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**Official CMS Information for
Medicare Fee-For-Service Providers**

Physician Quality Reporting System:
Satisfactorily Reporting 2011 Measures – Claims and Registry

FACT SHEET	**http://www.cms.gov/PQRS**

The Physician Quality Reporting System (Physician Quality Reporting, formerly called the Physician Quality Reporting Initiative or PQRI) is a voluntary quality reporting program that provides an incentive payment to practices whose eligible professionals (identified on claims by their individual National Provider Identifier [NPI]) satisfactorily report data on quality measures for covered Medicare Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-For-Service (FFS) beneficiaries. This includes Railroad Retirement Board and Medicare as a secondary payer patients. A web page dedicated to providing all the latest news on Physician Quality Reporting is available on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/PQRS.

Each eligible professional must satisfactorily report on at least 80 percent of eligible instances (patients for whom the measure applies) if reporting via a registry or Electronic Health Record (EHR), or 50 percent of eligible instances if reporting via claims-based reporting, to qualify for an incentive payment. For 2011 Physician Quality Reporting, eligible professionals may choose from several reporting options to submit quality data to CMS. This tip sheet focuses solely on claims-based and registry-based reporting. There is no requirement to register prior to submitting quality data via claims, but those seeking to report via a registry should check with the registry for any requirements the registry may have. If an eligible professional chooses to participate in Physician Quality Reporting, there are some preparatory steps that should be undertaken prior to reporting. This tip sheet describes those steps and provides helpful tips for eligible professionals and their billing staff.

It is recommended that you, the eligible professional, and your billing staff establish an office work flow that allows accurate identification of each denominator-eligible Medicare Part B beneficiary claim (i.e., claims for services listed in the denominator coding section of each measure specification you intend to report). The work flow process should also ensure that all eligible claims are accurately

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coded using Physician Quality Reporting quality-data codes (QDCs) found in the numerator section of the measure specification. The work flow process should also include discussions and coordination with your billing software vendor/clearinghouse to ensure it is reporting all QDCs accurately on your behalf. Consider implementing an edit on your billing software to ensure all eligible claims are flagged to include Physician Quality Reporting QDC coding for each measure you select to report prior to submitting claims to the Medicare Carrier/Medicare Administrative Contractor (MAC).

How to Get Started

STEP 1: Determine if you are eligible to participate. A list of eligible professionals who may participate in Physician Quality Reporting is available on the Physician Quality Reporting web page of the CMS website at http://www.cms.gov/PQRS. Read this list carefully, as not all providers are considered eligible because of how they are reimbursed by Medicare. That is, some professionals are reimbursed under other methods or fee schedules other than the PFS.

STEP 2: Determine which reporting option(s) best fits your practice (claims-based or registry-based reporting of either individual measures or measures groups) as well as the reporting period (12 months, or 6 months where applicable). This varies with the reporting option selected. Refer to the 2011 Physician Quality Reporting System Participation Decision Tree in Appendix C of the "2011 Physician Quality Reporting System Implementation Guide" (available as a downloadable document in the Measures Codes section of the Physician Quality Reporting web page at http://www.cms.gov/PQRS on the CMS website).

STEP 3: Review the "2011 Physician Quality Reporting System Measures List" (available as a downloadable document in the Measures Codes section of the Physician Quality Reporting web page at http://www.cms.gov/PQRS on the CMS website) and determine which measures apply to your practice.

Eligible professionals who choose to report 2011 Physician Quality Reporting individual measures should select at least three applicable measures to submit to participate in the Physician Quality Reporting program. If fewer than three measures are reported, CMS will apply a Measure-Applicability Validation (MAV) process when determining incentive eligibility. Information on MAV is available as downloadable documents in the Analysis and Payment section of the Physician Quality Reporting web page at http://www.cms.gov/PQRS on the CMS website.

Eligible professionals who choose to report 2011 Physician Quality Reporting measures groups should select at least one measures group to report to CMS. Refer to the "Measures Groups Specifications Manual" to review measures group(s) applicable to your practice.

If you have already been participating in Physician Quality Reporting, there is no requirement to select new/different measures for the 2011 program year. Please note that all Physician Quality Reporting measure specifications are updated and posted prior to the beginning of each program year; therefore, eligible professionals should review the most current measure specifications and look for any revisions.

STEP 4: Individual Physician Quality Reporting Measures

Once you have selected the measures (at least three), carefully review the following documents:

1. "2011 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry" for instructions on how to report claims-based or registry-based individual measures. Just print the pages for the measure specifications you are reporting as the document is very lengthy.

2. "2011 Physician Quality Reporting System Implementation Guide" which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in Form CMS-1500 format.

Both documents are available as downloadable documents in the Measures Codes section of the Physician Quality Reporting web page at http://www.cms.gov/PQRS on the CMS website.

