



**2016 Physician Quality Reporting System
(PQRS)
Measure Specification and Measure Flow Guide
for Claims and Registry Reporting of Individual
Measures**

**Utilized by Individual Eligible Professionals for Claims and Registry Reporting and
Clinical Practices Participating in Group Practice Reporting Option (GPRO) for
Registry Reporting**

11/17/15

Introduction

This document contains general guidance for the 2016 Physician Quality Reporting System (PQRS) Individual Measure Specifications and Measure Flows for claims and registry reporting. The individual measure specifications are detailed descriptions of the quality measures and are intended to be utilized by individual eligible professionals reporting individual measures via claims or registry and by group practices reporting via registry for the 2016 Physician Quality Reporting System (PQRS). In addition, each measure specification document includes a measure flow and associated algorithm as a resource for the application of logic for reporting and performance. Please note that the measure flows were created by CMS and may or may not have been reviewed by the Measure Steward. These diagrams should not be used in place of the measure specification but may be used as an additional resource.

Reporting Mechanism for Individual Measures to Avoid the 2018 Negative Payment Adjustment

Report on at least 9 individual measures covering 3 National Quality Strategy (NQS) domains for at least 50% of denominator eligible Medicare Part B FFS patients.

- Individual eligible professionals (EPs) (and group practices for registry reporting) that submit quality data for **only 1 to 8** PQRS measures covering 3 NQS domains for at least 50% of the individual EP's denominator eligible Medicare Part B FFS patients **OR** that submit data for **9 or more** PQRS measures covering **less than 3 domains** for at least 50% of the individual EP's Medicare Part B FFS patients eligible for each measure will be subject to Measure-Applicability Validation (MAV). (See 2016 PQRS Measure Applicability Validation (MAV) Process for Claims and Registry-Based Reporting of Individual Measures within [CMS Analysis and Payment Guide](#))
- Measures with a 0% performance rate will not be counted
- An EP that sees at least 1 Medicare patient in a face-to-face encounter must report a minimum of 1 cross-cutting measure. (See 2016 PQRS List of Face-To-Face Encounter Codes within [PQRS Measures Codes](#))

The PQRS Individual Measure Specifications for Claims and Registry Reporting may not be utilized for other reporting mechanisms. Below outlines which measure specifications can be utilized for the other reporting mechanisms and where they can be found. Qualified Clinical Data Registries (QCDRs) can utilize the PQRS Individual Measure Specifications for Claims and Registry Reporting as well as other measure specifications outlined below.

- Measure specifications for measures groups reporting are included in a separate manual, "2016 Physician Quality Reporting System Measures Groups Specifications Manual," which can be accessed at: [PQRS Measures Codes](#)
- Group practices electing to participate in the PQRS group practice reporting option (GPRO) reporting PQRS via GPRO Web-Interface may access the GPRO Web Interface Narrative Specifications and supporting documents at: [GPRO Web Interface](#)
- Measure specifications for electronic health record (EHR) based reporting should access the electronic clinical quality measures (eCQMs) at: [CMS Clinical Quality Measures Basics](#)
- Information regarding CG-CAHPS may be found at: [CAPHS Survey Information](#) (Please note that this link is directed to the Accredited Care Organization webpage.)

PQRS Individual Measure Specifications

Each measure is assigned a unique number. Measure numbers for 2016 PQRS represents a continuation in numbering from the 2015 measures. For 2016 PQRS measures that are continuing forward in the 2016 PQRS, measure specifications have been updated. In addition to the individual measure specifications documents and this guide, please refer to the “2016 Physician Quality Reporting System Implementation Guide” for additional information essential in assisting eligible professionals’ understanding and submission of measures. This document can be accessed at: [PQRS Measures Codes](#).

Eligible Professionals

Eligible professionals submitting billable services on Part B claims for allowable Medicare Physician Fee Schedule (PFS) charges may report the quality action for selected PQRS quality measure(s). Providers not defined as eligible professionals are not eligible to participate in PQRS. A list of eligible professionals can be found on the PQRS website at: [How to Get Started with PQRS](#).

Frequency and Performance Timeframes

The measure instructions 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. Each individual eligible professional or group practices participating in 2016 PQRS should report according to the frequency and timeframe listed within each measure specification.

Denominator Codes (Eligible Cases) and Numerator Quality-Data Codes

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome. The denominator population may be defined by demographic information, certain International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measure that are submitted **by individual eligible professionals** as part of a claim for **covered services** under the PFS for claims-based reporting. This same criterion is also applied for individual eligible professionals and group practices that chose to report via a registry although this data is not necessarily submitted via a claim.

