Open Door Forum:
The 2009 Physician Quality Reporting Initiative (PQRI)

Frame 1
Title – Open Door Forum: The 2009 Physician Quality Reporting Initiative (PQRI)
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Frame 2
Title – Disclaimers

Text – This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare and Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

Frame 3
Title – Overview

Text – The following text displays as seven vertical bullets:

First bullet = Value-Based Purchasing and PQRI

Second bullet = PQRI Introduction
Third bullet = 2009 PQRI

Fourth bullet = PQRI Reporting: Measures and Codes

Fifth bullet = Implementing PQRI

Sixth bullet = Resources

Frame 4
Title – Value-Based Purchasing and PQRI

Text – This frame contains text that is separated into three bulleted sections as follows:
First bullet = Key mechanism for transforming Medicare from passive payer to active purchaser.
Sub-bullet = Current Medicare Physician Fee Schedule (PFS) is based on quantity and resources consumed, NOT quality or value of services.

Second bullet = Value = Quality / Cost
Sub-bullet = Incentives can encourage higher quality and avoidance of unnecessary costs to enhance the value of care.

Third bullet = 12/9/08 VBP Issues Paper: Development of a Plan to Transition to Medicare Value-Based Purchasing for Physician and Other Health Professional Services

Centered at the bottom of the frame is the following Web address:
http://www.cms.hhs.gov/center/physician.asp

Frame 5
Title – Legislative Background

Text – The text on this frame is separated into two sections.

Section 1 – TRHCA – Tax Relief and Health Care Act, 2006
Bullet = Established 2007 PQRI, 7/1 through 12/31/07, authorized 1.5 percent incentive subject to a cap, claims-based reporting by eligible professionals (EPs) of up to 3 individual applicable measures for 80 percent of eligible cases

Section 2 – MMSEA - Medicare, Medicaid, and SCHIP Extension Act of 2007

First bullet = Authorized 2008 PQRI, 1.5 percent incentive, eliminated incentive cap

Second bullet = Required alternative reporting periods and alternative reporting criteria for 2008 and 2009
Note: “Alternative reporting criteria” is bolded.
Sub-bullet = Requires alternative reporting for measures groups and for registry-based reporting

Frame 6
Title – Legislative Background (continued)

Text –This frame highlights Sections 131 and 132 of the MIPPA - Medicare Improvements for Patients and Providers Act and displays the following text:

Section 131: 2009 PQRI

First bullet = Authorized raising 2009 PQRI incentive to 2 percent, adds qualified audiologists as EPs, no effect on 2007 or 2008 incentive payments
Note: The “2009” text is bolded.

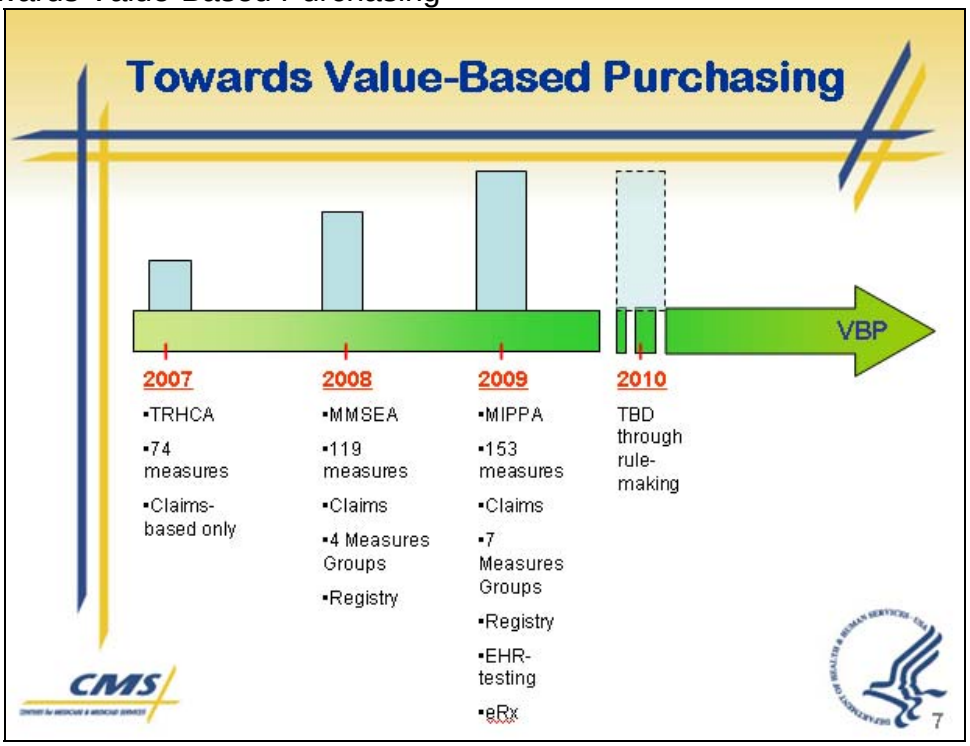
Second bullet = Requires CMS to post on our web site names of EPs who satisfactorily report quality measures for 2009 PQRI

Third bullet = Requires CMS to test EHR submission of quality measures for PQRI

Fourth bullet = 131(d) requires the Secretary of the Department of Health and Human Services to develop a plan to transition to a value-based purchasing program for Medicare payment for physician and other professional services. Report due to Congress May 1, 2010.
Note: The “131(d)” text is bolded.

Section 132: E-Prescribing Incentive Program
First bullet = Authorized separate 2 percent incentive payment to EPs who are successful e-prescribers

Frame 7
Title – Towards Value-Based Purchasing



Graphic – This frame displays a broad, green arrow originating at the left side of the frame and extending to the right side of the frame with the arrowhead on the right side. The arrow represents a continuum over time for the years 2007, 2008, 2009, and 2010. The green arrow is solid until it extends to 2010. At this point, there are three brief breaks in the arrow and then the arrow continues in a solid line to the arrowhead at the far right. The only text in the arrow is located in the arrowhead, which displays VBP (acronym for Value-Based Purchasing). Each year mark on the VBP arrow is labeled by year in red text and has a corresponding turquoise bar that extends upward vertically from the green horizontal VBP arrow. The heights of each vertical bar vary in height, increasing each year between 2007 (which is the shortest) and 2009. The vertical bars for these years are solid turquoise and bordered by solid black lines. For 2010, the height of the turquoise bar is the same as the one for 2009; however, the turquoise bar for 2010 contains some white dot shading and is bordered by a broken black line.

Text –
The 2007 bar has three bullets located vertically under the VBP continuum arrow.

First bullet = TRHCA (acronym for Tax Relief and Health Care Act)

Second bullet = 74 measures

Third bullet = Claims-based only.

The 2008 bar has five bullets located vertically under the VBP continuum arrow.

First bullet = MMSEA (acronym for Medicare, Medicaid, and SCHIP Extension Act of 2007)

Second bullet = 119 measures

Third bullet = Claims

Fourth bullet = 4 Measures Groups

Fifth bullet = Registry.

The 2009 bar has seven bullets located vertically under the VBP continuum arrow.

First bullet = MIPPAA (acronym for Medicare Improvements for Patients and Provider Act)

Second bullet = 153 measures

Third bullet = Claims

Fourth bullet = 7 Measures Groups

Fifth bullet = Registry

Sixth bullet = EHR-testing (acronym for electronic health record)

Seventh bullet = eRx (acronym for electronic prescription).

The 2010 bar has no bullets located vertically under the VBP continuum arrow, but the following text displays: TBD (acronym for To Be Determined) through rule-making.

This image contains the colored CMS logo and the HHS logo.

Frame 8
Title – Focus on Quality and Improvement

Text – This frame focuses on two things: 1) PQRI reporting focuses attention on quality of care (with four bullet points), and 2) Measures address various aspects of quality care (with six bullet points)

PQRI reporting focuses attention on quality of care

First bullet = Foundation is evidence-based measures developed by professionals.

Second bullet = Reporting data for quality measurement is rewarded with financial incentive.

Third bullet = Measurement enables improvements in care.

Fourth bullet = Reporting is the first step toward pay-for-performance.

