therapy. The clinician sees a patient for whom he will not choose to prescribe oral antiplatelet therapy and the reason is not specified. However, 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 service as 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 one diagnosis from the base claim should be referenced in the diagnosis pointer field. 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 Taxpayer Identification Number/National Provider Identifier (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 or 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.
 - Keep track of all PQRI cases reported so that you can verify QDCs reported against the remittance advice notice sent by the Carrier/MAC. Each QDC line-item will be listed with the N365 denial remark code.

- 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.
- Use of CPT II modifiers (1P, 2P, 3P, 8P) 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.
- 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/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.
- EPs should use the 8P reporting modifier judiciously for applicable measures they have selected to report. The 8P modifier may not be used indiscriminately in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

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 elements **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 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**.

Satisfactorily Reporting Measures

PQRI participants should also refer to a PQRI Tip Sheet: "Satisfactorily Reporting 2010 PQRI Measures – Claims and Registry," an educational resource to assist professionals and their staff with accurately reporting PQRI measures. This Tip Sheet provides helpful information on how to get started with PQRI reporting and is available as a downloadable document in the Educational Resources section of the CMS PQRI website <http://www.cms.hhs.gov/pqri>.

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 25, 2011 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 (Measure Tag) and Performance Timeframes

Reporting frequency and performance timeframes are considered whether reporting through claims or via a qualified registry.

Claims-based reporting: Quality data reported to CMS through Medicare Part B claims (containing QDC line items for each individual professional's NPI) are processed to final action by the Carrier/MAC and subsequently transferred to the NCH where it is available for PQRI analysis. See **Appendix E**. Quality measures data reported on claims denied for payment are not included in PQRI analysis. QDC line items from claims are analyzed according to the measure specifications, including coding instructions, reporting frequency, and performance timeframes. See **Appendix F** for a flow diagram of the PQRI claims-based process.

Note: Registries are not required to submit QDCs.

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 reportable only as a measures group.

Each measure specification includes a reporting frequency (measure tag) 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, according to the following measure tags:

- 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

Terms	Definitions
Base Claim Diagnosis	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.
CPT Category II Codes	<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 to contribute to quality patient care.²</p> <p>For PQRI, CPT Category II codes are used to report quality measures on a claim for measurement calculation.</p>
Denominator (Eligible Cases)	<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>
Denominator Statement	A statement that describes the population eligible for the performance measure. For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."
Diagnosis Pointer	<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>
Eligible Professional	<p>Refer to http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage for a list of EPs eligible to participate in 2010 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 facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRI since DME is not paid under the PFS.</p>
Encounter	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.
G-codes for PQRI	A set of CMS-defined temporary HCPCS codes used to report quality measures on a claim. G-codes are maintained by CMS.
ICD-9-CM Diagnosis Codes	The International Classification of Diseases, 9th Revision, Clinical Modification ⁵ is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office visits for reporting in PQRI.

Terms	Definitions
Line-Item Diagnosis	<p>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.</p> <p>QDCs are submitted on the line item in section 24 for PQRI reporting.</p>
Measure	<p>Performance Measure</p> <ul style="list-style-type: none"> • A quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process or outcome. • See also process measure and outcome measure.^{1,6} <p>Measure Types</p> <ul style="list-style-type: none"> • 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.⁶ • Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function(s) or process(es).⁶ • 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.⁶
Measure Reporting Frequency (Measure Tag)	<ul style="list-style-type: none"> • Patient-Process: Report a minimum of once per reporting period per individual eligible professional (NPI). <ul style="list-style-type: none"> ○ If the measure is reported more than once during the reporting period, performance rates are calculated using the most advantageous QDC submitted. ○ Reflect quality actions performed throughout the reporting period or other timeframe. • Patient-Intermediate: Report a minimum of once per reporting period per individual eligible professional (NPI). <ul style="list-style-type: none"> ○ If the measure is reported more than once during the reporting period, performance rates are calculated using the most recent QDC submitted. ○ Often reflect lab or other test value, so the most recent measurement is desired. • Patient-Periodic: Report once per timeframe specified in the measure for each individual eligible professional (NPI) during the reporting period. <ul style="list-style-type: none"> ○ Examples include once per month and three times per year. • Episode: 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"> ○ Usually reflect a clinical episode, difficult to determine from a single Part B claim. ○ Require specialized analytics to determine the episode. • Procedure: Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period. • Visit: Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008.
MMSEA	Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Extension Act of 2007.
NPI	National Provider Identifier of the individual eligible professional billing under the Tax ID ("NPI within the Tax ID").