If the specified denominator codes for a measure are not included on the patient’s claim (for the same date of service) as submitted by the individual eligible professional, then the patient does not fall into the denominator population, and the PQRS measure does not apply to the patient. Likewise, if the specified denominator codes for a measure are not associated with a patient for an individual eligible professional or group practice submitting to a registry, then the patient does not fall into the denominator population, and the PQRS measure does not apply to the patient. Some measure specifications are adapted as needed for implementation in PQRS in agreement with the measure steward. For example, CPT codes for non-covered services such as preventive visits are not included in the denominator.

PQRS measure specifications include specific instructions regarding CPT Category I modifiers, place of service codes, and other detailed information. Each **eligible professional and group practice** should carefully review the measure’s denominator coding to determine whether codes submitted on a given claim or to a registry meet denominator inclusion criteria.

If the patient does fall into the denominator population, the applicable Quality Data Codes or QDCs (CPT Category II codes or G-codes) that define the numerator should be submitted to satisfactorily report quality data for a measure for claims based reporting. When a patient falls into the denominator, but the measure specifications define circumstances in which a patient may be appropriately excluded, CPT Category II code modifiers such as 1P, 2P and 3P or quality-data codes are available to describe medical, patient, system, or other reasons for performance exclusion. When the performance exclusion does not apply, a measure-specific CPT Category II reporting modifier 8P or quality-data code may be used to indicate that the process of care was not provided for a

reason not otherwise specified. Each measure specification provides detailed Numerator Options for reporting on the quality action described by the measure. Although a registry may or may not utilize these same QDCs, the numerator clinical concepts described for each measure are to be followed when submitting to a registry.

G-codes that are associated with billable charges and found within the denominator, within this reporting program, are referred to as HCPCS coding. G-codes that describe clinical outcomes or results and are found within the denominator or numerator are described as QDC's.

For eligible professionals reporting individually, PQRS measures (including patient-level measure[s]) may be reported for the same patient by multiple eligible professionals practicing under the same Tax Identification Number (TIN). If a patient sees multiple providers during the reporting period, that patient can be counted for each individual NPI reporting if the patient encounter(s) meet denominator inclusion. The following is an example of two provider NPIs (National Provider Identifiers), billing under the same TIN who are intending to report PQRS Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy. Provider A sees a patient on February 2, 2016 and prescribes an aspirin and reports the appropriate quality-data code (QDC) for measure #6. Provider B sees the same patient at an encounter on July 16, 2016 and verifies that the patient has been prescribed and is currently taking an aspirin. Provider B must also report the appropriate QDCs for the patient at the July encounter to receive credit for reporting measure #6.

Eligible professionals reporting under a group practice selecting to participate in the PQRS group practice reporting option (GPRO) under the same Tax Identification Number (TIN), should be reporting on the same patient, when instructed within the chosen measure. For example, if reporting measure #130: Documentation of Current Medications in the Medical Record all eligible professionals under the same TIN would report each denominator eligible instance as instructed by this measure.

If the group practice chooses a measure that is required to be reported once per reporting period, then this measure should be reported at least once during the measure period by at least one eligible professional under the TIN. Measure #6: Coronary Artery Disease (CAD): Antiplatelet Therapy is an example of a measure that would be reported once per reporting period under the TIN.

CMS recommends review of any measures that an individual eligible professional or group practice intend to report. Below is an example measure specification that will assist with satisfactorily reporting. For additional assistance please contact the QualityNet Help Desk at the following:

QualityNet Help Desk – Available Monday – Friday; 7:00 AM–7:00 PM CST

Phone: 1-866-288-8912

Email: Qnetsupport@hcqis.org

Measure Specification Format (Refer to the Example Measure Specification Below)

Measure title and domain

Reporting option available for each measure (claims-based and/or registry)

