2012
Physician Quality Reporting System (Physician Quality Reporting)
Getting Started with Measures Groups

11/10/11

Introduction:

This document contains general implementation guidance for reporting 2012 Physician Quality Reporting System (Physician Quality Reporting) measures groups. Measures groups include reporting on a group of clinically-related measures identified by CMS for use in Physician Quality Reporting, either through claims-based and/or registry-based submission. Twenty-two measures groups have been established for 2012 Physician Quality Reporting: Diabetes Mellitus, Chronic Kidney Disease (CKD), Preventive Care, Coronary Artery Bypass Graft (CABG), Rheumatoid Arthritis (RA), Perioperative Care, Back Pain, Hepatitis C, Heart Failure (HF), Coronary Artery Disease (CAD), Ischemic Vascular Disease (IVD), HIV/AIDS, Community-Acquired Pneumonia (CAP), Asthma, Chronic Obstructive Pulmonary Disease (COPD), Inflammatory Bowel Disease (IBD), Sleep Apnea, Dementia, Parkinson's Disease, Hypertension, Cardiovascular Prevention, and Cataracts.

An eligible professional may choose to pursue more than one 2012 reporting option. However, an eligible professional who satisfactorily reports under more than one reporting option will earn a maximum of one incentive payment equal to 0.5 % of his/her total estimated allowed charges for Medicare Part B Physician Fee Schedule (PFS) covered professional services furnished during the longest reporting period for which he or she satisfied reporting criteria.

There are two reporting periods available for eligible professionals to report 2012 Physician Quality Reporting measures groups: a) 12-month reporting period from January 1 through December 31, 2012 (available for the 30 Patient Sample Method and the 50% Patient Sample Method via Claims and 80% Patient Sample Method via Registry) OR b) a 6-month reporting period from July 1 through December 31, 2012 (available only for the 80% Patient Sample Method via Registry). The 6-month reporting period allows those eligible professionals who may have decided to participate later in the year to begin reporting. Those eligible professionals who satisfactorily report quality data under the measures groups reporting option may earn an incentive payment equal to 0.5% of their total estimated allowed charges for Medicare Part B PFS covered professional services furnished during the reporting period. This document provides strategies and information to facilitate satisfactory reporting by each eligible professional who wishes to pursue this alternative.

The *2012 Physician Quality Reporting System Measures Groups Specifications Manual*, which can be found at http://www.cms.gov/PQRS/15_MeasuresCodes.asp, contains detailed descriptions for each quality measure within each measures group. Denominator coding has been modified from the original individual measure as specified by the measure developer to allow for implementation as a measures group. To get started, review the *2012 Physician Quality Reporting System Measures Groups Specifications Manual* to determine if a particular measures group is applicable to Medicare services the practice provides.

Measures Groups Participation Strategy:

1. Plan and implement processes within the practice to ensure satisfactory reporting of measures groups.
2. Become familiar with the following methods for satisfactory reporting of measures groups. The methods for measures groups are:

   30 Patient Sample Method – 12-month reporting period only

   - For claims-based and registry-based submissions, 30 unique Medicare Part B FFS patients who meet patient sample criteria (see Patient Sample Criteria Table starting on page 4) for the measures group. For claims-based submissions, Physician Quality Reporting analysis will be initiated when the measures group-specific intent G-code is submitted on a claim. However, all claims meeting patient sample criteria in the selected reporting period will be considered in the analysis regardless of the

date of service the measures group-specific intent G-code is submitted. If the eligible professional does not have a minimum of 30 unique Medicare Part B FFS patients who meet patient sample criteria for the measures group, the eligible professional would not meet the requirements for this method and should either choose another measures group or choose another reporting option. Please refer to Appendix A: *2012 Physician Quality Reporting Participation Decision Tree*.

- For both claims-based and registry-based submissions, all applicable measures within the group must be reported at least once for each patient within the sample population seen by the eligible professional during the reporting period (January 1 through December 31, 2012) for each of the 30 unique Medicare Part B FFS patients.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group.