Terms	Definitions
Numerator	<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).⁶</p> <p>PQRI measure numerators are CPT Category II codes and G-codes.</p>
Numerator Statement	<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>
Performance Timeframe	<p>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.</p>
Performance Measure Exclusion Modifiers	<p>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.²</p>
Performance Measure Reporting Modifier 8P	<p>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.</p> <p>8P Performance measure reporting modifier - action not performed, reason not otherwise specified²</p>
Place of Service	<p>References Place of Service Codes (POS) from the list provided in section 10.5 of the Medicare Claims Processing Manual.</p>
Quality-Data Code (QDC)	<p>Specified CPT Category II codes with or without modifiers and G-codes used for submission of PQRI data. The 2010 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.</p>
Rationale	<p>A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.⁴</p>
Remittance Advice (RA)	<p>Means utilized by Medicare contractors to communicate to providers claims processing decisions such as payments, adjustments, and denials.⁷</p>
Reporting Frequency	<p>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 2010 PQRI Measure Specifications Manual for Claims and Registry posted on the CMS Web site, http://www.cms.hhs.gov/PQRI.</p>
Reporting Options	<p>2010 PQRI reporting methods available for incentive payment: claims-based; registry-based; electronic health record (EHR); or measures group. Refer to the 2010 PQRI Participation Decision Tree (Appendix C).</p>
Reporting Period	<p>The period during which PQRI measures are to be reported for covered professional services provided.</p> <p>6-month (July 1, 2010 through December 31, 2010) or 12-month (January 1, 2010 through December 31, 2010) time periods are available depending upon the 2010 PQRI reporting option the eligible professional selects for submitting PQRI quality data.</p>
TRHCA	<p>Tax Relief and Health Care Act of 2006.</p>

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3. Institute of Medicine (IOM), Performance Measurement Accelerating Improvement, Appendix A Glossary, National Academies Press, http://www.nap.edu/catalog.php?record_id=11517#toc, accessed on 10/29/09.
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7. CMS Medicare Learning Network, Understanding the Remittance Advice: A Guide for Medicare Providers, Physicians, Suppliers, and Billers http://www.cms.hhs.gov/MLNProducts/downloads/RA_Guide_Full_03-22-06.pdf, accessed on 10/29/09.
8. Medicare Claims Processing Manual: Chapter 26 – Completing and Processing Form CMS – 1500 Data Set. See <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>, accessed on 10/29/09.

Appendix B: Sample 2010 PQRI Measure

This symbol (asterisk) represents the Measure Developer (as noted in the Symbol and Copyright Information section following the 2010 PQRI Measure Specifications Manual for Claims and Registry).

The following is a sample 2010 PQRI quality measure which includes text boxes to assist eligible professionals with PQRI reporting.

Official measure title

* Measure #19: Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care

2010 PQRI REPORTING OPTIONS FOR INDIVIDUAL MEASURES: CLAIMS, REGISTRY

Each individual measure specification identifies the available reporting option(s)

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

DESCRIPTION:

Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months

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 patients with diabetic retinopathy seen during the reporting period. It is anticipated that clinicians who provide the primary management of patients with diabetic retinopathy (in either one or both eyes) will submit this measure.

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 and/or G-codes are used to report the numerator of the measure.

Measure #19 can be reported via claims and registry.

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

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 **TIN/NPI** reporting the measure(s).