Measure description

Instructions on reporting including frequency, timeframes, and applicability

Denominator statement and coding

Numerator statement and coding options

Definition(s) of terms where applicable

Rationale statement for measure

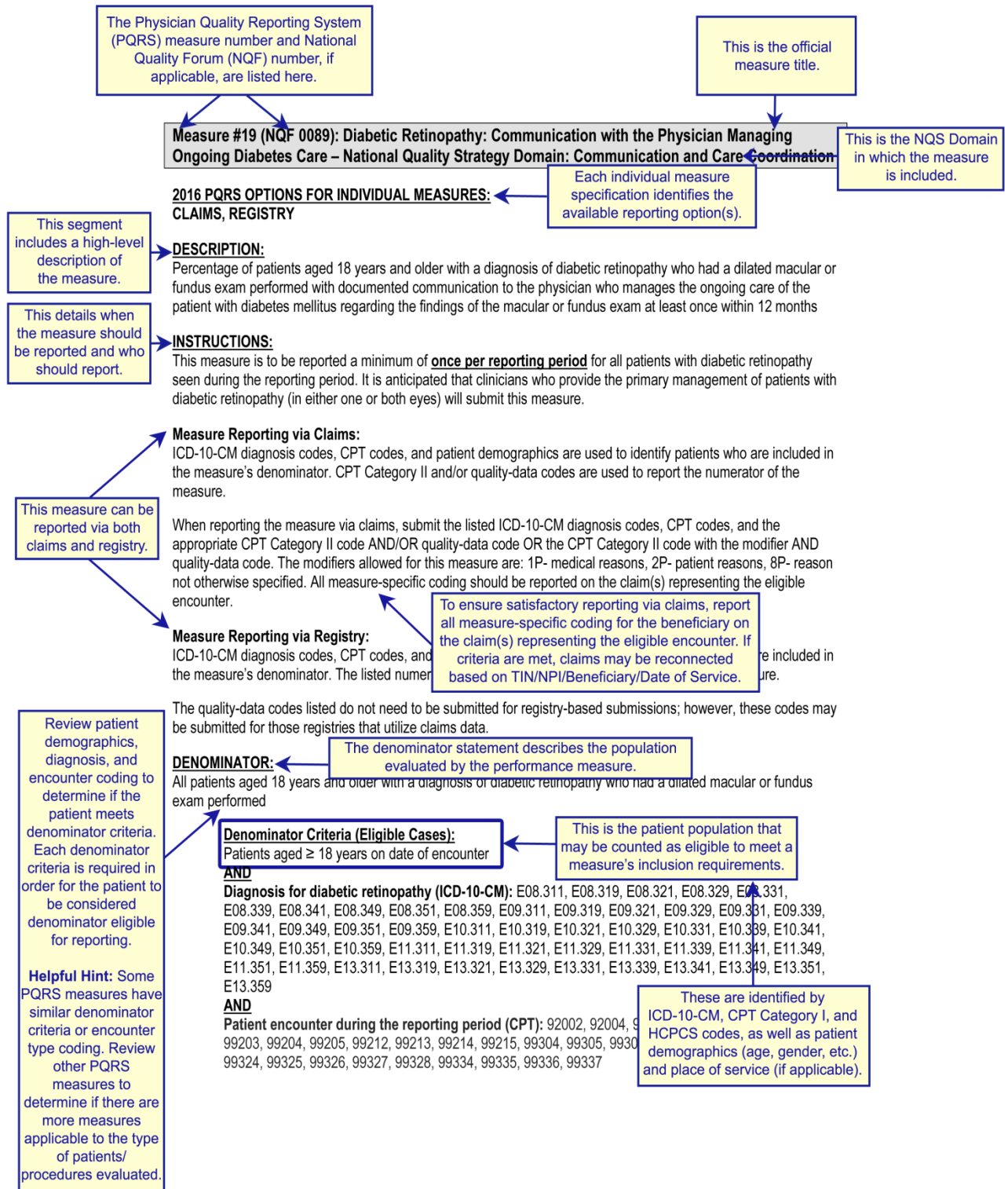
Clinical recommendations or evidence forming the basis for supporting criteria for the measure

The Rationale and Clinical Recommendation Statements sections provide limited supporting information regarding the quality actions described in the measure. Please contact the measure owner for section references and further information regarding the clinical rationale and recommendations for the described quality action. Measure owner

contact information is located on the last page of the Measures List document, which can be accessed at: [PQRS Measures Codes](#).

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Example Individual Measure Specification:



NUMERATOR: ← This is 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).
 Patients with documented communication to the physician who manages the patient's diabetic care

Measures may or may not contain definitions.

This measure is an example of a complex measure. Review carefully to submit the quality-data codes (QDCs) that meet the quality action being reported.

