Centers for Medicare & Medicaid Services

2008 Physician Quality Reporting Initiative (PQRI)

May 28, 2008

National Provider Call
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2008 PQRI Measures

- Published in 2008 Physician Fee Schedule (PFS) Rule November 2007
- 119 measures
  - 117 clinical measures
  - 2 structural measures (eRx and EHR use)
- Clinical measures apply to specialties, accounting for over 95% of Medicare Part B spending
- Structural measures apply broadly across specialties and disciplines
MMSEA authorized continuation of PQRI for 2008

- Eliminated cap on incentive payment
- Incentive payment remained 1.5% of total allowable charges for PFS covered professional services furnished during reporting period
- Required alternative reporting periods and alternative reporting criteria for 2008 and 2009.
2008 Reporting Options - Overview

- Two Reporting Periods
  - 12 months (January 1 - December 31, 2008)
  - 6 months (July 1 - December 31, 2008)
- Total of 9 PQRI Reporting Methods
  - 3 claims-based
  - 6 registry-based
Physician Quality Reporting Initiative (PQRI) Participation Decision Tree

I WANT TO PARTICIPATE IN 2008 PQRI FOR INCENTIVE PAYMENT
(Select Reporting Method)

CHOOSE CLAIMS-BASED REPORTING OPTIONS

< 3 MEASURES APPLY

ONLY OPTION IS TO REPORT CLAIMS FOR 12-MONTH REPORTING PERIOD
1/1/08-12/31/08
REPORT EACH MEASURE ≥ 80% OF APPLICABLE PATIENTS
Subject to Measure-Applicability Validation (MAV)

3 OR MORE MEASURES APPLY

CHOOSE TO REPORT ON ≥ 3 MEASURES FOR 12 MONTHS
1/1/08-12/31/08
REPORT ≥ 80% OF APPLICABLE PATIENTS ON AT LEAST 3 MEASURES

CHOOSE TO REPORT MEASURES GROUP FOR 6 MONTHS
7/1/08-12/31/08
REPORT ≥ 80% OF ELIGIBLE PATIENTS FOR A MEASURES GROUP THE FULL 6 MONTHS

REPORT 100% OF 15 CONSECUTIVE ELIGIBLE PATIENTS ANYTIME WITHIN 6 MONTHS

REGISTRY REPORTING

Subject to Measure-Applicability Validation (MAV)
I WANT TO PARTICIPATE IN 2008 PQRI FOR INCENTIVE PAYMENT
(Select Reporting Method)

CLAIMS-BASED REPORTING

CHOOSE REGISTRY-BASED REPORTING OPTIONS

CHOOSE TO SUBMIT DATA ON 80% OF ELIGIBLE PATIENTS ON AT LEAST 3 MEASURES

CHOOSE TO REPORT
12 MONTHS
1/1/08-12/31/08

CHOOSE TO REPORT
6 MONTHS
7/1/08-12/31/08

SUBMIT DATA ON 100% OF 30 CONSECUTIVE ELIGIBLE PATIENTS WITHIN 12 MONTHS

SUBMIT DATA ON 80% OF APPLICABLE PATIENTS FOR THE MEASURES GROUP

SUBMIT DATA ON 100% OF 15 CONSECUTIVE ELIGIBLE PATIENTS WITHIN 6 MONTHS

SUBMIT DATA ON 80% OF ELIGIBLE PATIENTS FOR A MEASURES GROUP

SUBMIT 12 MONTHS
1/1/08-12/31/08

SUBMIT 6 MONTHS
7/1/08-12/31/08
I WANT TO PARTICIPATE IN 2008 PQRI FOR INCENTIVE PAYMENT

(Select Reporting Period)

12-MONTH REPORTING PERIOD
1/1/08-12/31/08

- CLAIMS
- REGISTRY
- MEASURES GROUPS
  - ≥ 80% OF ELIGIBLE PATIENTS ON AT LEAST 3 MEASURES OR ON EACH MEASURE IF < 3 MEASURES
  - ≥ 80% OF ELIGIBLE PATIENTS ON AT LEAST 3 MEASURES
  - 100% OF 30 CONSECUTIVE ELIGIBLE PATIENTS ANYTIME WITHIN 12 MONTHS
  - ≥ 80% OF ELIGIBLE PATIENTS FOR THE FULL 12 MONTHS