Measures address various aspects of quality care

First bullet = Prevention

Second bullet = Chronic Care Management

Third bullet = Acute Episode of Care Management

Fourth bullet = Procedural Related Care

Fifth bullet = Resource Utilization

Sixth bullet = Care Coordination

Frame 9
Title – 2009 PQRI: Eligible Professionals

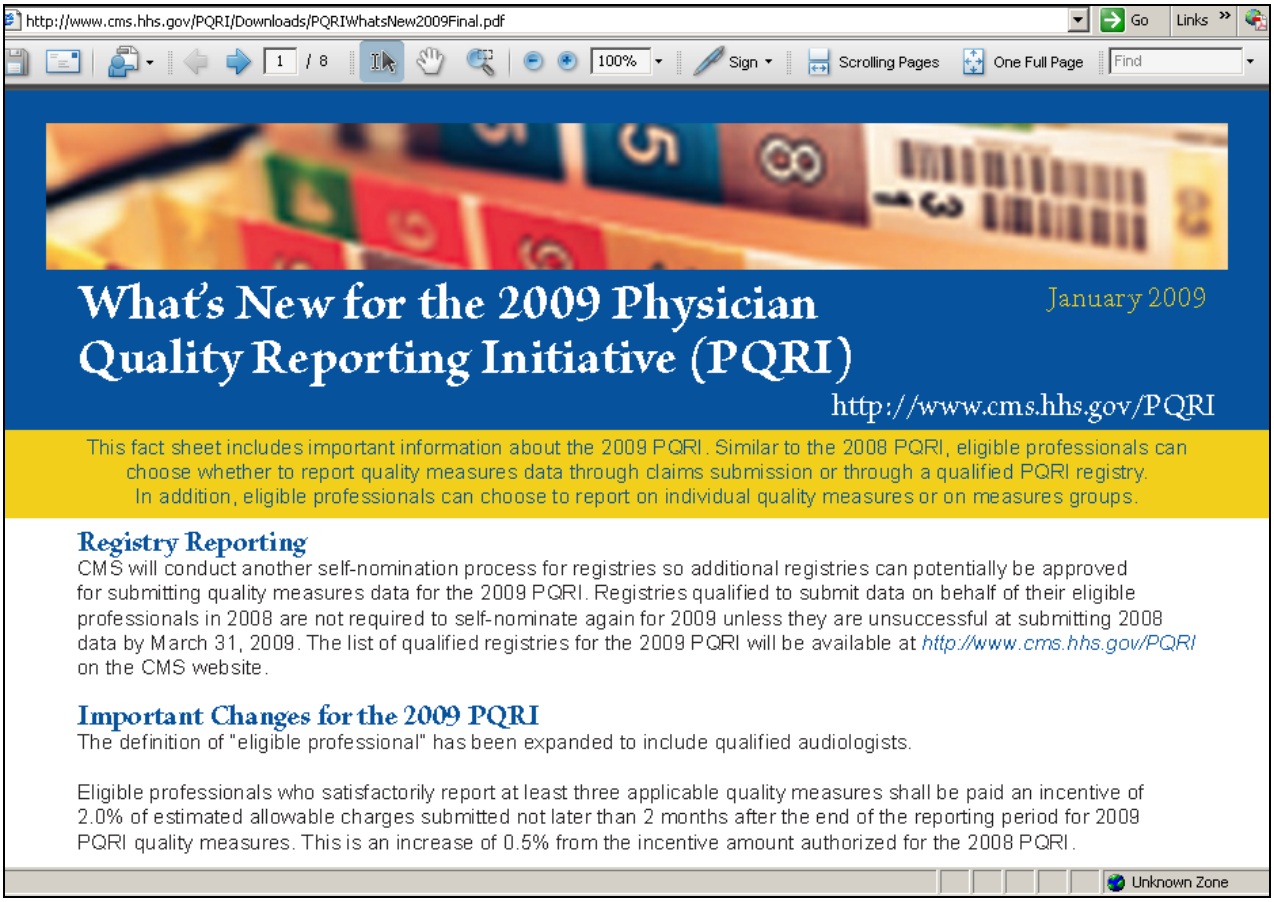
Text: This frame displays lists of eligible professionals in two columns. Column one contains physicians and therapists. Column two contains practitioners.

The following seven professionals are listed as sub-bullets under Physicians: MD/DO, Podiatrist, Optometrist, Oral Surgeon, Dentist, Chiropractor

The following three professionals are listed as sub-bullets under Therapists: Physical Therapist, Occupational Therapist, Qualified Speech-Language Pathologist

The following 12 professionals are listed as sub-bullets under Practitioners: Physician Assistant, Nurse Practitioner, Clinical Nurse, Specialist, Certified Registered Nurse, Anesthetist, Certified Nurse Midwife, Clinical Social Worker, Clinical Psychologist, Registered Dietician, Nutrition Professional, Audiologist

Frame 10
Title – Summary of Changes for 2009 PQRI



Graphic – This frame displays the top portion of a screen print from http://www.cms.hhs.gov/PQRI/Downloads/PQRIWhatsNew2009Final.pdf
The text on the screen print that displays is:

January 2009

Page title – What's New for the 2009 Physician Quality Reporting Initiative (PQRI)

http://www.cms.hhs.gov/PQRI

This fact sheet includes important information about the 2009 PQRI. Similar to the 2008 PQRI, eligible professionals can choose whether to report quality measures data through claims submission or through a qualified PQRI registry. In addition eligible professionals can choose to report on individual quality measures or on measures groups.

Section title – Registry Reporting
CMS will conduct another self-nomination process for registries so additional registries can potentially be approved for submitting quality measure data for the 2009 PQRI. Registries qualified to submit data on behalf of their eligible professionals in 2008 are not required to self-nominate again for 2009 unless they are unsuccessful at submitting 2008 data by March 31, 2009. The list of qualified registries for the 2009 PQRI will be available at http://www.cms.hhs.gov/PQRI on the CMS website.

Section title – Important Changes for the 2009 PQRI
The definition of "eligible professional" has been expanded to include qualified audiologists.

Eligible professionals who satisfactorily report at least three applicable quality measures shall be paid an incentive of 2.0 percent of estimated allowable charges submitted not later than 2 months after the end of the reporting period for 2009 PQRI quality measures. This is an increase o 0.5 percent from the incentive amount authorized for the 2008 PQRI.

Frame 11
Title - 2009 PQRI Quality Measures

Text – This frame is formatted with one main bullet and four sub-bullets as follows:

Main bullet = 153 PQRI quality measures for 2009
First sub-bullet = Includes 101 measures from the 2008 PQRI and 52 new measures
Second sub-bullet = E-prescribing measure (Measure #125) removed, as required by MIPPA as a separate incentive program
Third sub-bullet = 18 measures reportable only through registries
Fourth sub-bullet = Measure specifications are available in the Measures/Codes section of the website at http://www.cms.hhs.gov/pqri.

Frame 12
Title – 2009 PQRI Measures Groups

Text – This frame is formatted with two main bullets and sub-bullets as follows:

First main bullet = 7 measures groups:
First sub-bullet = Diabetes Mellitus
Second sub-bullet = Chronic Kidney Disease

Third sub-bullet = Preventive Care
Fourth sub-bullet = Coronary Artery Bypass Graft (CABG) (new-registry only)
Note: The “new registry only” text is formatted in red.
Fifth sub-bullet = Rheumatoid Arthritis (new)
Note: The “new” text is formatted in red.
Sixth sub-bullet = Perioperative Care (new)
Note: The “new” text is formatted in red.
Seventh sub-bullet = Back Pain* (new)
Notes: The “back pain” text is followed by an asterisk, which is noted beneath the sub-bullet as indicating that “Measures in this measures groups are reportable only as a measures group, not as individual measures.” The “new” text is formatted in red.

Second main bullet = ESRD measures group removed for 2009

Frame 13
Title – 2009 PQRI Reporting Periods

Text – This frame is formatted with two main bullets and sub-bullets as follows:
First main bullet = 1 reporting period for claims-based reporting of individual measures: January 1, 2009 through December 31, 2009
Note: The “January 1, 2009 through December 31, 2009” text is underlined.