Definitions:
Communication – May include documentation in the medical record indicating that the findings of the dilated macular or fundus exam were communicated (eg, 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.
Findings – Includes level of severity of retinopathy (eg, mild nonproliferative, moderate nonproliferative, severe nonproliferative, very severe nonproliferative, proliferative) AND the presence or absence of macular edema.

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.

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

Section 1: Satisfactory Reporting and Performance

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Dilated Macular or Fundus Exam Findings Communicated
 (One CPT II code & one quality-data code [5010F & G8397] are required on the claim form numerator option)

Performance Met:

CPT II 5010F:
AND
G8397:

These are examples of QDCs.

Findings of dilated macular or fundus exam communicated to the physician or other qualified health care professional managing the diabetes care

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

OR

Section 2: Satisfactory Reporting and Excluded from Performance

Dilated Macular or Fundus Exam Findings not Communicated for Medical Reasons or Patient Reasons
 (One CPT II code & one quality-data code [5010F-xP & G8397] are required on the claim form to submit this numerator option)

Append a modifier (1P or 2P) to CPT Category II code 5010F to report documented circumstances that appropriately exclude patients from the denominator.

Medical Performance Exclusion or Patient Performance Exclusion:

5010F with 1P:
OR
5010F with 2P:

Documentation of medical 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

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

These modifiers are 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.

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

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

This measure has two performance exclusion sections.

Section 2 (continued):
Satisfactory Reporting and Excluded from Performance

Section 3:
Satisfactory Reporting and Performance Not

If patient is not eligible for this measure because patient did not have dilated macular or fundus exam performed, report:
(One quality-data code [G8398] is required on the claim form to submit this numerator option)
Other Performance Exclusion: G8398: Dilated macular or fundus exam not performed

OR

Dilated Macular or Fundus Exam Findings not Communicated, Reason not Otherwise Specified
(One CPT II code & one quality-data 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.

Performance Not Met:
5010F with 8P: Findings of dilated macular or fundus exam were 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

This is 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.

RATIONALE:
The primary care 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 ongoing 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).

CLINICAL RECOMMENDATION STATEMENTS:
Ophthalmologists should communicate the ophthalmologic findings to the primary care physician as well as the need for optimizing metabolic control. (Good evidence; Strong recommendation) (AAO, 2014)

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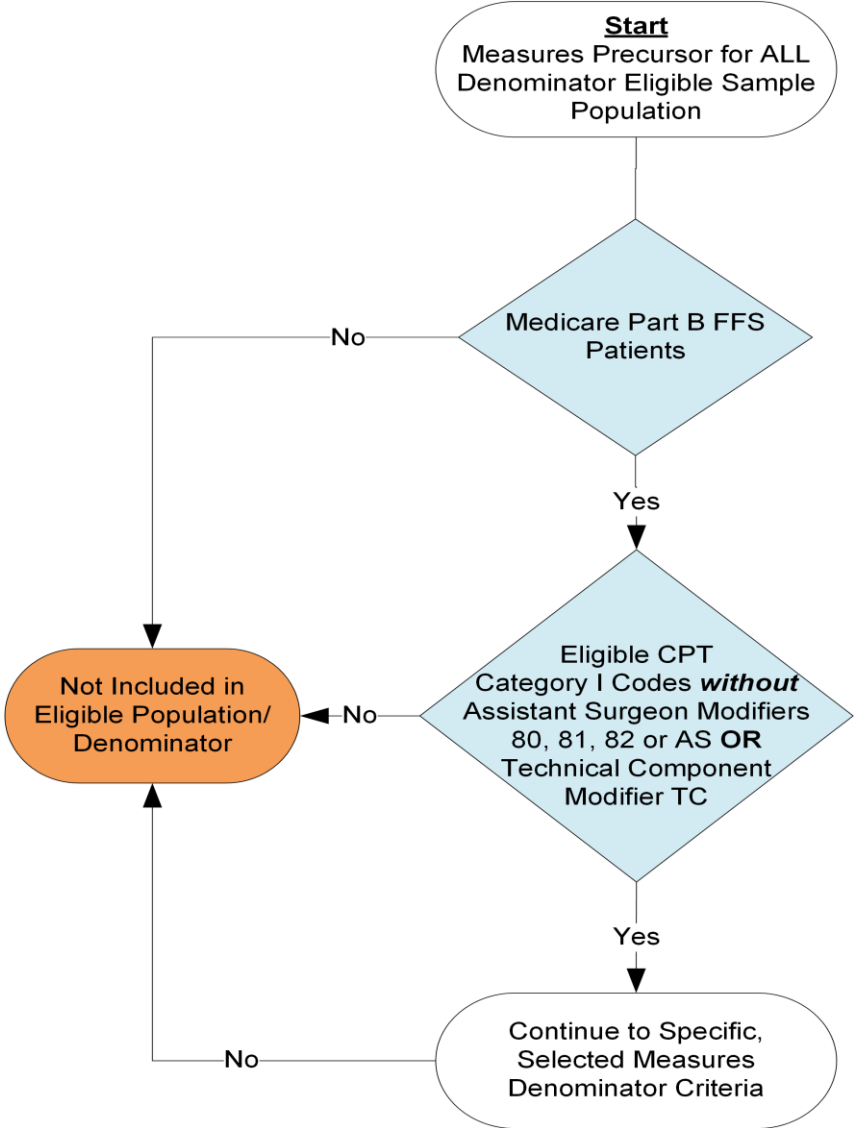
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Interpretation of Individual Measure Flows