6-MONTH REPORTING PERIOD
7/1/08-12/31/08

- CLAIMS
- REGISTRY
- MEASURES GROUPS
  - ≥ 80% OF ELIGIBLE PATIENTS ON AT LEAST 3 MEASURES
  - ≥ 80% OF ELIGIBLE PATIENTS IN MEASURES GROUP ANYTIME WITHIN 6 MONTHS
  - ≥ 80% OF ELIGIBLE PATIENTS FOR THE FULL 6 MONTHS
  - 100% OF 15 CONSECUTIVE ELIGIBLE PATIENTS FOR THE MEASURES GROUP ANYTIME WITHIN 6 MONTHS

- 100% OF 15 CONSECUTIVE ELIGIBLE PATIENTS FOR THE MEASURES GROUP ANYTIME WITHIN 6 MONTHS

- ≥ 80% OF ELIGIBLE PATIENTS FOR THE FULL 6 MONTHS

- 100% OF 15 CONSECUTIVE ELIGIBLE PATIENTS ANYTIME WITHIN 6 MONTHS
3 Claims-Based Options

January 1, 2008 –December 31, 2008 (full-year)
1. Claims-based reporting of Individual PQRI Measures
   --if <3, report each for ≥80% of eligible patients (this is the only way to report less than 3 measures)
   --if ≥3, report at least 3 for ≥80% of eligible patients

July 1, 2008 –December 31, 2008 (half-year)
2. Claims-Based Reporting of 1 Measures Group
   OR
3. for 80% of eligible patients for the measures group

Note: claims-based reporting for 6-month reporting period only available for reporting of Measures Groups
Measures Groups

• A measures group is a group of measures covering patients with a particular condition or preventive services.
• Each of the applicable measures in a measures group must be reported for each patient in the measures group.
Measures Groups Denominators

• A single set of codes (CPT I and/or ICD9) as well as **specific age ranges** make up the denominator for each measures group.

• The measure group specifications can be viewed on the PQRI website at [www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri). Click on the Measures/Codes tab on the left side of the page.
How to Determine if Patient Fits into a Measures Group

• Step 1—Does the Measures Group apply?
  – Does the patient have the required denominator codes (CPT I and/or ICD-9 codes) on the claim?
  – Does the patient fit into the listed age range?
• Step 2—Does the individual measure apply?
  – If the patient fits into the group but a particular measure does not apply due to age, gender, or diagnosis you can choose not to report the measure OR report the measure with an exclusion modifier.
How is Age Calculated?

• Age is determined based on the date of service (DOS).
• If the patient is of the proper age for a measure during anytime during the reporting period AND you are reporting using the 80% of a measures group option, that patient would count in the 80% cohort for the measures group.
• If you are reporting using the consecutive patient option, the patient’s age at the time they appear in the consecutive patient sequence is the age used to determine if they should count as one of the consecutive patients.
Measures Groups Using Claims

• For claims, you must submit the measures group specific G-code for the measures group with the first patient of the 15 consecutive patients you intend to report on for the group.
• A measure group specific G-code is also necessary to signal your intention to report a measures group even if you plan to use the 80% of the measures group option.
• A Quality Data Code (G-code or CPT II code) must be submitted for each applicable measure included in the measures group for each patient within that group.
G-codes for Measures Groups (using claims)

• Submission of a measures group specific G-code signals CMS that the provider has selected the measures group option.
• CMS will begin the consecutive patient count starting with the patient with whom the measures group G-code was submitted.
• For the consecutive patient option, it MUST be submitted with the first such patient in the measure group.
• You CAN submit it with each patient in the group but this is not necessary.
• You CANNOT restart the consecutive patient count if you miss a patient.
  – You may still qualify for reporting the group on 80% of your measure group eligible patients.
<table>
<thead>
<tr>
<th>Measures Group</th>
<th>CPT Patient Encounter Codes</th>
<th>ICD-9 Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td>99201-99205, 99212-99215</td>
<td>250.00-250.03, 250.10-250.13, 250.2-250.23,</td>
</tr>
<tr>
<td>Ages 18-75</td>
<td></td>
<td>250.3-250.33, 250.4-250.43, 250.5-250.53,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>250.6-250.63, 250.7-250.73, 250.8-250.83,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>250.9-250.93, 648.0-648.04</td>
</tr>
</tbody>
</table>
DM Measures Group (cont)