Second main bullet = 2 reporting periods for reporting measures groups and registry-based reporting:
First sub-bullet = January 1, 2009 through December 31, 2009
Second sub-bullet = July 1, 2009 through December 31, 2009

Frame 14
Title – 2009 PQRI Satisfactory Reporting Options

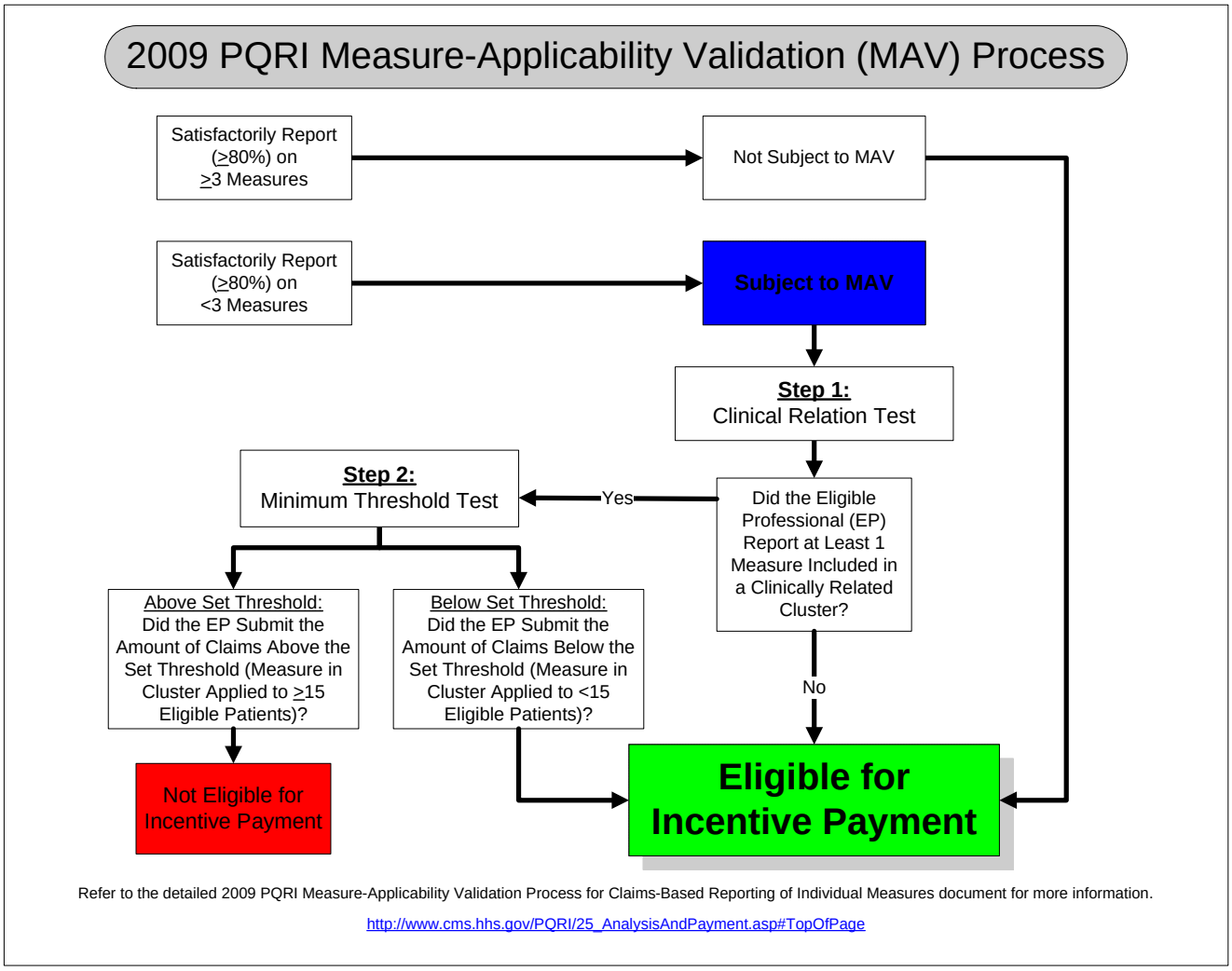
Text – This frame is formatted with one main point, two bullets, and one asterisk statement

Criteria for claims-based submission of individual measures (1 option):

First bullet = Reporting period: January 1, 2009 through December 31, 2009

Second bullet = greater than or equal to 3 PQRI measures or 1 to 2 measures if less than 3 apply*
Note: The second bullet is followed by a red asterisk, which is noted in red at the bottom of the frame as indicating that “If less than 3 measures reported, EP is subject to measure-applicability validation (MAV).”
Third bullet = greater than or equal to 80 percent of applicable Medicare Part B FFS patient claims for 1 to 3 measures

Frame 15
Title – Measure-Applicability Validation
Graphic –



The 2009 PQRI Measure-Applicability Validation (MAV) Process flowchart displays the MAV processes for Eligible Professionals (EPs) who: 1) satisfactorily report (greater than or equal to 80 percent) on greater than or equal to three measures, and 2) satisfactorily report (greater than or equal to 80 percent) on less than three measures.

The MAV process for EPs who satisfactorily report (greater than or equal to 80 percent) on greater than or equal to three measures is displayed in a total of three text boxes as follows:

Text box 1 Satisfactorily Report (greater than or equal to 80 percent) on greater than or equal to three Measures

Text box 2 Not Subject to MAV
Text box 3 Eligible for Incentive Payment

The MAV process for EPs who satisfactorily report (greater than or equal to 80 percent) on less than three measures is displayed in a total of nine text boxes as follows:

Text box 1 Satisfactorily Report (greater than or equal to 80 percent) on less than three Measures

Text box 2 Subject to MAV

Text box 3 Step 1: Clinical Relation Test

Text box 4 Did the Eligible Professional (EP) Report at Least 1 Measure Included in Clinically Related Cluster? Based on the answer to this question, the MAV process follows one of two paths.

Path A – If the answer to the question in Text box 4 is *No*, the MAV process is complete and Text box 5 applies.

Text box 5 Eligible for Incentive Payment

Path B – If the answer to the question in Text box 4 is *Yes*, the MAV process moves to Text box 6.

Text box 6 Step 2: Minimum Threshold Test. From here, the MAV process follows one of two paths.

Path A – If the EP submitted an amount of claims below the set threshold, Text box 7 applies.

Text box 7 Below Set Threshold: Did the EP Submit the Amount of Claims Below the Set Threshold (Measure in Cluster Applied to less than 15 Eligible Patients)? If the answer to this question is *Yes*, the MAV process is complete and Text box 5 once again applies (i.e., Eligible for Incentive Payment).

Path B – If the EP submitted an amount of claims above the set threshold, Text box 8 applies.

Text box 8 Above Set Threshold: Did the EP Submit the Amount of Claims Above the Set Threshold (Measure in Cluster Applied to greater than or equal to 15 Eligible Patients)? If the answer to this question is *Yes*, the MAV process is complete and Text box 9 applies.

Text box 9 Not Eligible for Incentive Payment

Refer to the detailed *2009 PQRI Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures* document for more information at http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage.

Frame 16
Title – 2009 PQRI Satisfactory Reporting Options

Text – Criteria for measures groups (6 options: 3 for claims-based submission addressed on this frame and for registry-based reporting addressed on Frame 17):
Claims-based submission:

First bullet = Reporting period: January 1, 2009 through December 31, 2009
First sub-bullet = 30 consecutive patients for 1 measures group
OR (Note: The "OR" text is bolded)
Second sub-bullet = greater than or equal to 80 percent of applicable Medicare Part B FFS patient claims for 1 measures group, with a minimum of 30 applicable patients

Second bullet = Reporting period: July 1, 2009 through December 31, 2009
First sub-bullet = greater than or equal to 80 percent of applicable Medicare Part B FFS patient claims for 1 measures group, with a minimum of 15 applicable patients

Third bullet = Criteria for claims-based submission of measures groups identical to criteria for registry-based reporting of measures groups except only Medicare Part B FFS patients can be included in consecutive patient sample for claims-based submission of measures groups

Frame 17
Title – 2009 PQRI Satisfactory Reporting Options (continued)

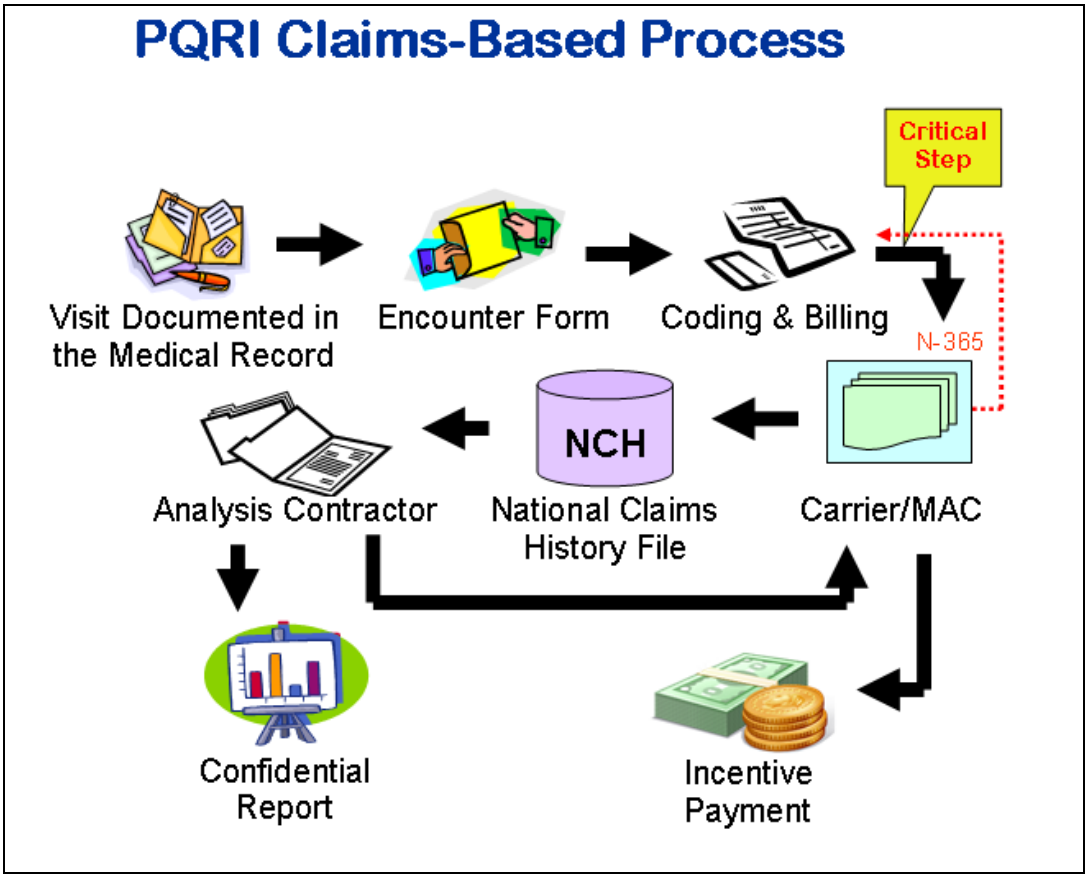
Text – Criteria for registry-based reporting of individual measures (2 options):