As you read the specifications and reporting instructions, you will notice that each of the measures has a QDC (a Current Procedural Terminology [CPT] Category II code or G-code) associated with it. Note that several measures allow the use of CPT II modifiers: 1P, 2P, 3P, and the 8P reporting modifier. Only **allowable** CPT II modifiers may be used with a CPT II code. Eligible professionals should use the 8P reporting modifier judiciously for applicable measures they have selected to report. The 8P modifier may not be used indiscriminately in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

To qualify for the incentive, the correct numerator QDC must be reported on at least 80 percent of eligible instances if reporting via registry-based reporting, or 50 percent of the eligible instances if reporting via claims-based reporting, for each selected measure. Measures reported by a registry with a 0 percent performance rate will not be analyzed for 2011 or counted as one of the required measures for satisfactory reporting. A claim is considered "eligible" in Physician Quality Reporting when the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis and the CPT Category I service codes on the claim match the diagnosis and encounter codes listed in the denominator criteria of the measure specification.

You will also notice that each measure has a reporting frequency or timeframe requirement (called a "measure tag" in Physician Quality Reporting analysis) for each eligible patient seen during the reporting period by each individual eligible professional (NPI). The reporting frequency (i.e., report each visit, once during the reporting period, each episode, etc.) is found in the Instructions section of each measure specification. Ensure that all members of the team understand and capture this information in the clinical record to facilitate reporting.

Or: As an alternative to reporting three individual measures, you can select to report one or more measures groups.

Physician Quality Reporting System Measures Groups

Once you have selected a measures group(s) to report, carefully review the following documents:

1. "2011 Physician Quality Reporting System Measures Groups Specifications Manual" for claims-based or registry-based reporting of measures groups. Just print the pages for the measures, including denominator coding, you are reporting. **Note that the specifications for a measures group are different from those for individual measures because they identify a common denominator across the measures group**. Be sure you use the correct specifications.

2. "Getting Started with 2011 Physician Quality Reporting of Measures Groups" is the implementation guide for reporting measures groups.

3. "2011 Physician Quality Reporting Fact Sheet: Physician Quality Reporting Made Simple for Reporting the Preventive Care Measures Group" provides a useful worksheet to keep track of each unique patient reported when using the 30 patient sample method to report a measures group.

The first two documents are available as downloadable documents in the Measures Codes section of the Physician Quality Reporting web page at http://www.cms.gov/PQRS on the CMS website. The third document is available as a downloadable document in the Educational Resources section of the Physician Quality Reporting web page.

Tips for Physician Quality Reporting

The following tips are offered to assist eligible professionals and their staff to submit Physician Quality Reporting measures accurately.

Claims-Based Reporting of Individual Measures

- Ensure all staff understands the measures you have selected to report. The only authoritative sources for measure specifications are those posted on the Physician Quality Reporting web page.

- Ensure the practice has a method to flag eligible cases when billing Medicare, including Medicare as a secondary payer, so that QDCs on those cases are properly reported. Review **all** the denominator codes that can affect **claims-based** reporting, particularly for broadly applicable measures or measures that do not have an associated diagnosis (e.g., #110 Influenza Vaccine, #154 Falls Risk Assessment, #47 Advance Care Planning, etc.), because you will need to report the measure for each eligible patient (on the claim form) as instructed in the measure specifications.

- Ensure you identify and capture **all** eligible claims per the measure denominator for each measure selected. Note that several measures apply broadly across various settings of care (not only office practices, but also hospitals, nursing homes, and home health). For example, the table below shows some measures that include only CPT Category I service codes in the denominator; no ICD-9-CM diagnosis code is required for denominator inclusion. Therefore, each individual eligible professional who chooses to report these broadly applicable measures will need to report the QDC on each eligible claim that falls into the denominator. Failure to submit a QDC on claims for these Medicare patients will result in a "missed" reporting opportunity that can impact incentive eligibility.

Table 1: Physician Quality Reporting Measures with CPT Category I Codes

Measure Number	Measure Title	Reporting
47	Advance Care Plan	Report a minimum of **once** for all patients aged 65 years and older meeting denominator encounter codes.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old	Report a minimum of **once** for all patients aged 50 years and older meeting denominator encounter codes.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	Report a minimum of **once** for all patients aged 65 years and older meeting denominator encounter codes.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Report a minimum of **once** for all patients aged 18 years and older meeting denominator encounter codes.
130	Documentation and Verification of Current Medications in the Medical Record	Report at **each visit** - all patients aged 18 years and older meeting denominator encounter codes.