OR

50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry – 12-month and 6-month reporting periods (only the registry method applies for the 6 month reporting period) available:

- For claims-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group on claims for at least 50% of all Medicare Part B FFS patients seen during the entire reporting period (January 1 through December 31, 2012) who meet the measures group patient sample criteria.
  - For claims-based submissions, the eligible professional must report the measures group-specific intent G-code once during the reporting period to indicate the eligible professional's selection of the measures group that the eligible professional intends to report.
- For registry-based submissions, a participating eligible professional must report on all applicable measures within the selected measures group for at least 80% of all Medicare Part B FFS patients seen during the entire reporting period (January 1 through December 31, 2012 OR July 1 through December 31, 2012) who meet the measures group patient sample criteria.
- Minimum Patient Sample Size
  - 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 satisfactorily. For the 6-month reporting period, a minimum of 8 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily. If an eligible professional does not have the minimum number of patients for inclusion in the patient sample for the reporting period that eligible professional should report either another measures group or select reporting of individual measures that are applicable to the eligible professional's practice. If the minimum number of patients does not meet the measures group patient sample criteria, the eligible professional is not incentive eligible.
- For both claims-based and registry-based submissions, all applicable measures within the group must be reported according to each measures group's reporting instructions contained within each group's overview section.
- Measures groups containing a measure with a 0% performance rate will not be counted as satisfactorily reporting the measures group.

3. Determine the patient sample based on the patient sample criteria, which is used for the 30 Patient Sample Method, the 50% Patient Sample Method via Claims and the 80% Patient Sample Method via Registry. The following table contains patient sample criteria (common codes) that will qualify an eligible professional's patient for inclusion in the measures group analysis. For claims-based submissions, claims must contain an ICD-9-CM diagnosis code (where applicable) accompanied by a specific CPT patient encounter code. All diagnoses included on the base claim are considered in Physician Quality Reporting analysis.

Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Diabetes Mellitus 18 through 75 years	97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271	250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04
Chronic Kidney Disease (CKD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	585.4, 585.5
Preventive Care 50 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	
Coronary Artery Bypass Graft (CABG) 18 years and older	33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536	
Rheumatoid Arthritis (RA) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	714.0, 714.1, 714.2, 714.81

Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Perioperative Care 18 years and older	19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369, 22558, 22600, 22612, 22630, 27125, 27130, 27132, 27134, 27137, 27138, 27235, 27236, 27244, 27245, 27269, 27440, 27441, 27442, 27443, 27445, 27446, 27447, 39545, 39561, 43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496, 43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870, 44005, 44010, 44020, 44021, 44050, 44055, 44120, 44125, 44126, 44127, 44130, 47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900, 48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48520, 48540, 48545, 48547, 48548, 48554, 48556, 49215, 50320, 50340, 50360, 50365, 50370, 50380, 60521, 60522, 61313, 61510, 61512, 61518, 61548, 61697, 61700, 62230, 63015, 63020, 63047, 63056, 63081, 63267, 63276 NOTE: CPT Category I procedure codes billed by surgeons performing surgery on the same patient, submitted with modifier 62 (indicating two surgeons, i.e., dual procedures) will be included in the denominator population. Both surgeons participating in Physician Quality Reporting will be fully accountable for the clinical action described in the measure.	

Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Back Pain 18 through 79 years	Diagnosis codes with CPT codes: 97001, 97002, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215 OR One of the following back surgical procedure codes: 22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22612, 22614, 22630, 22632, 22818, 22819, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63090, 63091, 63101, 63102, 63103 , 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200	Diagnosis codes for CPT 9XXXX codes: 721.3, 721.41, 721.42, 721.90, 722.0, 722.10, 722.11, 722.2, 722.30, 722.31, 722.32, 722.39, 722.4, 722.51, 722.52, 722.6, 722.70, 722.71, 722.72, 722.73, 722.80, 722.81, 722.82, 722.83, 722.90, 722.91, 722.92, 722.93, 723.0, 724.00, 724.01, 724.02, 724.09, 724.2, 724.3, 724.4, 724.5, 724.6, 724.70, 724.71, 724.79, 738.4, 738.5, 739.3, 739.4, 756.12, 846.0, 846.1, 846.2, 846.3, 846.8, 846.9, 847.2
Hepatitis C 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	070.54
Heart Failure (HF) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93, 428.0, 428.1, 428.20, 428.21, 482.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9
Coronary Artery Disease (CAD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	410.00, 410.01, 410.02, 410.10, 410.11, 410.12, 410.20, 410.21, 410.22, 410.30, 410.31, 410.32, 410.40, 410.41, 410.42, 410.50, 410.51, 410.52, 410.60, 410.61, 410.62, 410.70, 410.71, 410.72, 410.80, 410.81, 410.82, 410.90, 410.91, 410.92, 411.0, 411.1, 411.81, 411.89, 412, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.3, 414.8, 414.9, V45.81, V45.82

