January 2012

2012 Physician Quality Reporting System: Made Simple for Reporting the Preventive Care Measures Group Via Claims

Background

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

Purpose

This Fact Sheet provides guidance on satisfactorily reporting the Preventive Care Measures Group via claims for 2012 Physician Quality Reporting.

Is This Your Situation?

- You have not yet begun to participate in Physician Quality Reporting in 2012;
- You don't currently submit data to a registry; and
- You would like to participate in the Physician Quality Reporting in 2012 using claims.

Solution

- Report on the Preventive Care Measures Group using the 30 unique patient sample method or 50% Medicare Part B FFS patients between between January 1, 2012 and December 31, 2012

How to Start Using this Measures Group

- Select a start date to begin submitting quality data (e.g., January 1, 2012);
- Identify the next Medicare Part B PFS patient you will be seeing who is 50 years of age or older and for whom you will bill an evaluation and management (E/M) code of 99201-99205 or 99212-99215. No specific diagnosis is required for this measures group;
- Report the measures group specific intent G-code (G8486) with your first patient; and
- Refer to Table 1 below to see which measures apply to the patient based on age and gender.

Table 1: Preventive Measures Group Demographic Criteria

Age	Measures for Male Patients	Measures for Female Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 128, 173, 226	110, 112, 113, 128, 173, 226
65-69 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 112, 113, 128, 173, 226
70-75 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 113, 128, 173, 226
≥76 years	110, 111, 128, 173, 226	39, 48, 110, 111, 128, 173, 226

How to Report Using This Measures Group

- **When you identify your first patient, place intent G-code G8486 on the claim submitted for that patient. This signals CMS that you plan to submit the Preventive Care Measures Group.** Look at the Data Collection Worksheet (Appendix A) for a brief description of the measures in the Preventive Care Measures Group and the codes to report depending on the quality action or service you provide to the patient. The appropriate quality-data codes (QDCs) for the measures you are reporting for each patient will need to be included on the claim you submit for the patient during the 12-month reporting period. It is generally easier to report all of the applicable measures at one time on the same claim when the patient is seen. However, if a particular service has yet to be performed (e.g., a mammogram) you may report that measure at the time the patient returns post procedure if that patient is seen again prior to the end of the reporting period (December 31, 2011). If all quality actions for the patient have been performed for the group, the composite G-code G8496 (i.e., all quality actions for the applicable measures in the Preventive Care Measures Group have been performed for this patient) may be reported in lieu of the individual QDCs for each of the measures within the group.
- Check the Measures Codes section of the Physician Quality Reporting web page for the full measures groups specifications at http://www.cms.gov/PQRS on the CMS website.

Select Sample Method:

- **30 Patient Sample Method:** This method uses 30 unique Medicare Part B FFS (fee for service) patients meeting patient sample criteria for the measures group. Note: the 30 patients do not have to be seen on consecutive dates.)
    - Use the *Worksheet to Track Unique Medicare Part B FFS Patients for Reporting Preventive Care Measures Group* to track each of your 30 unique patients (note: you may want to collect more than 30 as a safeguard). You can list the measures which still need to be reported to help guide you during the patient's next visit. This is a suggested informal worksheet intended for your office's internal use only and should ***not*** be sent to CMS or your Medicare Carrier or A/B Medicare Administrative Contractor (MAC).

OR

- **50% Patient Sample Method via Claims:** This method uses all patients meeting patient sample criteria for the measures group during the entire reporting period (January 1 through December 31, 2012). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactory.
    - **All applicable measures within the group must be reported** using the appropriate QDCs on the claim you submit for each Medicare Part B PFS patient. To assist with tracking, consider photocopying the **Data Collection Worksheet** (*Appendix A*). Highlight or circle the appropriate measures and measures codes (QDCs) you need to submit for that patient's visit and staple the worksheet to your encounter form. Your clinical support staff can use this information to report the appropriate measures codes on the patient's claim. Your system may also help you select those patients eligible for this measure by identifying the appropriate ICD-9 and CPT codes for each measure.