Denominator

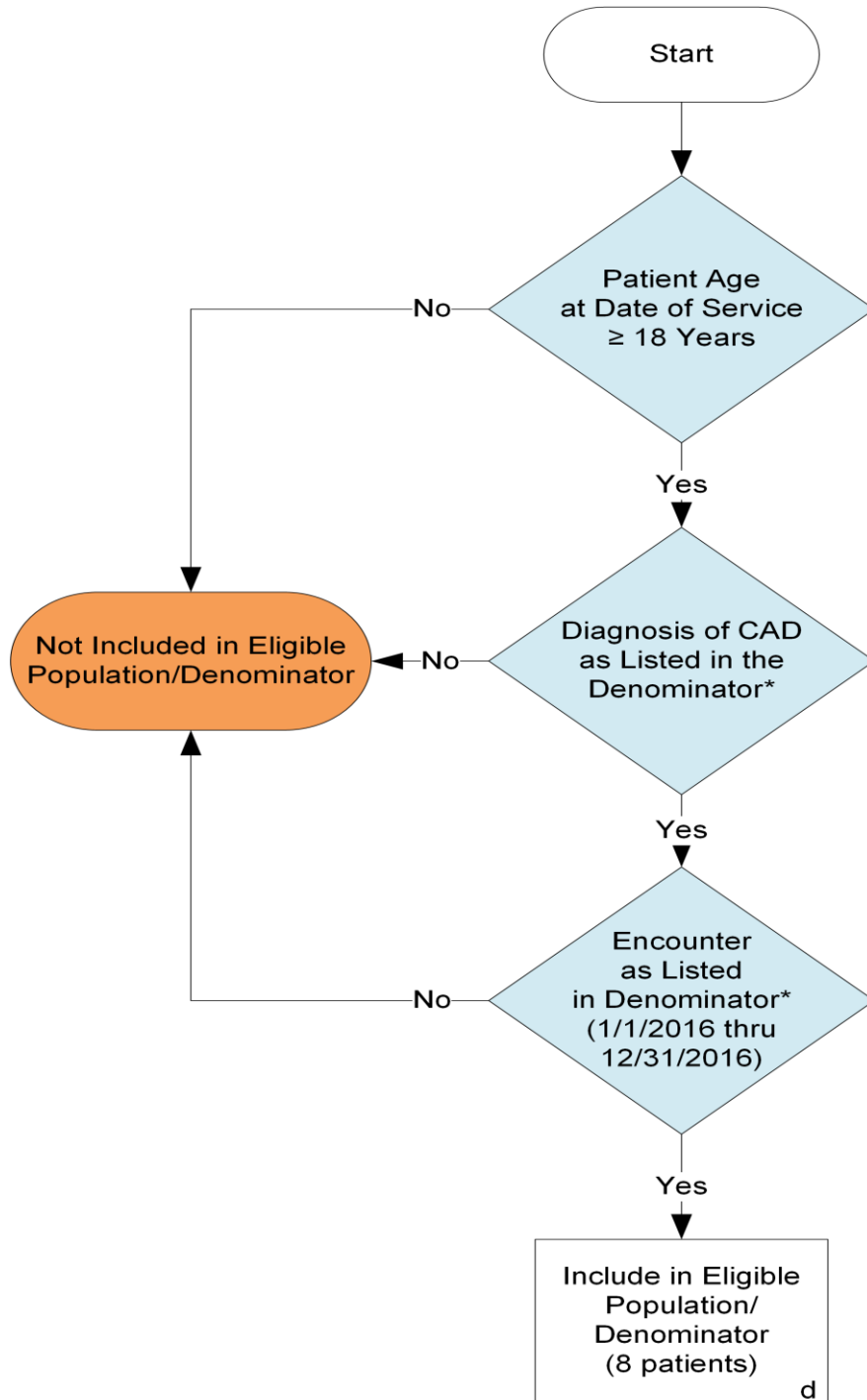
The Individual Measure Flows are designed to provide interpretation of the measure logic and calculation methodology for reporting and performance rates. The flows start with the identification of the patient population (denominator) for the applicable measure's quality action (numerator). When determining the denominator for all measures, please remember to include only Medicare Part B FFS patients and CPT I Categories without modifiers 80, 81, 82, AS or TC.