Measure Reporting via Registry:

ICD-9-CM diagnosis codes, CPT 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.

Refer to PQRI measure specification #33 to view a registry only specification.

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

NUMERATOR:

Patients with documentation, at least once within 12 months, of the findings of the dilated macular or fundus exam via communication to the physician who manages the patient's diabetic care

Measures may or may not contain definitions.

Definition:

Communication – May include documentation in the medical record indicating that the results of the dilated macular or fundus exam were communicated (e.g., verbally, by letter) with the clinician managing the patient’s diabetic care OR a copy of a letter in the medical record to the clinician managing the patient’s diabetic care outlining the findings of the dilated macular or fundus exam.

Measure #19 is an example of a complex measure. Review carefully to submit the quality-data codes (ODCs) that meet the quality action being

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.

Numerator section outlines applicable quality-data coding options for reporting the numerator.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Macular or Fundus Exam Findings Communicated

(One CPT II code & one G-code [5010F & G8397] are required on the claim form to submit this numerator option)

Section 1: Satisfactory Reporting and Performance

CPT II 5010F: Findings of dilated macular or fundus exam communicated to the physician managing the diabetes care

Examples of ODCs

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

OR

Dilated Macular or Fundus Exam Findings not Communicated for Patient Reasons

(One CPT II code & one G-code [5010F-2P & G8397] are required on the claim form to submit this numerator option)

Section 2: Satisfactory Reporting and Excluded from Performance

Append a modifier (2P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.

5010F with 2P: Documentation of patient reason(s) for not communicating the findings of the dilated macular or fundus exam to the physician who manages the ongoing care of the patient with diabetes

Modifiers developed exclusively for use with CPT II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure’s denominator.

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

Some measures allow no performance exclusions; some have only one or two.

OR

If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:

(One G-code [G8398] is required on the claim form to submit this numerator option)

Section 2: Satisfactory Reporting and Excluded from Performance

G8398: Dilated macular or fundus exam not performed

OR

Measure #19 has two performance exclusion sections

**Section 3:
Satisfactory
Reporting and
Performance Not Met**

Dilated Macular or Fundus Exam Findings not Communicated, Reason not Specified
(One CPT II code & one G-code [5010F-8P & G8397] are required on the claim form to submit this numerator option)

Append a **reporting modifier (8P)** to CPT Category II code **5010F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

5010F with 8P: Findings of dilated macular or fundus exam was not communicated to the physician managing the diabetes care, reason not otherwise specified

AND

G8397: Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy

Denominator statement describes the population evaluated by the performance measure.

DENOMINATOR:

All patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed

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

AND

Diagnosis for diabetic retinopathy (line-item ICD-9-CM): 362.01, 362.02, 362.03, 362.04, 362.05, 362.06

AND

Patient encounter during the reporting period (CPT): 92002, 92004, 92012, 92014, 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

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

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:

The physician that manages the ongoing care of the patient with diabetes should be aware of the patient's dilated eye examination and severity of retinopathy to manage the on-going diabetes care. Such communication is important in assisting the physician to better manage the diabetes. Several studies have shown that better management of diabetes is directly related to lower rates of development of diabetic eye disease. (Diabetes Control and Complications Trial – DCCT, UK Prospective Diabetes Study – UKPDS)

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.