First bullet = Reporting period: January 1, 2009 through December 31, 2009
First sub-bullet = greater than or equal to 3 PQRI measures
Second sub-bullet = greater than or equal to 80 percent of applicable Medicare Part B FFS patients for greater than or equal to 3 measures

Second bullet = Reporting period: July 1, 2009 through December 31, 2009
First sub-bullet = greater than or equal to 3 PQRI measures
Second sub-bullet = greater than or equal to 80 percent of applicable Medicare Part B FFS patients for greater than or equal to 3 measures

Frame 18
Title – PQRI Claims-Based Process

Graphic – Using a series of graphics, text, and arrows, this frame displays the PQRI process.



Located in the upper left corner of the frame is the first graphic.
Graphic 1 – Folders with papers, clips, and a writing utensil
Label for Graphic 1 – Visit Documented in the Medical Record

A black arrow leads from the first graphic to the second graphic, which is located to the right of Graphic 1.
Graphic 2 – one hand transferring a folder/envelope to another person's hand
Label for Graphic 2 – Encounter Form

A black arrow leads from the second graphic to the third graphic, which is located to the right of Graphic 2.
Graphic 3 – an unfolded statement with an envelope in the background
Label for Graphic 3 – Coding and Billing

A black arrow leads from the third graphic to the fourth graphic, which is located to the right of and below Graphic 3. A text box pointing at this arrow displays the following red text: Critical Step.
Graphic 4 – three pages
Label for Graphic 4 – Carrier/MAC N-365
Three arrows flow from this graphic: one is a red dotted line arrow that points back to Graphic 3; the second is a solid black arrow that leads from Graphic 4 to Graphic 5 (a lavender cylinder labeled National Claims History File), which is located to the left of Graphic 4; the third is a solid black arrow that leads from Graphic 4 to a money graphic

labeled Incentive Payment. The Incentive Payment graphic is the first of two final process outcomes and is located in the bottom right corner of the frame.

A black arrow leads from the fifth graphic to the sixth graphic, which is located to the left of Graphic 5.
Graphic 6 – open folder with report pages
Label for Graphic 6 – Analysis Contractor
Two arrows flow from this graphic: one is a solid black arrow that leads from Graphic 6 to Graphic 7 (an easel displaying a bar graph labeled Confidential Report) which is located below Graphic 6. Confidential Report is the second of two final process outcomes and is located in the lower left corner of the frame.
The second arrow is a solid black arrow that leads from Graphic 6 back to Graphic 4 (Carrier/MAC) and then to the Incentive Payment money graphic.

Frame 19
Title – 2009 PQRI Measures Resources

Text – This frame displays the following Web address - http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage - and displays corresponding text formatted in bullets and sub-bullets as follows:

First bullet = List of 153 2009 PQRI Measures – measure developer, reporting method

Second bullet = Reporting Individual Measures via Claims
First sub-bullet = 2009 PQRI Measures Specifications Manual for Claims and Registry and Release Notes
Second sub-bullet = 2009 PQRI Implementation Guide

Third bullet = Reporting Measures Groups via Claims
First sub-bullet = 2009 PQRI Measures Groups Specifications Manual and Release Notes
Second sub-bullet = Getting Started with 2009 PQRI Reporting of Measures Groups
Third sub-bullet = Measures Group Sample Claim

Frame 20
Title – 2009 PQRI Measures Resources

Text – This frame displays two Web address with corresponding text formatted in bullets and sub-bullets as follows:

First Web address = http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage
First bullet = Registry-based Reporting
First sub-bullet = Individual Measures
Second sub-bullet = Measures Groups

Second bullet = List of Qualified Registries

Second Web address =
http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage
First bullet = MLN Matters Articles

Second bullet = Fact Sheets

Third bullet = Tip Sheets

Fourth bullet = 2009 PQRI Patient-Level Measures List

Frame 21
Title – Claims-Based Reporting Principles

Text – This frame displays text formatted in bullets and sub-bullets as follows:

First bullet = The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
First sub-bullet = on the same claim
Second sub-bullet = for the same beneficiary
Third sub-bullet = for the same date of service (DOS)
Fourth sub-bullet = for the same EP (NPI within the holder of the tax ID number - NPI/TIN)

Second bullet = All diagnoses reported on the base claim will be included in PQRI analysis.

Third bullet = Claims may NOT be resubmitted simply to add or correct QDCs.
Note: The “NOT” text is capitalized and bolded.

Fourth bullet = QDCs must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed. If a system does not allow a $0.00 line-item charge, a nominal amount can be substituted.

Fifth bullet = The submitted charge field cannot be blank.

Frame 22
Title – Claims-Based Reporting Principles (continued)

Text – This frame displays bulleted text as follows:
First bullet = Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00 zero dollars.)
Note: The “Total” text is underlined.

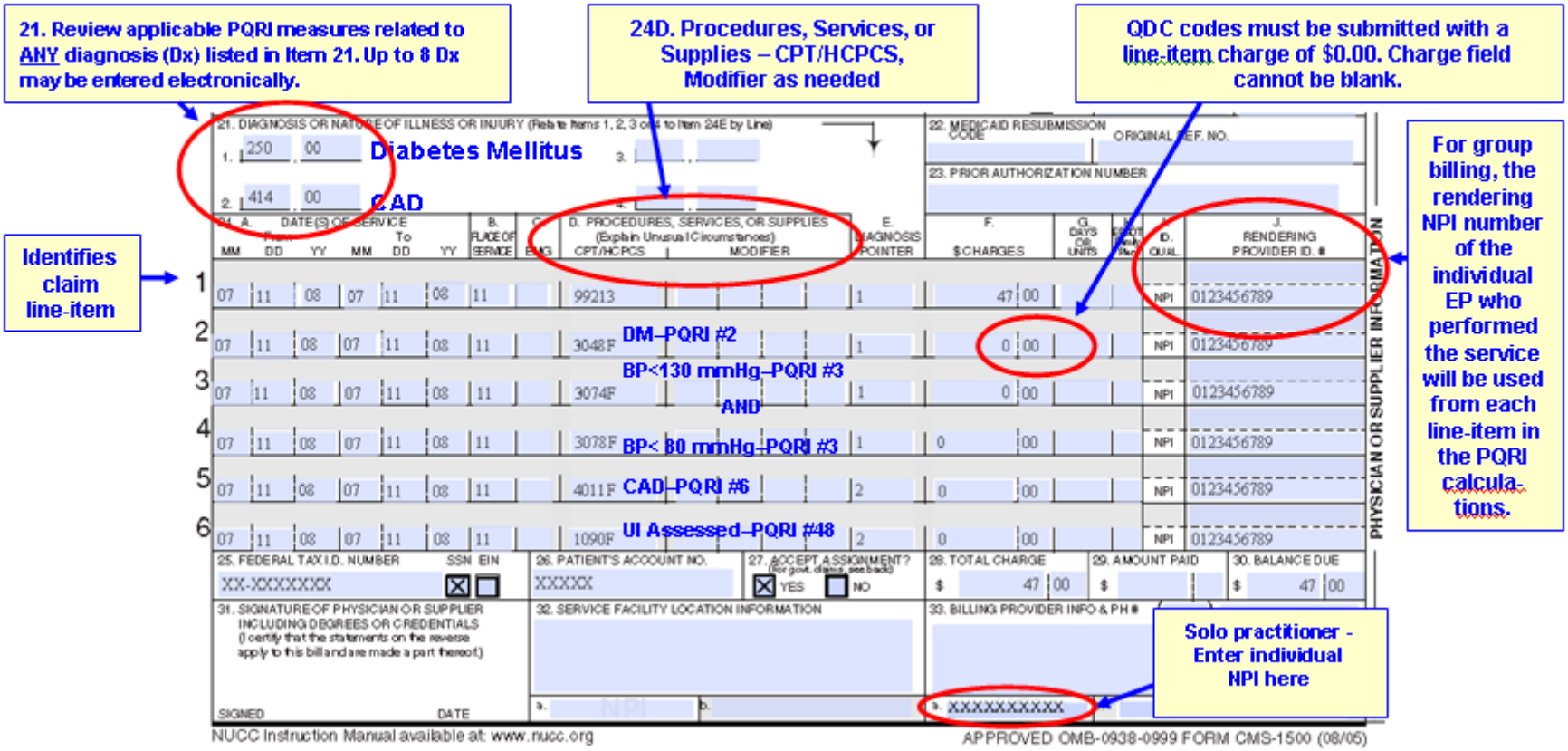
Second bullet = QDC line items will be denied for payment by the carrier, but are then passed through the claims processing system for PQRI analysis. EPs will receive a Remittance Advice (RA) associated with the claim which contains the PQRI QDC line-item and will include a standard remark code (N365) 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.
Note: The “Remittance Advice”, “N365”, and “NOT” text is bolded in the second bullet.