Below is an illustration of additional prerequisite denominator criteria to obtain the patient sample for all 2016 PQRS Individual Measures:

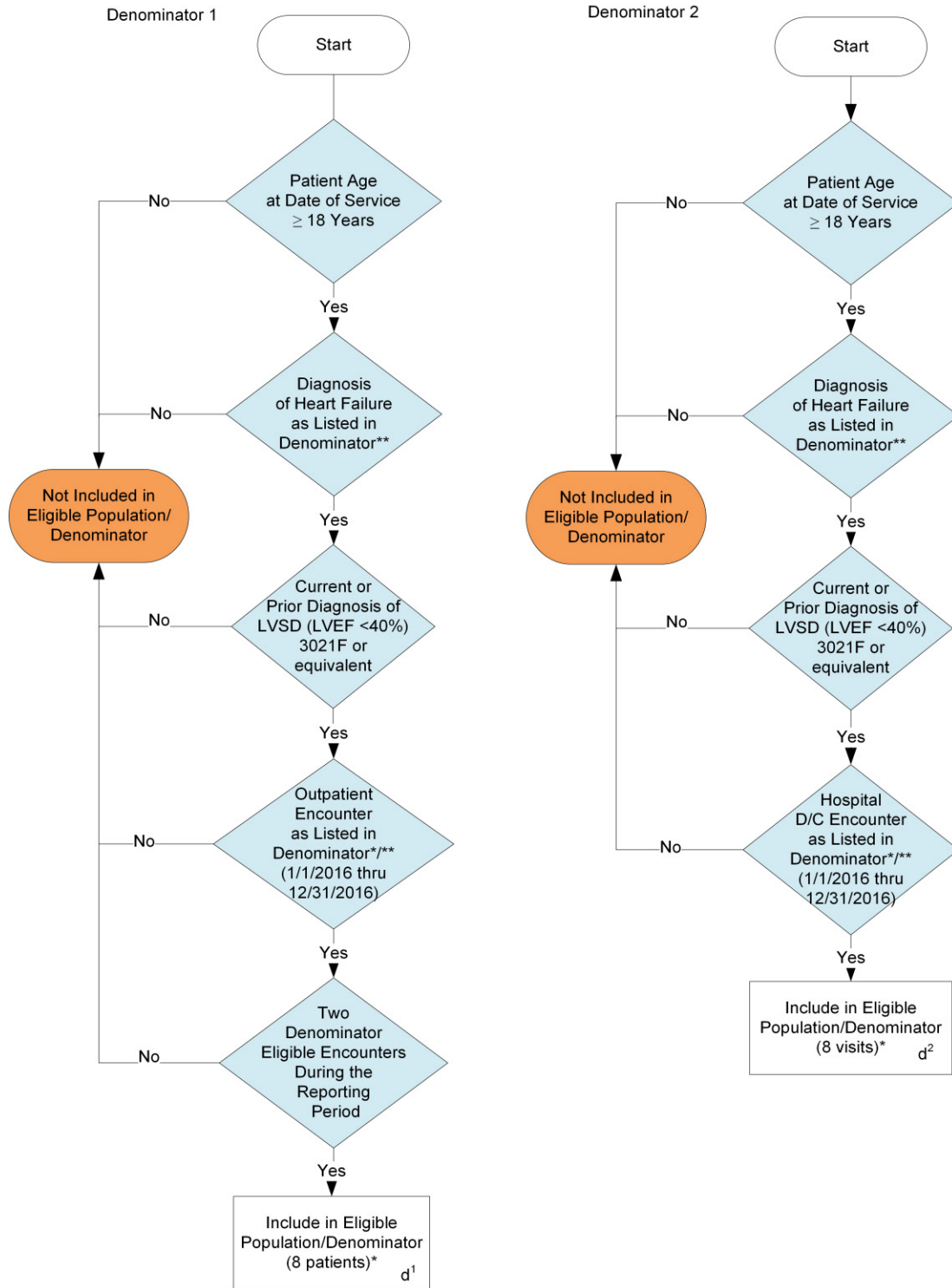


The Individual Measure Flows continue with the appropriate age group and denominator population for the measure. The Eligible Population box equates to the letter “d” by the patient population that meets the measures inclusion requirements. Below is an example of the