Appendix A: Data Collection Worksheet

Data Collection Worksheet: Physician Quality Reporting System Preventive Care Measures Group Measures in the Preventive Care Measures Group (G8486) and the Quality-Data Codes to be Reported on Patient Claim Depending on Action/Service Performed			
Patient Name:	**Date of Service:**	**Physician:**	
Measure number and title*	**Action performed**	**Action not performed / Reason documented**	**Action not performed / Reason not documented**
39: Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older	**G8399** DXA ordered, documented or patient on Rx treatment	**G8401** Central DXA measurement not ordered or performed or pharmacologic therapy not prescribed for documented reasons	**G8400** DXA not ordered, no Rx treatment, reason not specified
48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	**1090F** Incontinence assessed within past 12 months	**1090F-1P** Medical reason for not assessing incontinence	**1090F-8P** Presence or absence of urinary incontinence not assessed, reason not specified
110: Preventive Care and Screening: Influenza Immunization	**G8482** Influenza immunization ordered or administered	**G8483** Influenza immunization not administered for documented reasons **OR** **G0919** Influenza immunization ordered or recommended, but not administered	**G8484** Influenza immunization not administered, reason not specified
111: **Preventive Care and Screening: Pneumonia Vaccination for Patients 65 or older**	**4040F** Pneumococcal vaccine administered or previously received	**4040F-1P** Pneumococcal vaccine not administered or previously received for medical reasons	**4040F-8P** Pneumococcal vaccine not administered or previously received, reason not specified
112: **Preventive Care and Screening: Screening Mammography**	**3014F** Screening mammography results documented and reviewed	**3014F-1P** Mammogram not performed for medical reasons; Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies)	**3014F-8P** Screening mammography results were not documented and reviewed, reason not specified
113: **Preventive Care and Screening: Colorectal Cancer Screening**	**3017F** Colorectal cancer screening results documented and reviewed	**3017F-1P** Colorectal cancer screening not performed for medical reasons	**3017F-8P** Colorectal cancer screening results not documented and reviewed, reason not specified

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

Worksheet to Track Unique Medicare Part B PFS Patients for Reporting Preventive Care Measures Group				
Unique Patient #	**Date of Service**	**Patient Identifier**	**All Applicable Measures Submitted for this Patient?**	**Measure Numbers that still need to be submitted for this Patient (if any)**
Example A	02/15/2012	MS	No	112
Example B	02/16/2012	PF	Yes	None
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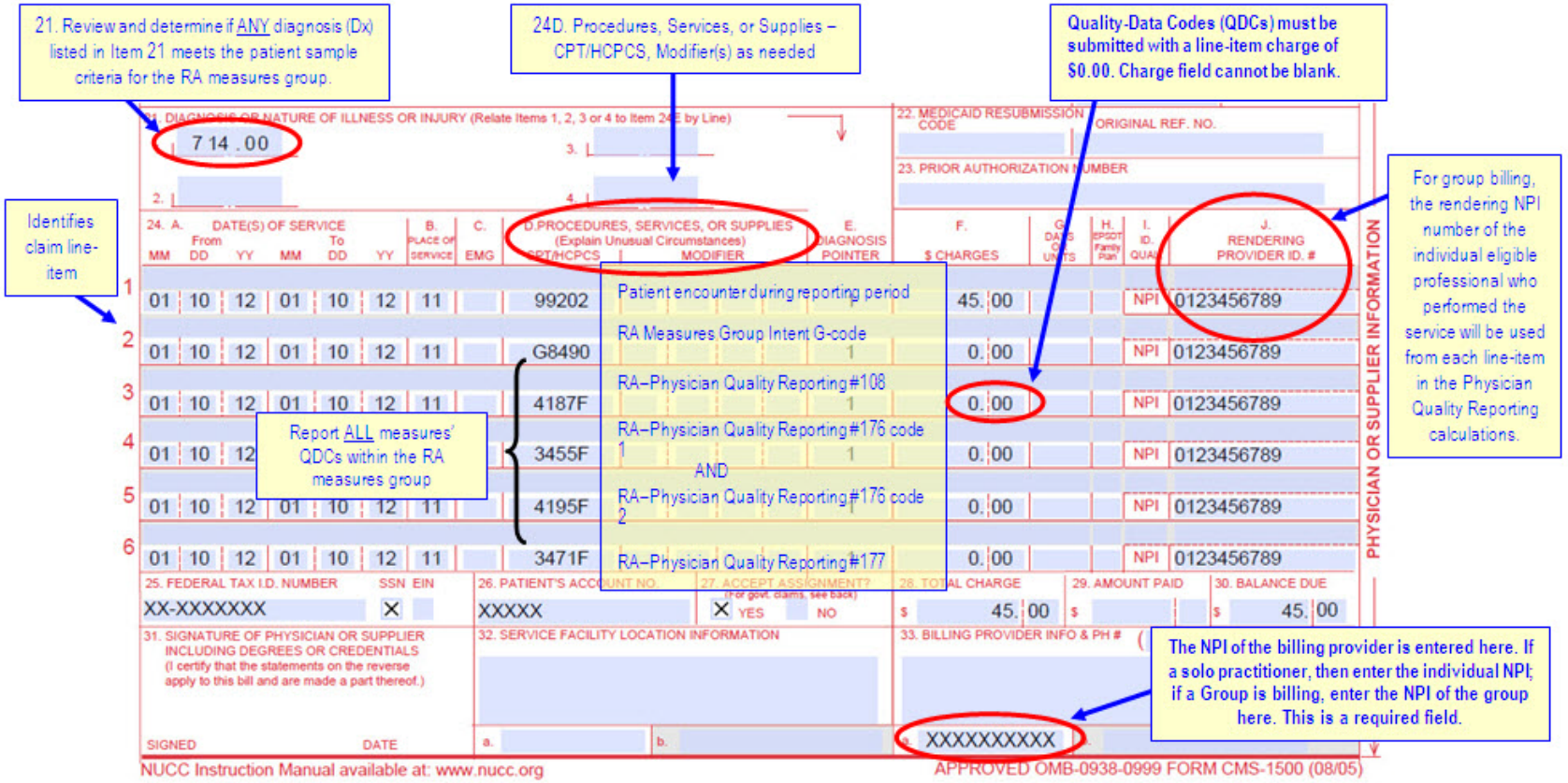
CMS-1500 Claim [Detailed Measures Group] – Sample 1 (continues on next page)