Frame 23
Title – CMS-1500 Claim Example

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.



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. This includes putting the individual NPI on the QDC line-items as well.
- The Tax ID associated with the NPI(s) on this claim is shown in **Item 25.**

Text – Description of CMS-1500 Claim Example
This frame displays an example of an individual NPI reporting on a single CMS-1500 claim, items 21 through 33. See http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf for more information. Some item fields contain sample data and associated text box comments. Item numbers and titles, sample data, and corresponding notes are displayed as follows:

Item – 21. Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, or 4 to Item 24E by Line)
Sample data – 1 displays 250.0 for Diabetes Mellitus. 2 displays 414.00 for CAD. 3 and 4 contain no sample data.
Text box note – Review applicable PQRI measures related to ANY diagnosis (DX) listed in Item 21. Up to 8 Dx may be entered electronically.
Note: The “ANY” text is underlined and capitalized.

Item – 22. Medicaid Resubmission Code / Original Ref. No.
Sample data – None
Note – None

Item – 23. Prior Authorization Number
Sample data – None
Note – None

Item – 24.A. Date(s) of Service, From MM/DD/YY, To MM/DD/YY
Sample data – All dates displayed for Lines 1 through 6 are 07/11/08
Note – Vertical numerals 1 through 6 identify claim line-items containing the sample data “From MM/DD/YY” and “To MM/DD/YY” dates.

Item – 24.B. Place of Service
Sample data – All lines display 11
Note – None

Item – 24.C. EMG
Sample data – None
Note – None

Item – 24.D. Procedures, Services, or Supplies (Explain Unusual Circumstances), CPT/HCPCS / Modifier
Text box note – 24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier as needed
Sample data for CPT/HCPCS, Modifier cells – Line 1 = 99213, Line 2 = 3048F (DM-PQRI number 2), Line 3 = 3074F BP less than 130 mmHg-PQRI number 3), Line 4 = 3078F (CAD-PQRI number 6), Line 5 = 4011F (BP less than 80 mmHG-PQRI number 3), Line 6 = 1090F (UI Assessed-PQRI number 48)

Item – 24.E. Diagnosis Pointer

Sample data – Lines 1 through 4 display 1. Lines 5 and 6 display 2.
Note – None

Item – 24.F. Dollar Charges
Sample data – Line 1 displays 47.00. Line 2 through 6 display 0.00.
Note – Quality Data Codes (QDCs) must be submitted with a line-item charge of 0.00 dollars. Charge field cannot be blank.

Item – 24.G. Days or Units
Sample data – None
Note – None

Item – 24.H. EPSOT Family Plan
Sample data – None
Note – None

Item – 24.I. ID. Qual.
Sample data – Lines 1 through 6 display NPI
Note – None

Item – 24.J. Rendering Provider ID. Number
Sample data –Lines 1 through 6 display 0123456789
Note – For group billing, the rendering NPI number of the individual Eligible Professional (EP) who performed the service will be used from each line-item in the PQRI calculations.

Item – 25. Federal Tax ID. Number, SSN/EIN
Sample data – XX-XXXXXXX, SSN is marked
Note – None

Item – 26. Patient's Account No.
Sample data – XXXXX
Note – None

Item – 27. Accept Assignment? (For govt. claims, see back), Yes/No
Sample data – Yes is marked
Note – None

Item – 28. Total Charge, Dollars
Sample data – 47.00
Note – None

Item – 29. Amount Paid, Dollars
Sample data – None
Note – None

Item – 30. Balance Due, Dollars
Sample data – 47.00
Note – None

Item – 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.)
Signed/Date
Sample data – None
Note – None

Item – 32. Service Facility Location Information, a./b.
Sample data – None
Note – None

Item – 33. Billing Provider Info and Phone Number (including area code), a./b.
Sample data – None
Note – a. Solo practitioner – Enter individual NPI here

Footer 1 – NUCC Instruction Manual available at www.nucc.org
Footer 2 – Approved OMB-0938-0999 Form CMS-1500 (08/05)

Beneath the claim example, eight bulleted statements display as follows:

First bullet = 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:

Second bullet = Measure number 2 (LDL-C) with QDC 3048F plus diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);

Third bullet – Measure number 3 (BP in Diabetes) with QDCs 3074F plus 3078F plus diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);

Fourth bullet = Measure number 6 (CAD) with QDC 4011F plus CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and

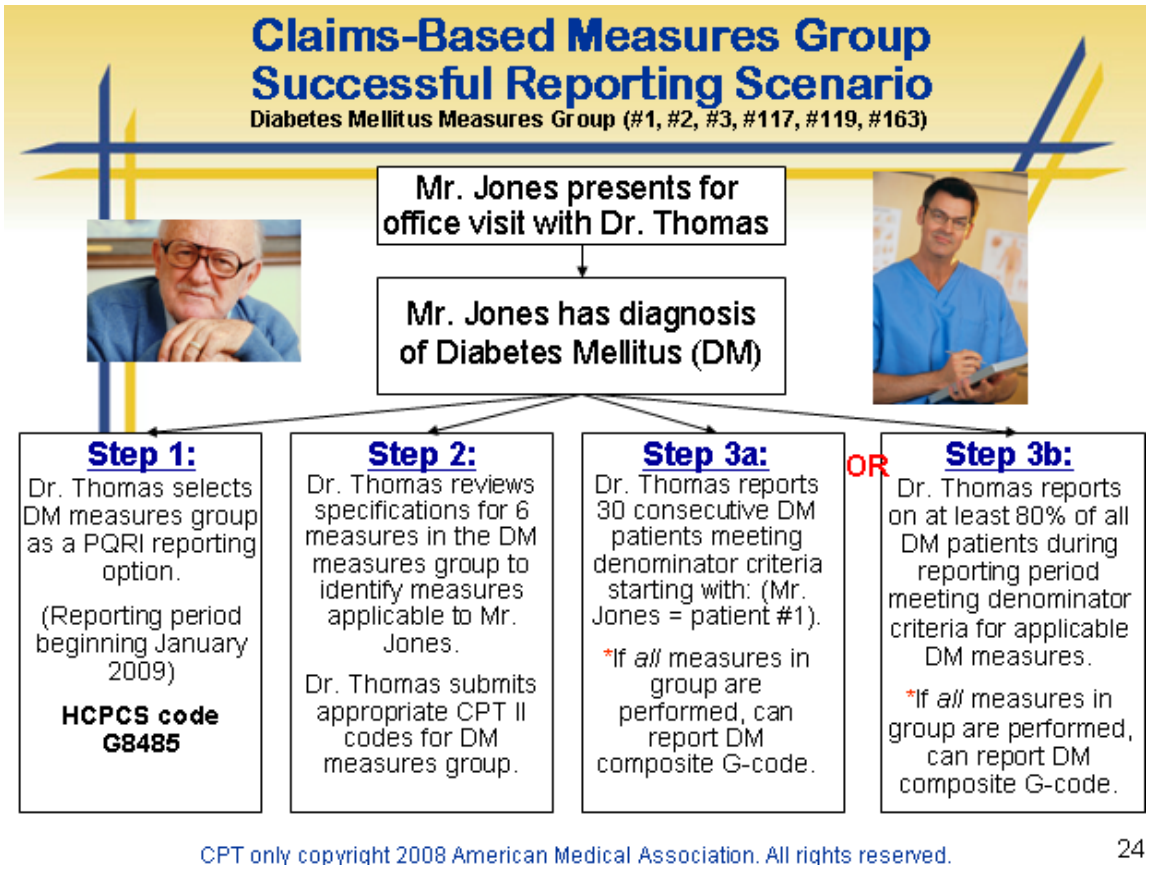
Fifth bullet = Measure number 48 (Assessment – Urinary Incontinence) with QDC 1090F. For PQRI, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.