denominator criteria used to determine the eligible population for PQRS #6 NQF # 0067: Coronary Artery Disease (CAD): Antiplatelet Therapy:

Denominator

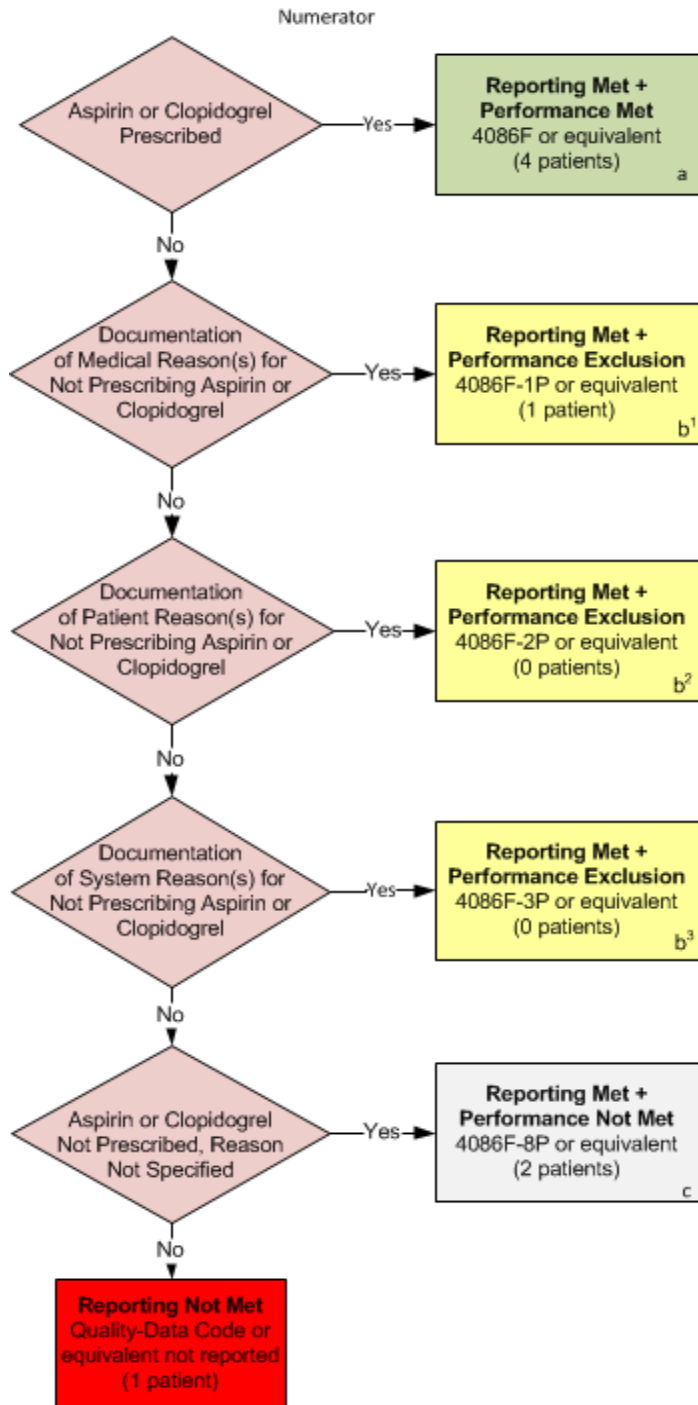


Some measures, such as Measure #5 Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD), have multiple options to determine the measure denominator. Patients meeting the criteria for either denominator option are included as part of the eligible population.