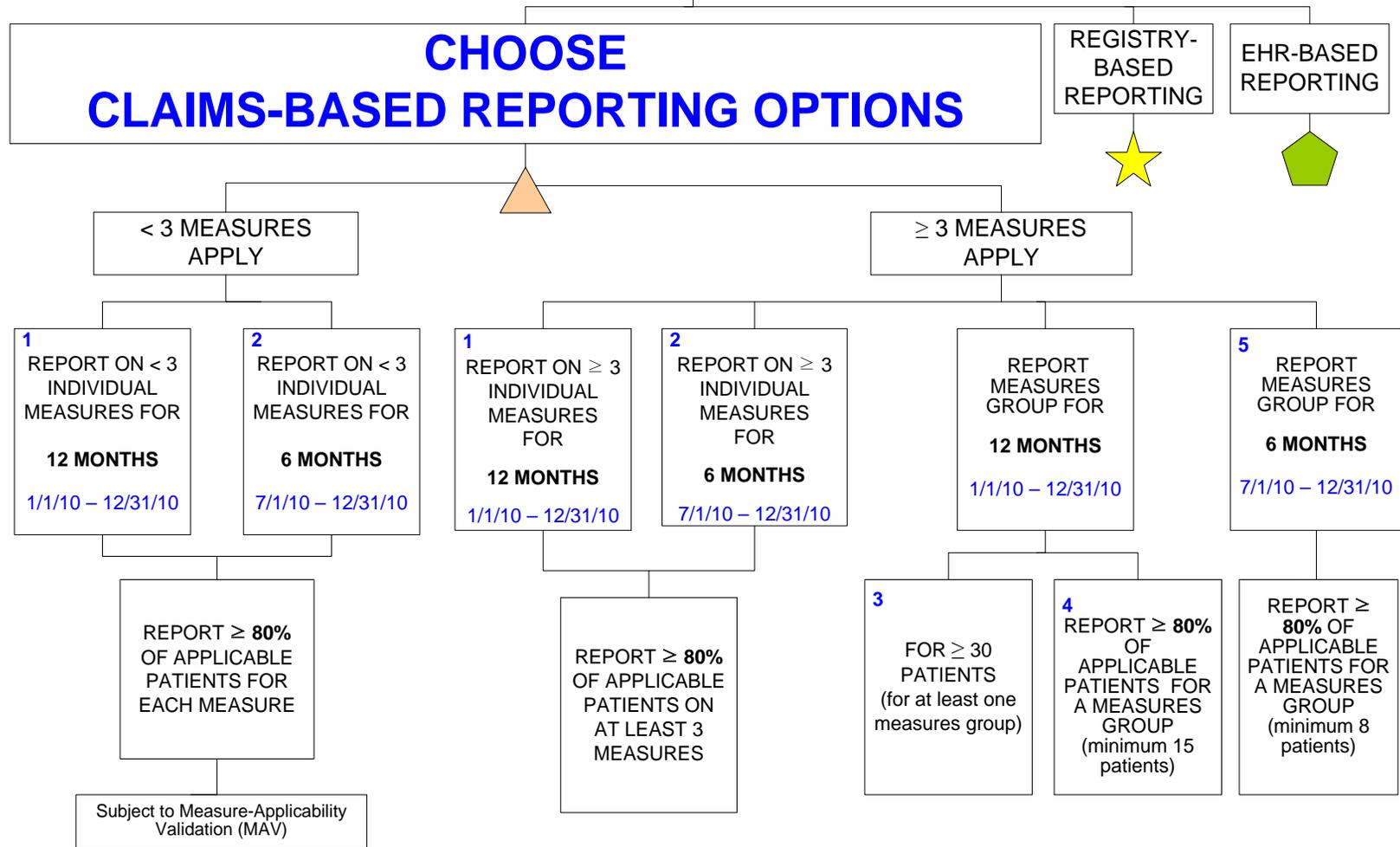
Summary of clinical recommendations based on best practices.

CLINICAL RECOMMENDATION STATEMENTS:

While it is clearly the responsibility of the ophthalmologist to manage eye disease, it is also the ophthalmologist's responsibility to ensure that patients with diabetes are referred for appropriate management of their systemic condition. It is the realm of the patient's family physician, internist or endocrinologist to manage the systemic diabetes. The ophthalmologist should communicate with the attending physician. (Level A: III Recommendation) (AAO, 2003)