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



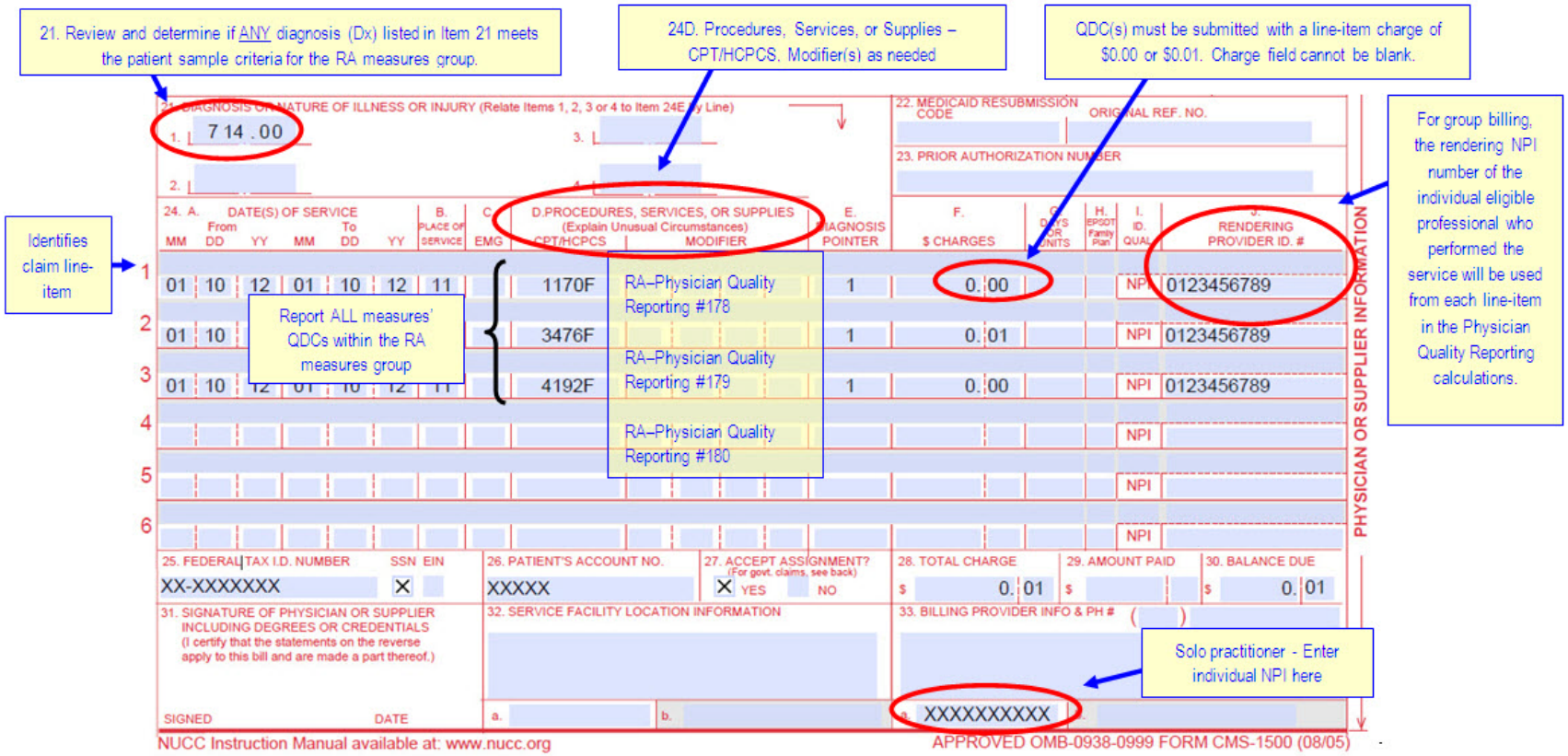
The patient was seen for an **office visit (99202)**. The provider reports **all measures (#108, #176, #177, #178, #179, and #180) in the RA Measures Group:**

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

RA Measures Group Sample 1 continues on the next page.