Diabetes Mellitus:
(report measure group specific G-code G8485 on first patient to signal intent to report a measures group if submitting via claims)

1 – Hgb A1c Poor Control
2 – LDL Control
3 – High Blood Pressure Control
117 – Dilated Eye Exam
119 – Urine Screening for Microalbumin

Note: All 5 measures apply to any patient who meets the denominator criteria (age, CPT I and ICD-9 code) for the measures group.
# ESRD Measures Group Common Denominators

<table>
<thead>
<tr>
<th>Measures Group</th>
<th>CPT Patient Encounter Codes</th>
<th>IcD-9 Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>End Stage Renal Disease</td>
<td>90935, 90937, G0314, G0315, G0316, G0317, G0318, G0319</td>
<td>585.6</td>
</tr>
<tr>
<td>Ages: 18 years and older</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ESRD Measures Group (cont)

End Stage Renal Disease (ESRD):

(report measure group specific G-code G8488 on first patient to signal intent to report a measures group if submitting via claims)

78 - Vascular Access for hemodialysis (HD) patients

79 - Influenza Vaccination

80 - Plan of Care for patients with anemia

81 - Plan of Care for inadequate HD

Note: All 4 measures apply to any patient who meets the denominator criteria (age, CPT I and ICD-9 code) for the measures group.
# CKD Measures Group Common Denominators

<table>
<thead>
<tr>
<th>Measures Group</th>
<th>CPT Patient Encounter Codes</th>
<th>ICD-9 Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Kidney Disease</td>
<td>99201-99205, 99212-99215, 99241-99245</td>
<td>585.4, 585.5</td>
</tr>
<tr>
<td>Ages: 18 years and older</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CKD Measures Group (cont)

Chronic Kidney Disease (CKD):

(report measure group specific G-code G8487 on first patient to signal intent to report a measures group if submitting via claims)

120 – ACE or ARB
121 – Testing for Ca, Phos, IPTH, Lipids
122 – Blood Pressure Management
123 – Plan of Care: Elevated Hgb for patients on ESA
CKD Measures Group (cont)

• Measures 121-123 apply to all patients who meet the CKD denominator criteria (age, CPT I codes, and ICD-9 codes)
• For measure 120 to apply, the patient must meet the above criteria AND have a diagnosis of hypertension and proteinuria (by ICD-9 code) on the claim. If the measure does not apply to the patient, the professional does not need to report this measure for the group OR the professional can report G8480 (no treatment for documented reason).
## Preventive Care Measures Group

### Common Denominators

<table>
<thead>
<tr>
<th>Measures Group</th>
<th>CPT Patient Encounter Codes</th>
<th>ICD-9 Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Care</td>
<td>99201-99205, 99212-99215</td>
<td>None</td>
</tr>
<tr>
<td>Ages: 50 years and older</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Measures Groups (cont)

Preventive Care:
   (report measure group specific G-code G8486 on first patient to signal intent to report a measures group if submitting via claims)

39 - Screening/Therapy for Osteoporosis in Women aged 65 and Older*
48 - Assessment of Urinary Incontinence in Women aged 65 and Older*
110 - Influenza Vaccination for Patients > 50 years old
111 - Pneumonia Vaccination for Patients 65 Years and Older
112 - Screening Mammography*
113 - Colorectal Cancer Screening
114 - Inquiry Regarding Tobacco Use
115 - Advising Smokers to Quit
128 - Weight Screening and Follow-up

*Apply to female patients only
## Preventive Care Measures Group (continued)

<table>
<thead>
<tr>
<th>AGE (in years)</th>
<th>Male Patients (Measures)</th>
<th>Female Patients (Measures)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50</td>
<td>Patient does not qualify for group</td>
<td>Patient does not qualify for group</td>
</tr>
<tr>
<td>50 - 64</td>
<td>110, 113, 114, 115</td>
<td>110, 112, 113, 114, 115</td>
</tr>
<tr>
<td>70 - 80</td>
<td>110, 111, 113, 114, 115, 128</td>
<td>39, 48, 110, 111, 113, 114, 115, 128</td>
</tr>
<tr>
<td>81 +</td>
<td>110, 111, 114, 115, 128</td>
<td>39, 48, 110, 111, 114, 115, 128</td>
</tr>
</tbody>
</table>
If a Measure in a Group is Not Applicable to a Specific Patient