- For measures that require capturing clinical values for coding, make sure that these clinical values are available to those who are coding claims for Physician Quality Reporting.
- Some measures have specified patient demographics, such as age parameters and gender, for denominator inclusion.
- For measures that you have selected to report, carefully review all ICD-9-CM diagnoses (if applicable) and CPT service (encounter) codes that will qualify claims for inclusion in Physician Quality Reporting measurement calculations (i.e., claims that are denominator-eligible) and ensure that each claim includes the appropriate QDC(s) or QDC with the allowable CPT II modifier with the individual eligible professional's NPI in the rendering provider ID field on the claim. Refer to the "2011 Physician Quality Reporting System Implementation Guide." If the diagnosis or encounter code is different on the claim than those listed in the Physician Quality Reporting denominator, then that claim is considered not applicable for the measure and will not count toward the determination of satisfactory reporting.

Regardless of the reference number in the diagnosis pointer field in the CMS-1500 form, all diagnoses are considered for the analysis of reporting and apply to all rendering providers on the claim reporting the measures. Note that many Physician Quality Reporting measures only require encounter codes in the denominator. The Physician Quality Reporting quality measure specifications identify the combinations of diagnosis and encounter codes that make a claim eligible for a given measure. **Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to ensure they are capturing ALL reported measures applicable to that patient's encounter.** Due to using all diagnoses on the base claim, it is highly recommended that participants avoid including multiple dates of service and/or multiple rendering providers on the same claim. This will help eliminate diagnosis codes associated with other services being attributed to another professional's services.

- For measures that require more than one QDC (CPT II or G-code), please ensure that **all** codes are captured on the claim. For example, when submitting codes for Measure #3 High Blood Pressure Control in Type I and Type II Diabetes Mellitus, be sure to include codes for both the systolic and diastolic blood pressure. Refer to the Form CMS-1500 Claim Sample in Appendix D of the "2011 Physician Quality Reporting System Implementation Guide."

- If all billable services on the claim are denied for payment by the carrier/MAC, the QDCs will not be included in Physician Quality Reporting analysis. The claim, as a whole, must include the payment codes (usually ICD-9-CM, CPT Category I, or Healthcare Common Procedure Coding System [HCPCS] codes) which supply the denominator, as well as the QDCs, which supply the numerator, in order for the measure's QDCs to be included in Physician Quality Reporting analysis. If the denied claim is subsequently corrected and paid through an adjustment, re-opening, **or** the appeals process by the carrier/MAC, with accurate codes that also correspond to the measure's denominator, then QDCs that correspond to the numerator should also be included on the corrected claim as instructed in the measure specifications. Claims may **not** be resubmitted only to add or correct QDCs, and claims with only QDCs on them with a zero total dollar amount may not be resubmitted to the carrier/MAC. Remember that claim adjustments, re-openings, **or** appeals processed by the carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History [NCH] file) by February 28, 2012, to be included in the 2011 Physician Quality Reporting analysis.

- QDCs should be submitted on the line item of the claim as a zero charge. A nominal amount, such as a penny, may be entered if billing software does not permit a zero charge line item. The submitted charge field ($Charges) cannot be left blank. Since there is no allowed charge for the Physician Quality Reporting QDC line items, all Physician Quality Reporting QDC line items will be denied by the carrier/MAC claims processing system and passed onto the NCH file for analysis and incentive-payment eligibility calculation. The Remittance Advice (RA) with Remittance Advice Remark Code (RARC) denial code N365 is your indication that the Physician Quality Reporting codes were passed into the NCH file for use in calculating incentive eligibility. Review the measure specifications to determine the appropriate numerator codes to place on the claim. When applicable (and detailed in the measure's specification), utilize the 8P reporting modifier (or G-code equivalent) when the action required is not performed and the reason is not otherwise specified so that the claim will count toward satisfactory reporting.

- Check your RA notices regularly to ensure you receive RARC N365 for each QDC submitted, denoting that QDCs for individual measures and/or measures groups were passed into the NCH.

  NOTE: The RARC does not confirm QDC accuracy.

Claims-based Reporting of Measures Groups

There are two reporting methods for submission of measures groups that involve a patient sample selection: either the 30 patient sample method or the 50 percent patient sample method. An "intent G-code" must be submitted for either method to initiate your intent to report measures groups via claims-based reporting.

- When reporting quality actions for Physician Quality Reporting measures groups, the individual eligible professional may report QDCs on each individual measure within the measures group **or** report one (composite) G-code, which indicates that all quality actions for **all** the applicable measures (for the particular patient) in the group were performed. For example, G8499 indicates all quality actions for the measures in the rheumatoid arthritis measures group have been performed for the patient.

  If all of the quality actions for the measures within the measures group were performed at an encounter during the reporting period, the eligible professional could report the composite G-code instead of reporting QDCs for each measure individually. Note that performance exclusion modifiers (i.e., 1P, 2P, 3P, or G-code equivalent) and the 8P reporting modifier cannot apply to the reporting of any measure within the measures group if the composite G-code is used for reporting because **all** of the quality actions for each measure must have been performed and documented. Refer to the "Getting Started with 2011 Physician Quality Reporting of Measures Groups" (available as a downloadable document posted in the Measures Codes section of the Physician Quality Reporting web page).