Appendix C: 2010 PQRI Participation Decision Tree

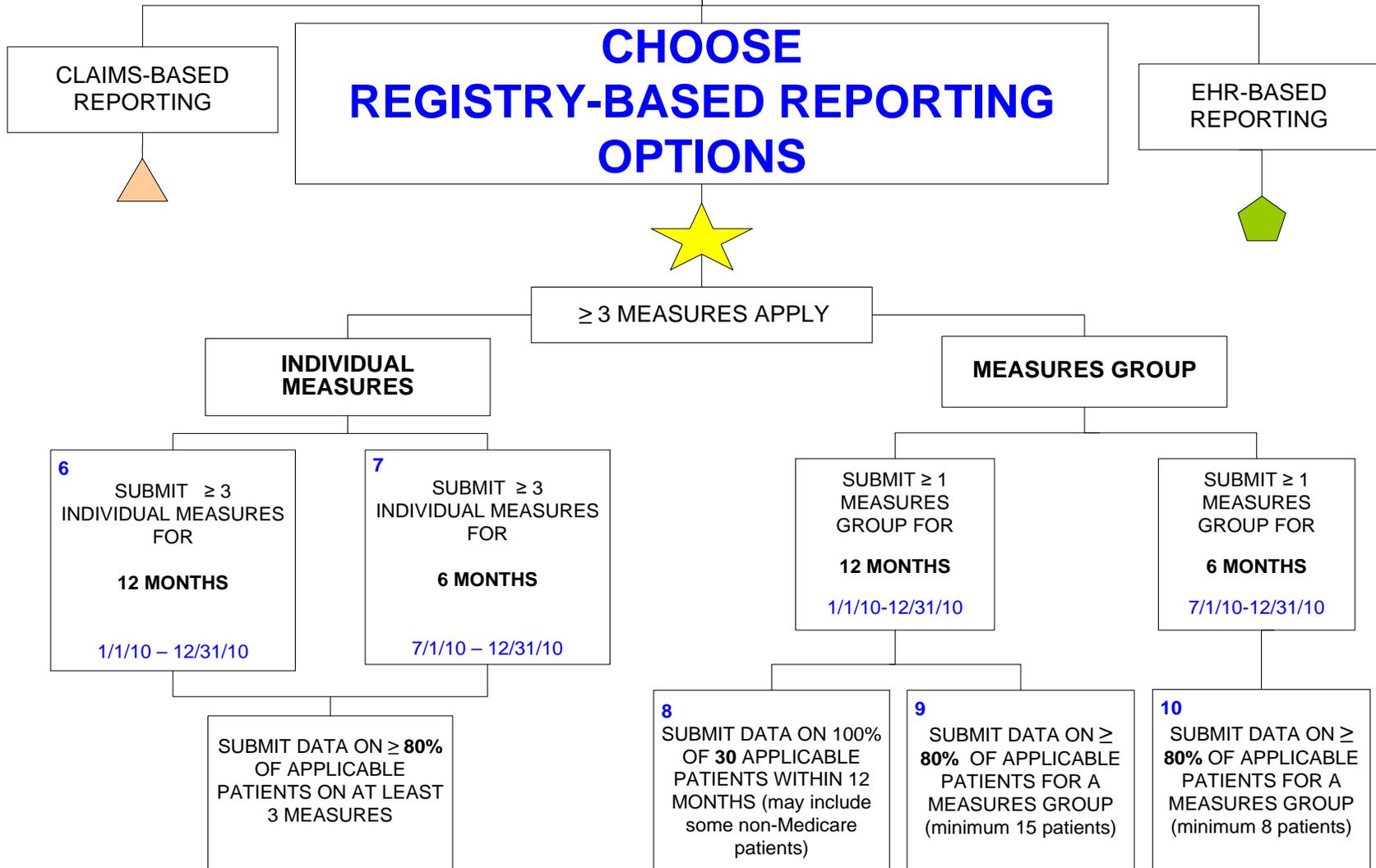
**I WANT TO PARTICIPATE IN 2010 PQRI
FOR INCENTIVE PAYMENT**
Select Reporting Method
(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2010 PQRI)



I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2010 PQRI)



I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2010 PQRI)