Sixth bullet = 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.

Seventh bullet = NPI placement: Item 24J must contain the NPI of the individual provider that rendered the service when a group is billing. This includes putting the individual NPI on the QDC line-items as well.

Eighth bullet = The Tax ID associated with the NPI(s) on this claims is shown in Item 25.

Frame 24
Title – Claims-Based Measures Group Successful Reporting Scenario
Diabetes Mellitus Measures Group (#1, #2, #3, #117, #119, #163)



Graphic – This frame uses a photo graphic of a patient in the upper left corner and a photo graphic of a provider in the upper right corner. Between the two photos are two vertically aligned text boxes aligned that display the following text:
Text box 1 - Mr. Jones presents for office visit with Dr. Thomas
Text box 2 - Mr. Jones has diagnosis of Diabetes Mellitus (DM)

Four arrows extend from Text box 2.

Arrow 1 points to a text box in the lower left corner that displays the following text:
Step 1: Dr. Thomas selects DM measures group as a PQRI reporting option.
(Reporting period up to 6 months, beginning January 2009)

HCPCS code G8485

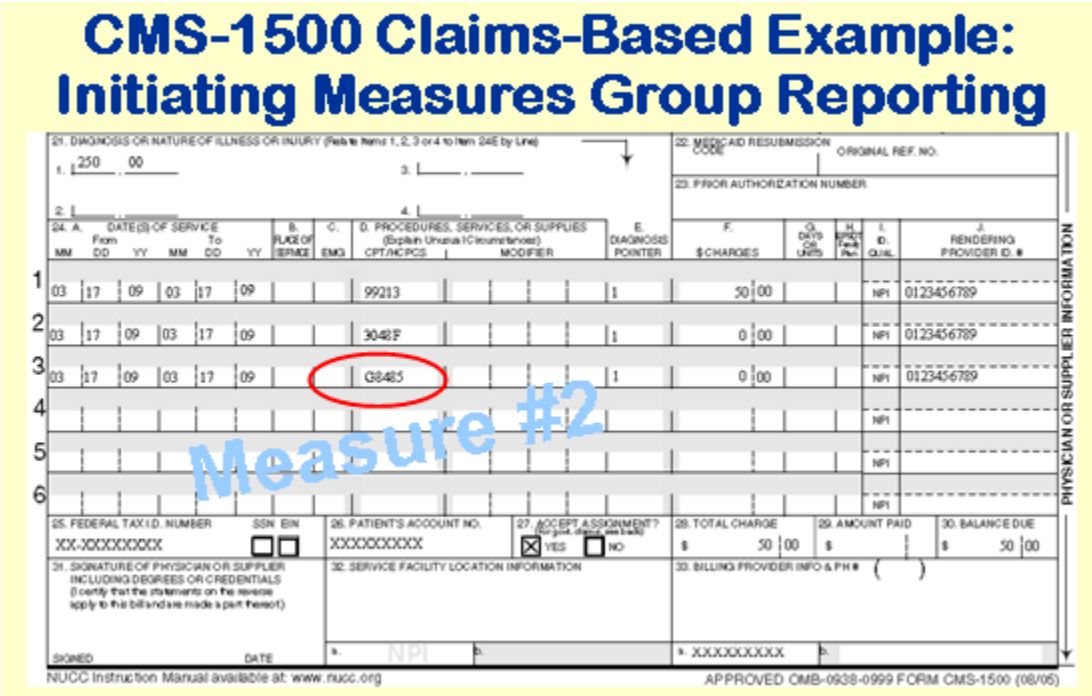
Arrow 2 points to a text box to the right of Step 1 that displays the following text:
Step 2: Dr. Thomas reviews specifications for 5 measures in the DM measures group to identify measures applicable to Mr. Jones.
Dr. Thomas submits appropriate CPT II codes for measures group.

Arrow 3 points to a text box to the right of Step 2 that displays the following text:
Step 3a: Dr. Thomas reports 30 consecutive DM patients meeting denominator criteria starting with: (Mr. Jones = patient #1).
(Red asterisk) If all measures in group are performed, can report DM Composite G-code

Note: There is a bold, red OR between Step 3a and Step 3b

Arrow 4 points to a text box to the right of Step 3a that displays the following text:
Step 3b: Dr. Thomas reports on at least 80 percent of all DM patients during reporting period meeting denominator criteria for applicable DM measures
(Red asterisk) If all measures in group are performed, can report DM Composite G-code

Frame 25
Title – CMS-1500 Claims-Based Example: Initiating Measures Group Reporting



Graphic – This frame displays a sample CMS-1500 similar to the one found on frame 23 of this file. Some Item fields contain sample data and associated text box comments.

Item numbers and titles, sample data, and corresponding notes are displayed as follows:

Item – 21. Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, or 4 to Item 24E by Line)
Sample data – 1 displays 250.0. 2 through 4 contain no sample data.

Item – 22. Medicaid Resubmission Code / Original Ref. No.
Sample data – None
Note – None

Item – 23. Prior Authorization Number
Sample data – None
Note – None

Item – 24.A. Date(s) of Service, From MM/DD/YY, To MM/DD/YY
Sample data – All dates displayed for Lines 1 through 3 are 01/12/09. Lines 4 through 6 display no sample data.
Note – Vertical numerals 1 through 6 identify claim line-items containing the sample data “From MM/DD/YY” and “To MM/DD/YY” dates.

Item – 24.B. Place of Service
Sample data – None
Note – None

Item – 24.C. EMG
Sample data – None
Note – None

Item – 24.D. Procedures, Services, or Supplies (Explain Unusual Circumstances), CPT/HCPCS / Modifier
Note – 24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier as needed
Sample data for CPT/HCPCS, Modifier cells – Line 1 = 99213, Line 2 = 3048F, Line 3 = G8485, Lines 4 through 6 display no sample data.
Note: 24.D. Line 3, which displays G8485 is circled in red. Just below this, “Measure Number 2” is displayed in large, bolded, blue text.

Item – 24.E. Diagnosis Pointer
Sample data – Lines 1 through 3 display 1. Lines 4 through 6 display no sample data.
Note – None

Item – 24.F. Dollar Charges
Sample data – Line 1 displays 50.00. Lines 2 and 3 display 0.00. Lines 4 through 6 display no sample data.
Note – Quality Data Codes (QDCs) must be submitted with a line-item charge of 0.00 dollars. Charge field cannot be blank.

Item – 24.G. Days or Units
Sample data – None
Note – None

Item – 24.H. EPSOT Family Plan
Sample data – None
Note – None

Item – 24.I. ID. Qual.
Sample data – Lines 1 through 6 display NPI
Note – None

Item – 24.J. Rendering Provider ID. Number
Sample data –Lines 1 through 3 display 0123456789. Lines 4 through 6 display no sample data.
Note – For group billing, the rendering NPI number of the individual Eligible Professional (EP) who performed the service will be used from each line-item in the PQRI calculations.

Item – 25. Federal Tax ID. Number, SSN/EIN
Sample data – XX-XXXXXXX, SSN is marked
Note – None

Item – 26. Patient's Account No.
Sample data – XXXXX
Note – None

Item – 27. Accept Assignment? (For govt. claims, see back), Yes/No
Sample data – Yes is marked
Note – None

Item – 28. Total Charge, Dollars
Sample data – 50.00
Note – None

Item – 29. Amount Paid, Dollars
Sample data – None
Note – None

Item – 30. Balance Due, Dollars
Sample data – 50.00
Note – None

Item – 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.)
Signed/Date

Sample data – None
Note – None

Item – 32. Service Facility Location Information, a./b.
Sample data – None
Note – None

Item – 33. Billing Provider Info and Phone Number (including area code), a./b.
Sample data – None
Note – a. Solo practitioner – Enter individual NPI here

Sample form footer 1 – NUCC Instruction Manual available at www.nucc.org
Sample form footer 2 – Approved OMB-0938-0999 Form CMS-1500 (08/05)

A note below the sample displays the following: Measures group-specific G-code submitted on first diabetic patient (meeting the denominator for one or more measures within the Diabetes Mellitus measures group). Submitting G8485 (circled above) starts counting consecutive patients for Diabetes measures group.
Review remaining DM measures within group and report QDCs for each applicable measure.

Frame 26
Title – Where to Begin

Text – This frame displays bulleted text as follows:

First bullet = Gather information from the PQRI web page: www.cms.hhs.gov/pqri (e.g., Measures/Codes, Educational Resources, Tool Kit web pages).