Patient Sample Criteria Table		
Measures Group	**CPT Patient Encounter Codes**	**ICD-9-CM Diagnosis Codes**
Ischemic Vascular Disease (IVD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456 OR 33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92980, 92982, 92995	Diagnosis codes for CPT 99XXX codes: 410.11 , 410.21 , 410.31, 410.41, 410.51, 410.61, 410.71 , 410.81 , 410.91 , 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.01, 444.09, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89
HIV/AIDS 13 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	042, 079.53, V08
Community-Acquired Pneumonia (CAP) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99291*, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 *Clinicians utilizing the critical care code (99291) must indicate the emergency department place of service (23) on the Part B claim form in order to report this measure.	481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.40, 482.41, 482.42, 482.49, 482.81, 482.82, 482.83, 482.84, 482.89, 482.9, 483.0, 483.1, 483.8, 485, 486, 487.0
Asthma 5 through 50 years	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.81, 493.82, 493.90, 493.92
Chronic Obstructive Pulmonary Disease (COPD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	491.0, 491.1, 491.20, 491.21, 491.22, 491.8, 491.9, 492.0, 492.8, 496
Inflammatory Bowel Disease (IBD) 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99401, 99402, 99403, 99404, 99406, 99407	555.0, 555.1, 555.2, 555.9, 556.0, 556.1, 556.2, 556.3, 556.4, 556.5, 556.6, 556.8, 556.9
Sleep Apnea 18 years and older	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215	327.23, 780.51, 780.53, 780.57

Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Dementia Any age	90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90810, 90811, 90812, 90813, 90814, 90815, 90816, 90817, 90818, 90819, 90821, 90822, 90823, 90824, 90826, 90827, 90828, 90829, 90862, 96116, 96118, 96119, 96120, 96150, 96151, 96152, 96154, 96155, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350	094.1, 290.0, 290.10, 290.11, 290.12, 290.13, 290.20, 290.21, 290.3, 290.40, 290.41, 290.42, 290.43, 290.8, 290.9, 294.10, 294.11, 294.8, 331.0, 331.11, 331.19, 331.82
Parkinson's Disease Any age	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310	332.0
Hypertension 15-90 years	99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0438, G0439 AND NOT ICD-9-CM 585.5, 585.6	401.0, 401.1, 401.9, 402.00, 402.01, 402.10, 402.11, 402.90, 402.91, 403.00, 403.01, 403.10, 403.11, 403.90, 403.91, 404.00, 404.01, 404.02, 404.03, 404.10, 404.11, 404.12, 404.13, 404.90, 404.91, 404.92, 404.93

Patient Sample Criteria Table		
Measures Group	CPT Patient Encounter Codes	ICD-9-CM Diagnosis Codes
Cardiovascular Prevention 18 years and older	99201, 99202, 99203, 99205, 99212, 99213, 99214, 99215	One of the following diagnosis codes indicating diabetes mellitus: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04 AND/OR One of the following diagnosis codes indicating ischemic vascular disease: 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91, 411.0, 411.1, 411.81, 411.89, 413.0, 413.1, 413.9, 414.00, 414.01, 414.02, 414.03, 414.04, 414.05, 414.06, 414.07, 414.2, 414.8, 414.9, 429.2, 433.00, 433.01, 433.10, 433.11, 433.20, 433.21, 433.30, 433.31, 433.80, 433.81, 433.90, 433.91, 434.00, 434.01, 434.10, 434.11, 434.90, 434.91, 440.01, 440.09, 440.1, 440.20, 440.21, 440.22, 440.23, 440.24, 440.29, 440.4, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89
Cataracts 18 years and older	66840, 66850, 66852, 66920, 66930, 66940, 66983, 66984 WITHOUT Modifier 56 (preoperative management only)	

4. For claims-based submissions, to initiate reporting of measures groups submit by using the measures group-specific intent G-codes which will indicate your intention to begin reporting on a measures group. It is not necessary to submit the measures group-specific intent G-code on more than one claim. It is not necessary to submit the measures group-specific intent G-code for registry-based submissions. However, the measures group-specific intent G-codes have been included for registry only measures groups for use by registries that utilize claims data.