- For measures in the measures group that do not apply to a particular patient (due to age or gender requirements of the specific measure) the professional may choose not to report the measure for the group OR may report the measure with an exclusion modifier.
 Claims-Based Measures Group  
Successful Reporting Scenario  
Diabetes Mellitus Measures Group (#1, #2, #3, #117, #119)  

Mr. Jones presents for office visit with Dr. Thomas  
Mr. Jones has diagnosis of Diabetes Mellitus (as defined by the denominator [CPT &/or ICD9 & age])

**Step 1:** Dr. Thomas selects DM measures group as a PQRI reporting option.  
(Reporting period up to 6 months, beginning July 1, 2008)  
HCPCS code G8485

**Step 2:** Dr. Thomas reviews specifications for 5 measures in the DM measures group and reports those measures on Mr. Jones.  
Dr. Thomas submits all appropriate CPT II codes based on measures identified.

**Step 3a:** Dr. Thomas reports 15 consecutive patients meeting denominator criteria starting with: (Mr. Jones = patient #1).

**Step 3b:** Dr. Thomas reports on at least 80% of diabetes patients during reporting period meeting denominator criteria for applicable DM measures

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Note: 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.
6 Registry-Based Options

<table>
<thead>
<tr>
<th>Reporting Period:</th>
<th>Reporting Period:</th>
</tr>
</thead>
</table>

**Individual Measures:**
- 80% of applicable cases
- Minimum 3 measures

**One Measures Group:**
- 30 consecutive patients
  - OR
- 80% of applicable cases

**Individual Measures:**
- 80% of applicable cases
- Minimum 3 measures

**One Measures Group:**
- 15 consecutive patients
  - OR
- 80% of applicable cases
Registry-Based Options (cont)

• Individual Measures
  (all Medicare FFS patients)
  – At least 3 measures on 80% of eligible patients for either the 6 month or 12 month reporting period.

• Measure Groups (no measure group specific G-code required to be submitted)
  – 30 consecutive* patients for 12 months or 80% of eligible pts for measure group
  – 15 consecutive* patients for 6 months or 80% of eligible pts for measure group
    – *Must contain some Medicare FFS patients
How to Submit Via a Registry

• Contact the registry you will be using to ensure they will be self-nominating to participate in 2008.
• Inquire as to whether the registry believes it can meet the technical requirements?
• If both answers are yes, ask the registry how data is collected from their professionals?
2008 PQRI Registry Timeline

• Apr 30, 2008: CMS to post registry requirements for payment
• Aug 31, 2008: CMS will announce qualified registries
• Jan 2009 - Feb 28, 2009: CMS accepts 2008 PQRI quality measure data submission from registries (for payment).
Payment

• EP must satisfactorily report under one method to qualify for 1.5% incentive

• CMS will review data submitted via all methods to determine satisfactory reporting and eligibility
  – Maximum incentive payment = 1.5% of total allowed PFS charges for Part B covered services for the applicable reporting period

• If qualify for more than one 2008 PQRI reporting method -- receive incentive for longest reporting period
Incentive Payment

• The incentive payment for successful reporting is based on the length of the reporting period.

  – Reporting Period:
    • 1/1/08-12/31/08 earns 1.5% of allowable Medicare Part B charges on all Medicare patients cared for during that time.
    • 7/1/08-12/31/08 earns 1.5% of allowable Medicare Part B charges on all Medicare patients cared for during that time.
• Not Too Late to Begin Reporting
  – Alternative half-year reporting period
    (July 1, 2008 – December 31, 2008)
  – 60 measures can be reported only once per patient per reporting period (patient-level measures).
    • This list will be available on the PQRI website.
  – Registry-based reporting options
Additional PQRI Resources

For more information on PQRI you may contact your Regional Office, Carrier, or visit [http://www.cms.hhs.gov/pqri](http://www.cms.hhs.gov/pqri)

Thank you!