CLAIMS-BASED
REPORTING



REGISTRY-BASED
REPORTING



**CHOOSE
EHR-BASED REPORTING
OPTION**



≥ 3 MEASURES APPLY

11
SUBMIT ≥ 3 INDIVIDUAL
MEASURES FOR
12 MONTHS
1/1/10 – 12/31/10

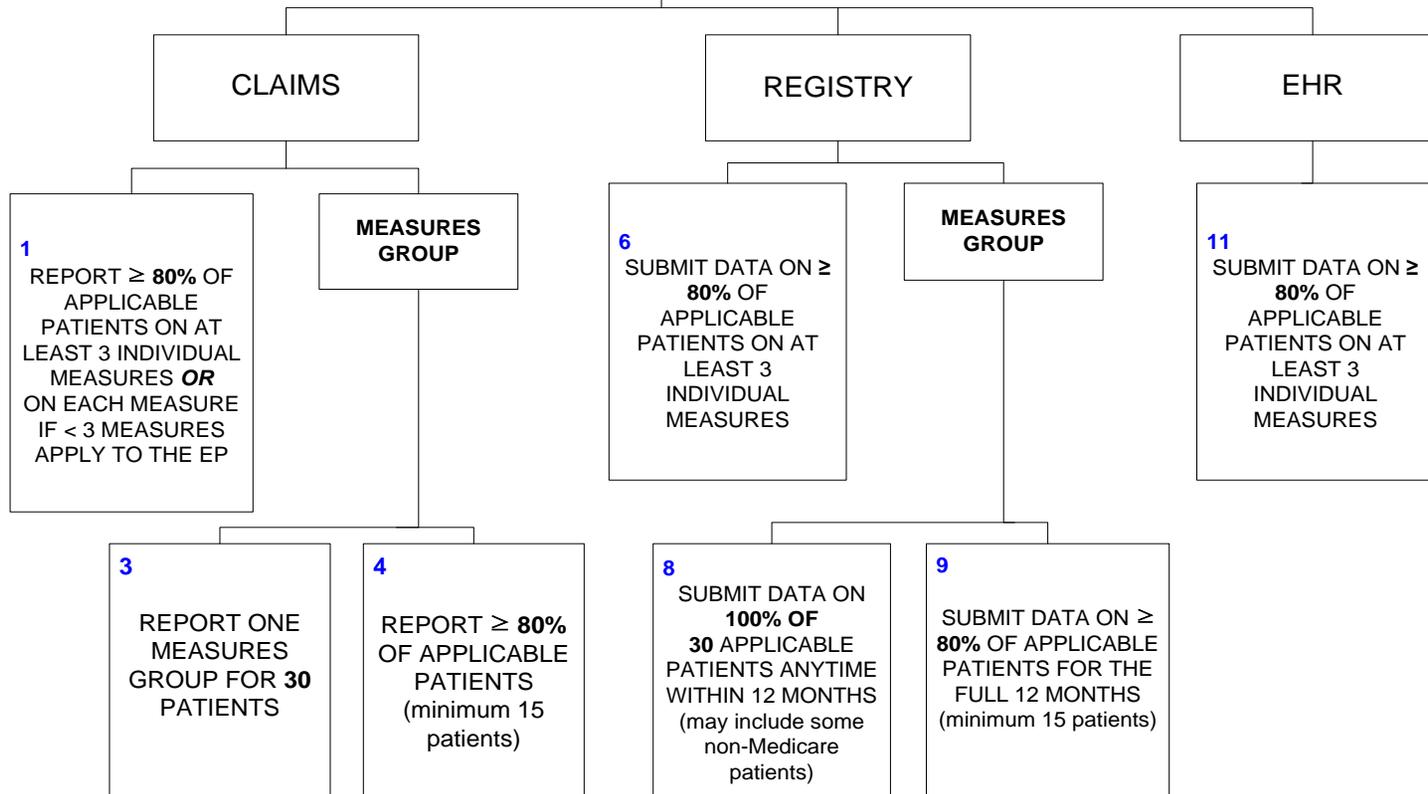
EHR SUBMITS DATA ON ≥
80% OF APPLICABLE
PATIENTS ON AT LEAST 3
INDIVIDUAL MEASURES