Claims and Registry G-codes
G8485: I intend to report the Diabetes Mellitus Measures Group
G8487: I intend to report the Chronic Kidney Disease (CKD) Measures Group
G8486: I intend to report the Preventive Care Measures Group
G8490: I intend to report the Rheumatoid Arthritis Measures Group
G8492: I intend to report the Perioperative Care Measures Group
G8493: I intend to report the Back Pain Measures Group
G8545: I intend to report the Hepatitis C Measures Group
G8547: I intend to report the Ischemic Vascular Disease (IVD) Measures Group
G8546: I intend to report the Community-Acquired Pneumonia (CAP) Measures Group
G8645: I intend to report the Asthma Measures Group
G8898: I intend to report the Chronic Obstructive Pulmonary Disease (COPD) Measures Group
G8905: I intend to report the Cardiovascular Prevention Measures Group

Registry-only G-codes
G8544: I intend to report the Coronary Artery Bypass Graft (CABG) Measures Group
G8548: I intend to report the Heart Failure (HF) Measures Group
G8489: I intend to report the Coronary Artery Disease (CAD) Measures Group
G8491: I intend to report the HIV/AIDS Measures Group
G8899: I intend to report the Inflammatory Bowel Disease (IBD) Measures Group
G8900: I intend to report the Sleep Apnea Measures Group
G8902: I intend to report the Dementia Measures Group
G8903: I intend to report the Parkinson's Disease Measures Group
G8904: I intend to report the Hypertension (HTN) Measures Group
G8906: I intend to report the Cataracts Measures Group

5. Report all applicable measures for the measure group on each denominator-eligible patient included in the patient sample for each individual eligible professional. Report quality-data codes (QDCs) as instructed in the *2012 Physician Quality Reporting System Measures Groups Specifications Manual* on all applicable measures within the measures group for each patient included in the sample population for each individual eligible professional. For claims-based submissions, eligible professionals may choose to submit QDCs either on a current claim or on a claim representing a subsequent visit, particularly if the quality action has changed. For example, a new laboratory value may be available at a subsequent visit. Only one instance of reporting for each patient included in the sample population will be used in Physician Quality Reporting analysis to calculate reporting and performance rates for each measure within a group.

   For claims-based submissions, if all quality actions for the applicable measures in the measures group have been performed for the patient, one composite G-code may be reported in lieu of the individual quality-data codes (QDCs) for each of the measures within the group. This composite G-code has also been created for registry only measures groups for use by registries that utilize claims data. However, it is not necessary to submit this composite G-code for registry-based submissions. Refer to the *2012 Physician Quality Reporting System Measures Groups Specifications Manual* for detailed instructions about how to report QDCs for each of the measures groups at http://www.cms.gov/PQRS/15_MeasuresCodes.asp.

   An eligible professional is only required to report QDCs on those individual measures in the measures group that meet the criteria (e.g., age, gender, etc.) according to the *2012 Physician Quality Reporting System Measures Groups Specifications Manual*. For example, if an eligible professional is reporting the Preventive Care Measures Group for a 52-year old female patient, only 7 measures out of 10 apply. See the Preventive Measures Group Demographic Criteria table below.

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

Claims-Based Reporting Principles

The following principles apply to the reporting of QDCs for Physician Quality Reporting measures:

- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
  - on the claim(s) with the denominator billing code(s) that represents the eligible encounter
  - for the same beneficiary
  - for the same date of service (DOS)
  - by the same eligible professional (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the denominator.