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

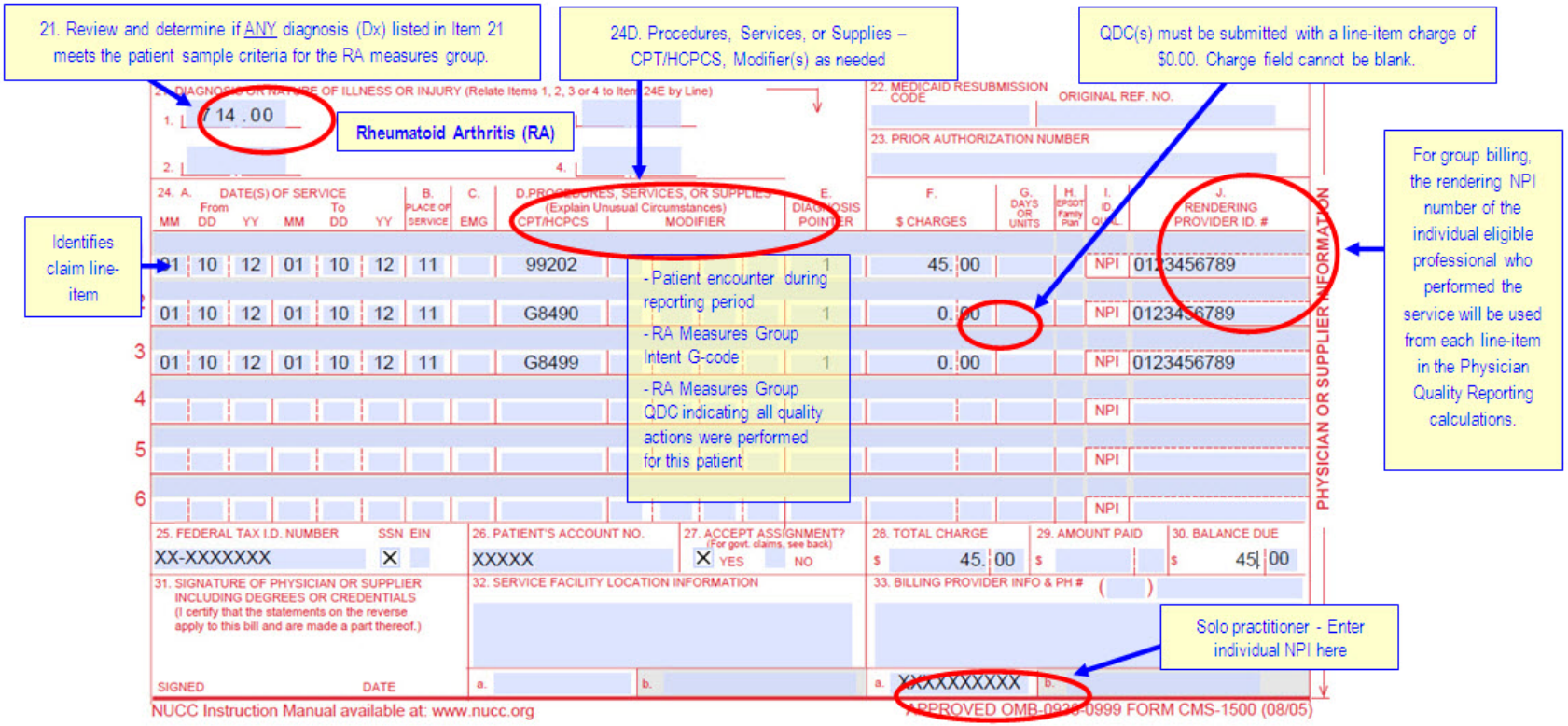
If billing software limits the line items on a claim, you may add a nominal amount such as a penny to one of the QDC line items on that second claim for a total charge of $0.01.



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

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

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



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

- Intent **G-code (G8490)** was submitted to initiate the eligible professional's submission of the RA Measures Group.
- Measures Group **QDC Composite G-code G8499** (indicating all quality actions related to the RA Measures Group were performed for this patient) + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21)**. The composite G-code G8499 may not be used if performance modifiers (1P, 2P, 3P, or G-code equivalent) or the 8P reporting modifier apply.
- **Note:** All diagnoses listed in **Item 21** will be used for Physician Quality Reporting 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.