I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

(Select Reporting Period)

**12-MONTH
REPORTING PERIOD**
1/1/10 – 12/31/10

**6-MONTH
REPORTING PERIOD**
7/1/10 – 12/31/10



I WANT TO PARTICIPATE IN 2010 PQRI FOR INCENTIVE PAYMENT

(Select Reporting Period)

**12-MONTH
REPORTING PERIOD
1/1/10 – 12/31/10**



**6-MONTH
REPORTING PERIOD
7/1/10 – 12/31/10**



CLAIMS

REGISTRY

2
REPORT \geq **80%** OF
APPLICABLE
PATIENTS ON AT
LEAST 3 INDIVIDUAL
MEASURES **OR**
ON EACH MEASURE
IF $<$ 3 MEASURES
APPLY TO THE EP

**MEASURES
GROUP**

5
REPORT \geq
80% OF
APPLICABLE
PATIENTS
(minimum 8)

7
SUBMIT DATA ON
 \geq **80%** OF
APPLICABLE
PATIENTS ON AT
LEAST 3
INDIVIDUAL
MEASURES

**MEASURES
GROUP**

10
SUBMIT DATA
ON \geq **80%** OF
APPLICABLE
PATIENTS

Appendix C: 2010 Participation Decision Tree

2010 PQRI Reporting Options

Number assigned coordinates with appropriate box on the Appendix C: 2010 PQRI Participation Decision Tree.

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

Appendix D: CMS-1500 Claim Example

Example of an individual NPI reporting on a single CMS-1500 claim. See <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf> for more information.

21. Review applicable PQRI measures related to ANY diagnosis (Dx) listed in Item 21. Up to 8 Dx may be entered electronically.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier(s) as needed

QDC codes must be submitted with a line-item charge of \$0.00 or \$0.01. Charge field cannot be blank.

Identifies claim line-item

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.					
23. PRIOR AUTHORIZATION NUMBER																	
24. A. DATE(S) OF SERVICE		B. PLACE OF SERVICE		C. ICD-9-CM CODE		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS		F. CHARGES		G. DAYS OR UNITS		H. ICD-9-CM CODE		I. RENDERING PROVIDER ID. #	
MM	DD	YY	MM	DD	YY		CPT/HCPCS	MODIFIER	DIAGNOSIS	POINTER	\$						
07	11	10	07	11	10	11	99213			1	47	00			NPI	0123456789	
07	11	10	07	11	10	11	3048F			1	0	00			NPI	0123456789	
07	11	10	07	11	10	11	3074F			1	0	00			NPI	0123456789	
07	11	10	07	11	10	11	3078F			1	0	00			NPI	0123456789	
07	11	10	07	11	10	11	4011F			2	0	00			NPI	0123456789	
07	11	10	07	11	10	11	1090F			2	0	00			NPI	0123456789	

For group billing, the rendering NPI number of the individual EP who performed the service will be used from each line-item in the PQRI calculations.

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. XXXXXX

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

28. TOTAL CHARGE \$ 47.00

29. AMOUNT PAID \$

30. BALANCE DUE \$ 47.00

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)