- All diagnoses reported on the base claim will be included in Physician Quality Reporting analysis, as some Physician Quality Reporting measures require reporting more than one diagnosis on a claim. For line items containing a QDC, only one diagnosis from the base claim should be referenced in the diagnosis pointer field. To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, all diagnoses on the claim(s) are considered in Physician Quality Reporting analysis.

- Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically. Physician Quality Reporting analyzes claims data using ALL diagnoses from the base claim (Item 21 of the CMS-1500 or electronic equivalent) and service codes from each individual professional identified by his or her rendering individual NPI on allowed/paid service line for a Physician Quality Reporting QDC line. Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to make sure they are capturing ALL reported measures applicable to that patient's care.

- If your billing software limits the number of line items available on a claim, you may add a nominal amount such as a penny to one of the line items on that second claim for a total charge of one penny. Physician Quality Reporting analysis will subsequently join claims based on the same beneficiary for the same date-of-service, for the same Taxpayer Identification Number/National Provider Identifier (TIN/NPI) and analyze as one claim. Providers should work with their billing software vendor/clearinghouse regarding line limitations for claims to ensure that diagnoses ,QDCs, or nominal charge amounts are not dropped.

- QDCs must be submitted with a line-item charge of zero dollars ($0.00) at the time the associated covered service is performed.
    - The submitted charge field cannot be blank.
    - The line item charge should be $0.00.
    - If a system does not allow a $0.00 line-item charge, a nominal amount can be substituted – the beneficiary is not liable for this nominal amount.
    - Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00.)
    - Whether a $0.00 charge or a nominal amount is submitted to the Carrier or A/B Medicare Administrative Contractor (MAC), the Physician Quality Reporting code line is denied and tracked.

- QDC line items will be denied for payment, but are then passed through the claims processing system for Physician Quality Reporting analysis. Eligible professionals will receive a Remittance Advice (RA) associated with the claim which will contain the Physician Quality Reporting QDC line-item and will include a standard remark code (N365) and a message that confirms that the QDCs passed into the 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 eligible professional is attempting to report.
    - Keep track of all Physician Quality Reporting cases reported so that you can verify QDCs reported against the RA notice sent by the Carrier or A/B (MAC). Each QDC line-item will be listed with the N365 denial remark code.

- Multiple eligible professionals' QDCs can be reported on the claim(s) representing the eligible encounter using their individual NPI. Therefore, when a group is billing, they should follow their normal billing practice of placing the NPI of the individual eligible professional who rendered the service on each line item on the claim including the QDC line(s).

- Some measures require the submission of more than one QDC in order to properly report the measure. Report each QDC as a separate line item, referencing one diagnosis and including the rendering provider NPI.

- Use of CPT II modifiers (1P, 2P, 3P, and the 8P reporting modifier) is unique to CPT II codes and may not be used with other types of CPT codes. Only CPT II modifiers may be appended to CPT II codes. CPT II modifiers can only be used as indicated in the measures group specification.

- Solo practitioners should follow their normal billing practice of placing their individual NPI in the billing provider field, (#33a on the CMS-1500 form or the electronic equivalent).

- Eligible professionals may submit multiple codes for more than one measure on a claim.

- Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the claim(s) representing the eligible encounter, as long as the corresponding denominator CPT codes are also line items on those claim(s).

- If a denied claim is subsequently corrected through the appeals process to the Carrier or A/B 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 resubmitted claim as instructed in the measure specifications.

- Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs.

- Eligible professionals should use the 8P reporting modifier sensibly for applicable measures they have selected to report. The 8P modifier may not be used freely in an attempt to meet satisfactory reporting criteria without regard toward meeting the practice's quality improvement goals.

Submission through Carriers or A/B MACs

QDCs shall be submitted to Carriers or A/B MACs either through:

- Electronic-based Submission: Physician Quality Reporting QDCs are submitted on the claim just like any other code; however, QDCs will have a $0.00 (or nominal) charge. Electronic submission, which is accomplished using the ASC X 12N Health Care Claim Transaction (Version 5010), should follow the current HIPAA standard version of the ASC x12 technical report 3.

OR

- Paper-based submission: Paper-based submissioins are accomplished by using the CMS-1500 claim form (version 08-05) as described in the sample claim provided in Appendix B.