Numerator

Once the denominator is identified, the flow illustrates and stratifies the quality action (numerator) for reporting satisfactorily. Depending on the measure being reported, there are several outcomes that may be applicable for reporting the measures outcome: Performance Met = “a”/green, Performance Exclusion = “b”/yellow, Performance Not Met = “c”/gray, and Not Reported = red box. On the flow, these outcomes are color-coded and labeled to identify the particular outcome of the measure represented. This is illustrated below for PQRS #6 NQF # 0067: Coronary Artery Disease (CAD): Antiplatelet Therapy:



Denominator/Numerator Variation of Claims-Based vs. Registry-Based Reporting

For some measures reportable via claims and registry, two Individual Measure Flows may be included. The denominator for the registry-based Individual Measure Flow may differ slightly from the denominator as outlined in the 2016 PQRS Measure Specifications Manual for Claims and Registry Reporting of Individual Measures. Some measures, such as Measure #19, have a clarifying code and/or language (e.g. G-code G8397 for Measure #19) in the numerator to identify eligible patients when no CPT I or ICD-10 diagnosis code exists. In the case of Measure #19, an applicable CPT I code does not exist for Dilated macular or fundus exam performed, including documentation of the presence or absence of macular edema AND level of severity of retinopathy. In claims-based reporting, an eligible professional would report the numerator code G8397 to identify patients who had a dilated macular or fundus exam with documentation of the results. To comply with the measure developer's intent of the measures and since registries may not necessarily be reliant on claims data; the flow shows these numerator codes in the denominator. Therefore the numerator quality-data code options for registry-based flows may vary from the 2016 PQRS Measure Specifications Manual for Claims and Registry Reporting of Individual Measures.

Reporting and Performance Algorithms

Reporting Algorithm

The Reporting Algorithm is based on the eligible population and sample outcomes of the possible quality actions as described in the flow of the measure. Avoiding the 2018 PQRS Payment Adjustment is based on reporting satisfactorily for PQRS by reporting on at least 50% of the eligible patients for the measure. The Reporting Algorithm provides the calculation logic for patients who have been reported in the eligible professionals' appropriate denominator. Reporting satisfactorily may include the following categories provided in the numerator: Performance Met, Performance Exclusion, and Performance Not Met. Below is a sample reporting rate algorithm for Measure #6. In the example, 8 patients met the denominator criteria for eligibility, where 4 patients had the quality action performed (Performance Met), 1 patient did not receive the quality action for a documented reason (Performance Exclusion), and 2 patients were reported as not receiving the quality action (Performance Not Met). **Note:** In the example, 1 patient was eligible for the measure but was not reported (Reporting Not Met).

Reporting Rate=

$$\frac{\text{Performance Met (a=4 patients)} + \text{Performance Exclusion (b1+b2+b3=1 patients)} + \text{Performance Not Met (c=2 patients)}}{\text{Eligible Population / Denominator (d=8 patients)}} = \frac{7 \text{ patients}}{8 \text{ patients}} = 87.50\%$$

Performance Algorithm

The Performance Algorithm calculation is based on only those patients that were reported for the measure. For those patients reported, the numerator is determined by completing the quality action as indicated by Performance Met. Meeting the quality action for a patient, as indicated in the Individual Measure Specifications Manual, would add one patient to the denominator and one to the numerator. Patients reporting with Performance Exclusions are subtracted from the performance denominator when calculating the performance rate percentage. Below is a sample performance rate algorithm that represents this calculation for Measure #6. In this scenario, the patient sample equals 7 patients where 4 of these patients had the quality action performed (Performance Met) and one patient was reported as having a Performance Exclusion.

Performance Rate=

$$\frac{\text{Performance Met (a=4 patients)}}{\text{Reporting Numerator (7 patients) - Performance Exclusion (b1+b2+b3=1 patient)}} = \frac{4 \text{ patients}}{6 \text{ patients}} = 66.67\%$$

For measures with inverse performance rates, such as Measure #1 Diabetes: Hemoglobin A1c Poor Control, a lower rate indicates better performance. Reporting the Performance Not Met is actually the clinically recommended outcome or quality action.

There are some measures that require the calculation of multiple performance rates. The Individual Measure Flow for these measures includes algorithm examples to understand the different reporting and performance rates required for the measure. Please note, only the performance rates outlined in the measure specification are to be submitted

for registry submissions. The PQRS system will calculate an overall performance rate for the measure if none is specified within the measure.

Measure Analytical Reporting Frequency Definitions

Analytical reporting frequency labels are provided for each measure. The analytical reporting frequency defines the time period or event in which the measure should be reported. Below are definitions of the analytical reporting frequencies that are utilized for calculations of the individual measures:

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