Second bullet = Gather information from other sources, such as your professional association, specialty society, or the American Medical Association.

Third bullet = Select measures or measures group, reporting method, reporting period, and date to begin.

Frame 27
Title – Selection of Measures and Reporting Method

Text – This frame displays text formatted in bullets and sub-bullets as follows:

First bullet = Consider:

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

Second bullet = Review the list of measures and determine which measures apply most frequently to the practice's Medicare FFS patients. Many PQRI measures require one-time reporting per patient per reporting period per eligible professional (See Patient Level Measures List).

Third bullet = Review Measures Specifications Manual for Claims and Registry and Release Notes for selected measures carefully to understand reporting instructions, coding and frequency of reporting.

Fourth bullet = Select a reporting method: via claims or via a qualified registry, each of which include multiple reporting options for each method of submission. “2009 PQRI Participation Decision Tree,” is a tool designed to help EPs/practices select among the multiple reporting options available (See 2009 PQRI Implementation Guide).

Frame 28
Title – Prepare to Participate in PQRI

Text – This frame displays bulleted text as follows:

First bullet = Ensure that the practice's billing software and clearinghouse can capture all the codes and associated modifiers used in PQRI for the measures you have selected. Discuss with vendors.

Second bullet = Read and discuss with staff: reporting principles and specifications for each of the measures selected for reporting in PQRI.

Third bullet = Develop a process for concurrent data collection so that eligible claims and PQRI codes are correctly identified and submitted.

Fourth bullet = Regularly review the Remittance Advice notices from the Carrier/AB MAC to ensure you receive N365 remark code for each QDC submitted.

Frame 29
Title – Understanding the Measure Construct

Text – This frame displays text that explains measure calculation in terms of numerator (located at the top of the frame) and denominator (located at the bottom of the frame.

NUMERATOR
Note: The word “Numerator” is formatted in bolded, red text and all letters capitalized
CPT II Code or Temporary G-code (describes clinical action required for performance)
Note: “Clinical action” is bolded.

A large, bolded “divided by” sign

DENOMINATOR
Note: The word “Denominator” is formatted in bolded, jade text and all letters are capitalized
ICD-9-CM and CPT Cat I Codes
(Describes eligible cases for which a clinical action was performed: the eligible patient population as defined by denominator specification)
Note: “Eligible cases” and “clinical action” are bolded.

Frame 30
Title – Understanding the Measures: PQRI Quality-Data Codes (QDCs)

Text – This frame displays text as follows:
QDCs translate clinical actions so they can be captured in the administrative claims process – they describe whether:

First bullet = the measure requirement was met
Note: The “Met” text is bolded
OR
Second bullet = the measure requirement was not met due to documented allowable performance exclusions (i.e., using CPT II performance exclusion modifiers)
Note: The “Not met” text is bolded
OR

Third bullet = the measure requirement was not met and the reason is not documented or is not consistent with an accepted performance exclusion (i.e., using the 8P reporting modifier)
Note: The “Not met” text is bolded

Frame 31
Title – Understanding the Measures: The Performance Modifiers

Text – This frame displays bulleted and sub-bulleted text as follows:

First bullet = Unique modifiers used with CPT II codes only

Second bullet = Performance exclusion modifiers indicate that an action specified in the measure was not provided due to medical, patient or systems reason(s) documented in the medical record:
First sub-bullet = 1P- Performance exclusion modifier due to Medical Reasons
Second sub-bullet = 2P- Performance exclusion modifier used due to Patient Reasons
Third sub-bullet = 3P- Performance exclusion modifier used due to System Reasons

Third bullet = One or more exclusions may be applicable for a given measure. Certain measures have no applicable exclusion modifiers. Refer to the measure specifications to determine the appropriate exclusion modifiers.

Frame 32
Title – Understanding the Measures: The Reporting Modifier

Text – This frame displays bulleted and sub-bulleted text as follows:

Performance Measure Reporting Modifier
Bullet = Facilitates reporting a case when the patient is eligible but the action described in a measure is not performed and the reason is not specified or documented
Sub-bullet = 8P modifier: action not performed, reason not otherwise specified

Frame 33
Title – Understanding the Measures: Performance Timeframe

Text – This frame displays bulleted and sub-bulleted text as follows:

Bullet = Some measures have a Performance Timeframe related to the clinical action that may be distinct from the reporting frequency.
Note: The “Performance Timeframe” text is bolded and “may be distinct” is italicized.

First sub-bullet = Perform within 12 months or annually
Second sub-bullet = Most Recent result
Note: The “Most recent” text is bolded.

First sub-sub-bullet = Clinical test result needs to be obtained, reviewed, reported one time for each EP.
Second sub-sub-bullet = It need not have been performed during the reporting period.

Frame 34
Title – Understanding the Measures: Reporting Frequency

Text – This frame displays bulleted and sub-bulleted text as follows:

Bullet = Each measure has a Reporting Frequency requirement for each eligible patient seen during the reporting period for each EP:
Note: The “Reporting Frequency” text is bolded.
First sub-bullet = Report one-time
Second sub-bullet = Report once for each procedure performed Report for each acute episode
Third sub-bullet = Report for each visit

Frame 35
Title – 2007 PQRI Experience Report

Text – This frame displays bulleted and asterisked text as follows:

QDC Submission Attempts

First bullet = 12.15 percent Missing NPI

Second bullet = 18.89 percent Incorrect HCPCS code*
Note: A red asterisk displays after the word code to indicate denominator mismatch

Third bullet = 13.93 percent Incorrect DX code*
Note: A red asterisk displays after the word code to indicate denominator mismatch

Fourth bullet = 7.24 percent Both incorrect HCPCS code and incorrect DX code*
Fifth bullet = 4.97 percent All line items were QDCs only

Red asterisk = Denominator mismatch

Frame 36
Title – Some Common Errors

Text – This frame displays bulleted and sub-bulleted text as follows:

First bullet = Eligible claim without individual NPI

Second bullet = Eligible claim without QDC(s)

Third bullet = Eligible claim submitted as a QDC-only claim (no denominator information on the claim)

Fourth bullet = Ineligible claim with QDC for measure
First sub-bullet = Dx is incorrect on claim for measure reported
Second sub-bullet = Surgical procedure is incorrect on claim for measure reported
Third sub-bullet = Age/gender is on claim is incorrect for measure reported

Frame 37
Title – Benefits of PQRI Participation

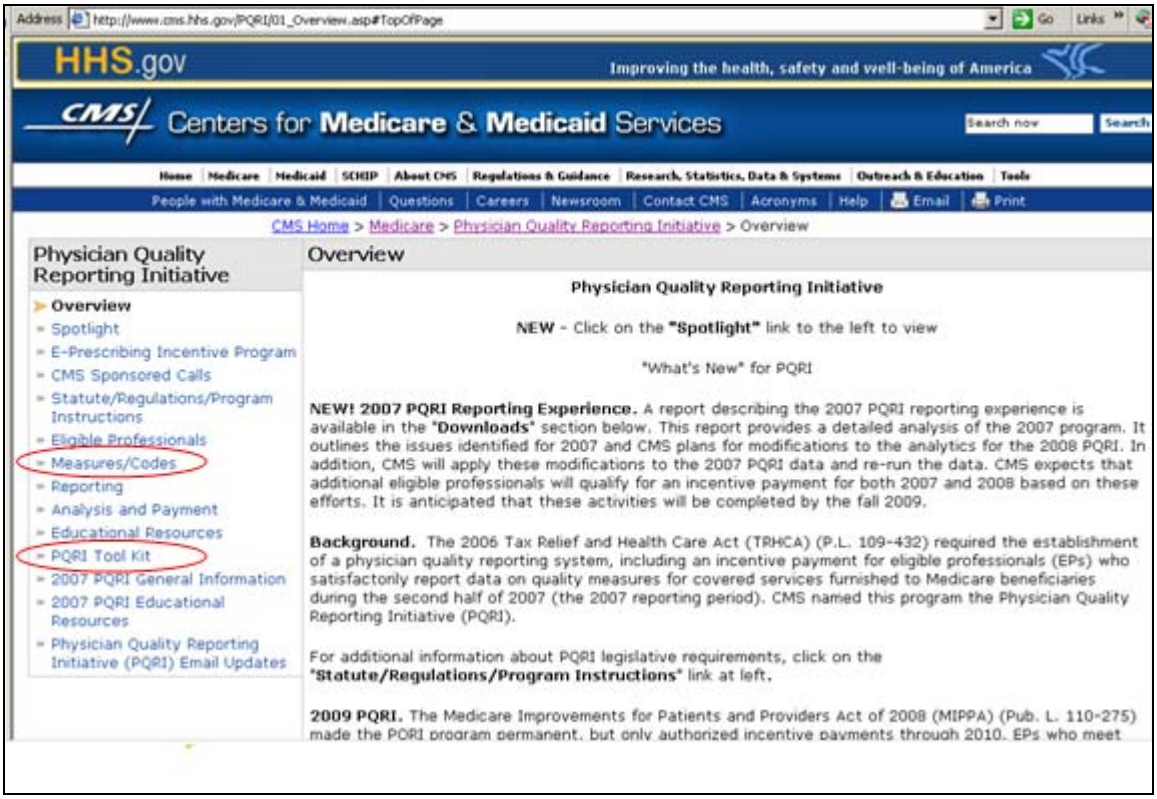
Text – This frame displays bulleted and sub-bulleted text as follows:

First bullet = Receive confidential feedback reports to support quality improvement

Second bullet = Earn a bonus incentive payment

Third bullet = Make an investment in the future of the practice
First sub-bullet = Prepare for higher bonus incentives over time
Second sub-bullet = Prepare for pay-for-performance
Third sub-bullet = Prepare for public reporting of performance results

Frame 38
Title – PQRI Website: www.cms.hhs.gov/pqri



Graphic – This frame displays the top portion of a screen print from http://www.cms.hhs.gov/PQRI/

The text on the screen print is divided into two columns.