- If a patient selected for inclusion in the 30 patient sample did not receive all the quality actions and that patient returns at a subsequent encounter, QDC(s) may be added (where applicable) to that subsequent claim to indicate that the quality action was performed during the reporting period. Physician Quality Reporting analysis will consider all QDCs submitted across multiple claims for patients included in the 30 patient sample.

- Eligible professionals only need to report the applicable measures for each patient who meets denominator inclusion in the patient sample. Denominator inclusion for both the 30 patient sample method and the 50 percent patient sample method is determined by diagnoses and/or encounters common to measures within a selected measures group. For example, if patient #3 in the sample does not meet the age requirements for all of the measures within the measures group, report those measures that **are** applicable to patient #3. All patients may not meet all of the measure criteria (denominator criteria) within a particular measures group.

- Only Medicare Part B FFS patients should be included for the reporting of measures groups.

Common Reporting Errors Associated with Claims-based Reporting

- No QDC submitted on an eligible claim. Failure to submit a QDC on claims for eligible Medicare patients will result in a "missed" reporting opportunity that can impact incentive eligibility.
- Eligible claim without an individual NPI or with the NPI incorrectly placed on the claim will result in a claim rejection by the carrier/MAC and will not be included in Physician Quality Reporting analysis.
- Eligible claim submitted as a QDC-only claim (no denominator information is accompanied).
- QDC submitted on a denominator-ineligible claim for the Physician Quality Reporting measure:
  - Diagnosis is incorrect on claim for measure reported;
  - Encounter code is incorrect on claim for measure reported; or
  - Age/gender on claim is incorrect for measure reported.
- Billing software does not allow enough lines on the claim and splits the claim. CMS will reconnect split claims before Physician Quality Reporting System analysis.

Registry-based Reporting of Individual Measures or Measures Groups

Submission of at least three individual measures or at least one measures group via registry-based reporting is governed by the "2011 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry" and "2011 Physician Quality Reporting System Measures Groups Specifications Manual," respectively, and is required. To become eligible for an incentive, an eligible professional must submit each measure or measures group on 80 percent of eligible beneficiaries, and no measure or measures group can have a 0 percent performance rate. The qualified registry is responsible for providing its clients with instructions on how to submit the selected measures or measures group through the registry. Information regarding qualified registries is available in the Alternative Reporting Mechanisms section of the Physician Quality Reporting web page.

NOTE: Some 2011 Physician Quality Reporting individual measures and measures groups are only reportable through the registry-based reporting option and not through other reporting methods, such as claims-based reporting.

When reporting using the 30 patient sample method for measures groups via registry-based reporting, the patient sample must only include Medicare Part B FFS patients.

Medical Record Documentation

Eligible professionals should document fulfillment of measure requirements in the medical record.

Feedback Reports

Registration in Individuals Authorized Access to CMS Computer Services (IACS) after the conclusion of the program year is needed to receive a tax identification number (TIN)-level feedback report. Individual eligible professionals may request an NPI-level feedback report through their carrier/MAC, which does not require registration in IACS.

Table 2: Physician Quality Reporting System References

Physician Quality Reporting Reference	Physician Quality Reporting Web Page
"2011 Physician Quality Reporting System Fact Sheet: What's New for 2011 Physician Quality Reporting"	Educational Resources Download
"Eligible Professionals List"	Overview Download
"2011 Physician Quality Reporting System Implementation Guide" Appendix A: Glossary of Terms Appendix B: Sample 2011 Physician Quality Reporting System Measure Appendix C: 2011 Physician Quality Reporting System Participation Decision Tree Appendix D: CMS-1500 Claim Example	Measures Codes Download
"2011 Physician Quality Reporting System Measures List"	Measures Codes Download
"2011 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry"	Measures Codes Download
"2011 Physician Quality Reporting System Measures Groups Specifications Manual"	Measures Codes Download
"Getting Started with 2011 Physician Quality Reporting of Measures Groups" Appendix A: Decision Tree Appendix B: CMS-1500 Claim Examples	Measures Codes Download
"2011 Physician Quality Reporting System Tip Sheet: Physician Quality Reporting System Made Simple For Reporting Preventive Care Measures Group"	Educational Resources Download
"2011 Physician Quality Reporting System Measure Applicability Validation Process for Claims-Based Reporting of Individual Measures"	Analysis and Payment Download
Physician Quality Reporting System National Provider Calls (NPC)	CMS Sponsored Calls Download
Frequently Asked Questions (FAQs)	Physician Quality Reporting System FAQs - Related Links Inside CMS, bottom of Physician Quality Reporting web page