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

SIGNED _____ DATE _____

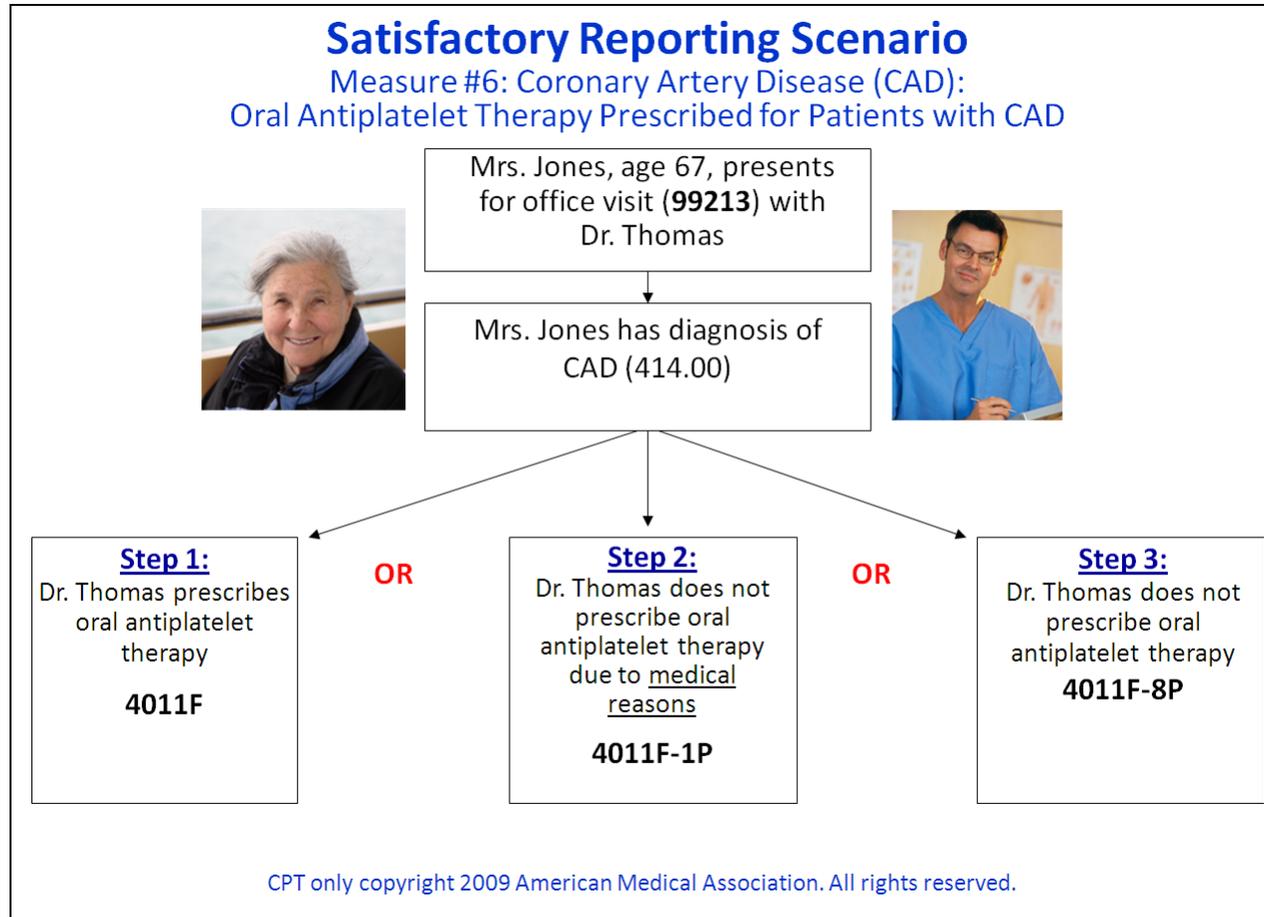
a. _____ b. _____

The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; if a Group is billing, enter the NPI of the group here. This is a required field.

The patient was seen for an office visit (99213). The provider is reporting several measures related to diabetes, coronary artery disease (CAD), and urinary incontinence:

- Measure #2 (LDL-C) with QDC 3048F + diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);
- Measure #3 (BP in Diabetes) with QDCs 3074F + 3078F + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);
- Measure #6 (CAD) with QDC 4011F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and
- Measure #48 (Assessment - Urinary Incontinence) with QDC 1090F. For PQRI, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.
- Note: All diagnoses listed in Item 21 will be used for PQRI 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.
- 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. 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.

Appendix E: Satisfactory Reporting Scenario



Appendix F: PQRI Claims-Based Process