The column on the left covers approximately one-third of the frame and is titled Physician Quality Reporting Initiative. A list of bulleted text below this displays the following:

Bullet = Overview
First sub-bullet = Spotlight
Second sub-bullet = E-prescribing Incentive Program
Third sub-bullet = CMS Sponsored Calls
Fourth sub-bullet = Statue/Regulations/Program Instructions
Fifth sub-bullet = Eligible Professionals
Sixth sub-bullet = Measures/Codes (encased in a red oval)
Seventh sub-bullet = Reporting
Eighth sub-bullet = Analysis and Payment
Ninth sub-bullet = Educational Resources (encased in a red oval)
Tenth sub-bullet = PQRI Toolkit (encased in a red oval)
Eleventh sub-bullet = 2007 PQRI General Information
Twelfth sub-bullet = 2007 PQRI Educational Resources

The column on the right covers approximately two-thirds of the frame and is labeled Overview. The following text is displayed in this section:

Physician Quality Reporting Initiative

NEW – Clink on the “Spotlight” link to the left to view “What’s New” for PQRI

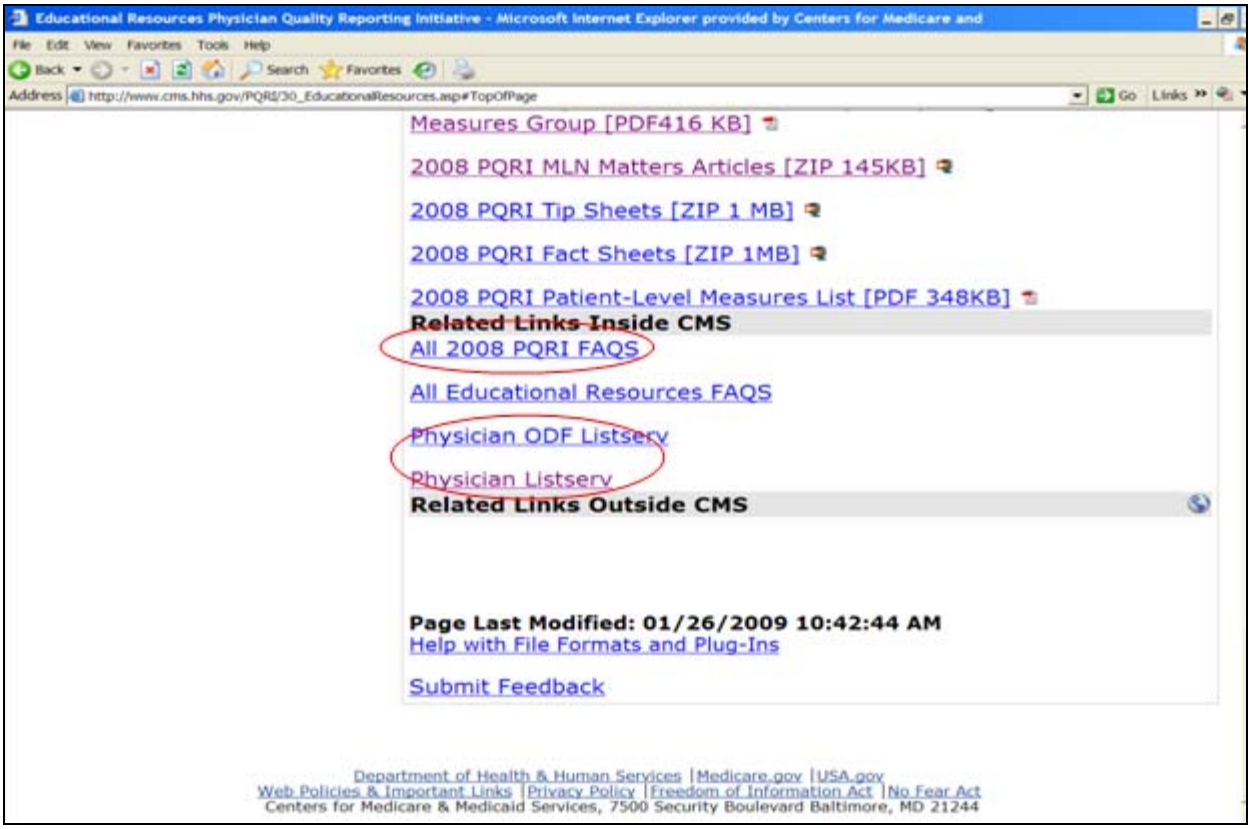
NEWS! 2007 PQRI Reporting Experience. A report describing the 2007 PQRI reporting experience is available in the “Downloads” section below. This report provides a detailed analysis of the 2007 program. It outlines the issues identified for 2007 and CMS plans for modifications to the analytics for the 2008 PQRI. In addition, CMS will apply these modifications to the 2007 PQRI data and re0run the data. CMS expects that additional eligible professionals will qualify for an incentive payment for both 2007 an 2008 based on these efforts. It is anticipated that these activities will be completed by the fall 2009.

Background. The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPS) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI).

For additional information about PQRI legislative requirements, click on the “Statue/Regulations/Program Instructions” link at the left.

2009 PQRI. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) Pub. L. 110-275) made the PQRI program permanent, but only authorized incentive payments through 2010. EPs who meet

Frame 39
Title – FAQs, Listserv, Submit Feedback



Graphic – This frame displays a screen print of http://cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage, which includes the following items and links:

Measures Group [PDF416 KB]
2008 PQRI MLN Matters Articles [ZIP 145KB]
2008 PQRI Tip Sheets [ZIP 1 MB]
2008 PQRI Fact Sheets [ZIP 1 MB]
2008 PQRI Patient-Level Measures List [ZIP 1 MB]

Category – Related Links Inside CMS
All 2008 PQRI FAQS – Note: This is circled in red.
All Educational Resources FAQS
Physician ODF Listserv – Note this is circled in red.
Physician Listserv – Note this is circled in red.

Category – Related Links Outside CMS

Page Last Modified: 01/26/2009 10:42:44 AM
Help with File Formats and Plug-Ins
Submit Feedback

Frame 40
Title – Resources Available

Text – This frame displays topics and corresponding Web sites as follows:

Physician Quality Reporting Initiative:
https://www.cms.hhs.gov/pqri
CMS Quality Initiatives – General Information:
http://www.cms.hhs.gov/QualityInitiativesGenInfo/

12/9/08 Issues Paper: Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services
http://www.cms.hhs.gov/center/physician.asp

Hospital Quality Reporting:
www.hospitalcompare.hhs.gov

Open Door Forums:
http://www.cms.hhs.gov/OpenDoorForums/

National Provider Identifier:
https://nppes.cms.hhs.gov/NPPES/Welcome.do

Demonstrations:
http://www.cms.hhs.gov/DemoProjectsEvalRpts/

Frame 41
Title – Additional Resources

Text – This frame displays topics and corresponding Web sites as follows:
American Medical Association – Physician Consortium for Performance Improvement
http://www.ama-assn.org

National Committee on Quality Assurance
http://www.ncqa.org/

National Quality Forum
http://www.qualityforum.org

Medicare Payment Advisory Commission
http://www.medpac.gov

National Academies Press – Pathways to Quality Health Care series – performance measurement and improvement
http://www.nap.edu

Frame 42
Title – Thank You

Text – This frame displays follow-up contact information as follows:

For questions about PQRI contact:

First bullet = Carrier

Second bullet = Regional Office or

Third bullet = Submit through the PQRI mailbox:
pqri_inquiry@cms.hhs.gov

For questions regarding measure construct contact measure developer identified on 2009 PQRI Measures List

End of Presentation