Group NPI Submission

When a group bills, the group's NPI is submitted at the claim level, therefore, the individual rendering physician's NPI must be placed on each line item, including all allowed charges and quality-data line items.

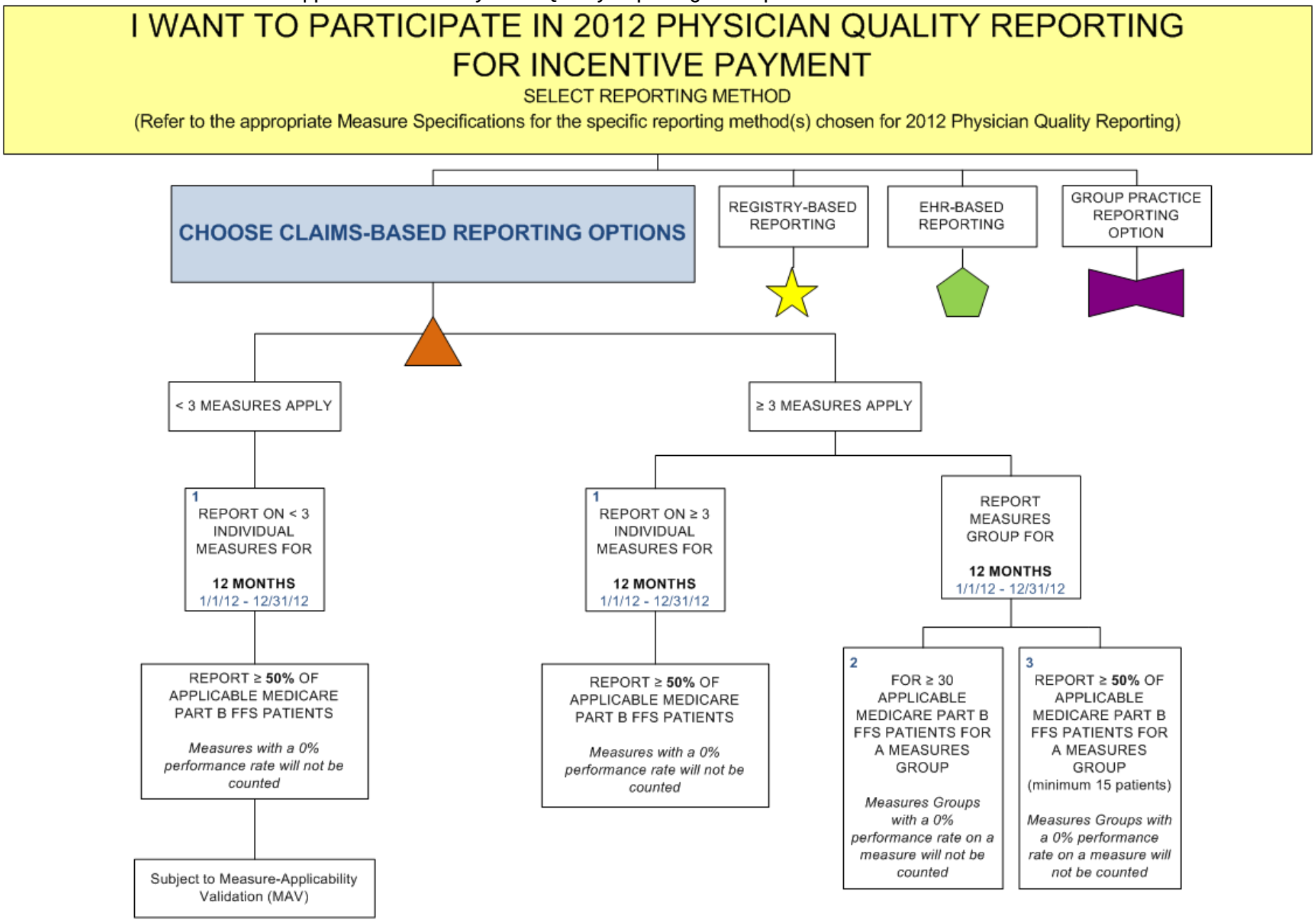
Solo NPI Submission

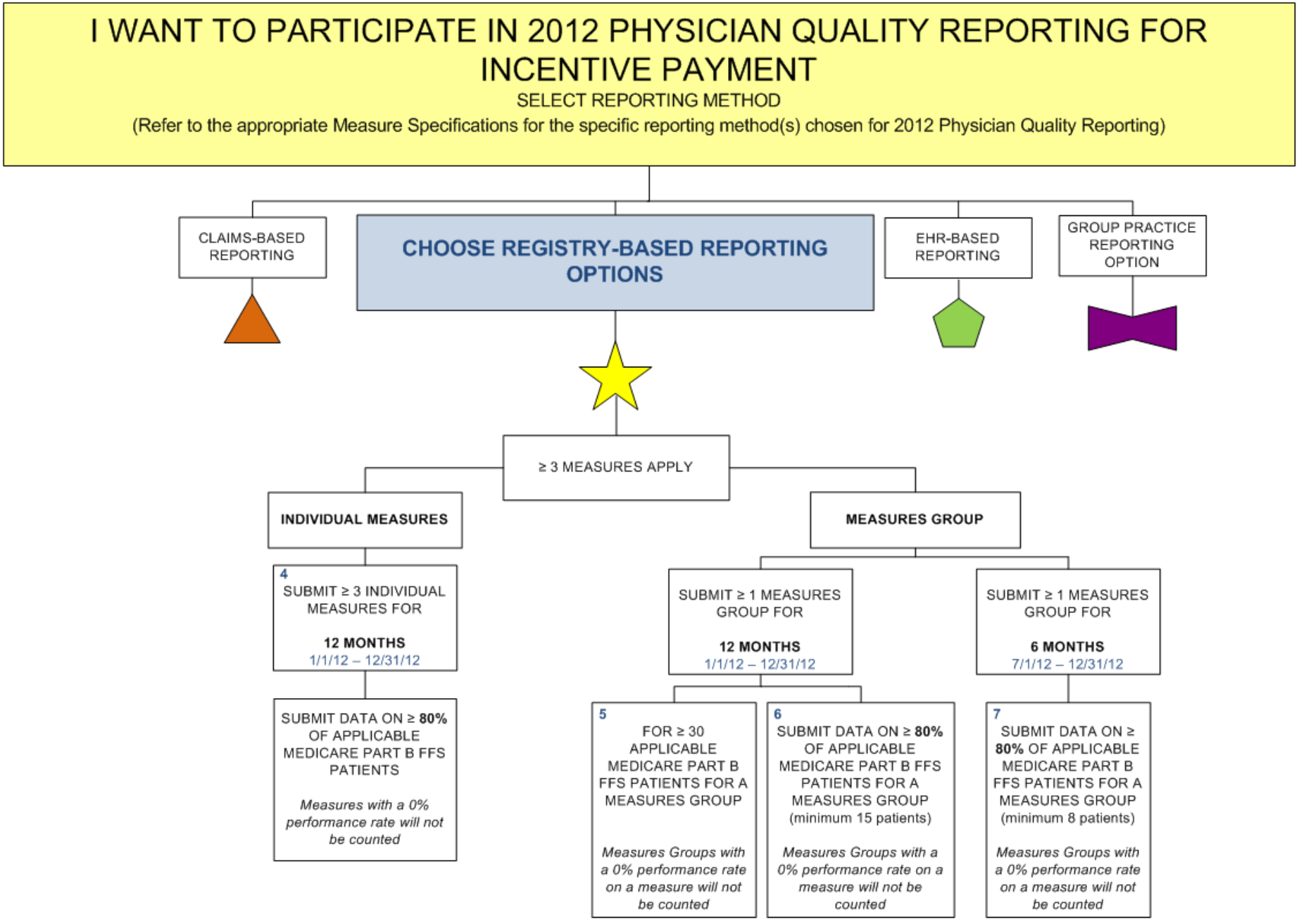
The individual NPI of the solo practitioner must be included on the claim as is the normal billing process for submitting Medicare claims. For Physician Quality Reporting, the QDC must be included on the claim(s) representing the eligible encounter that is submitted for payment at the time the claim is initially submitted in order to be included in Physician Quality Reporting analysis.

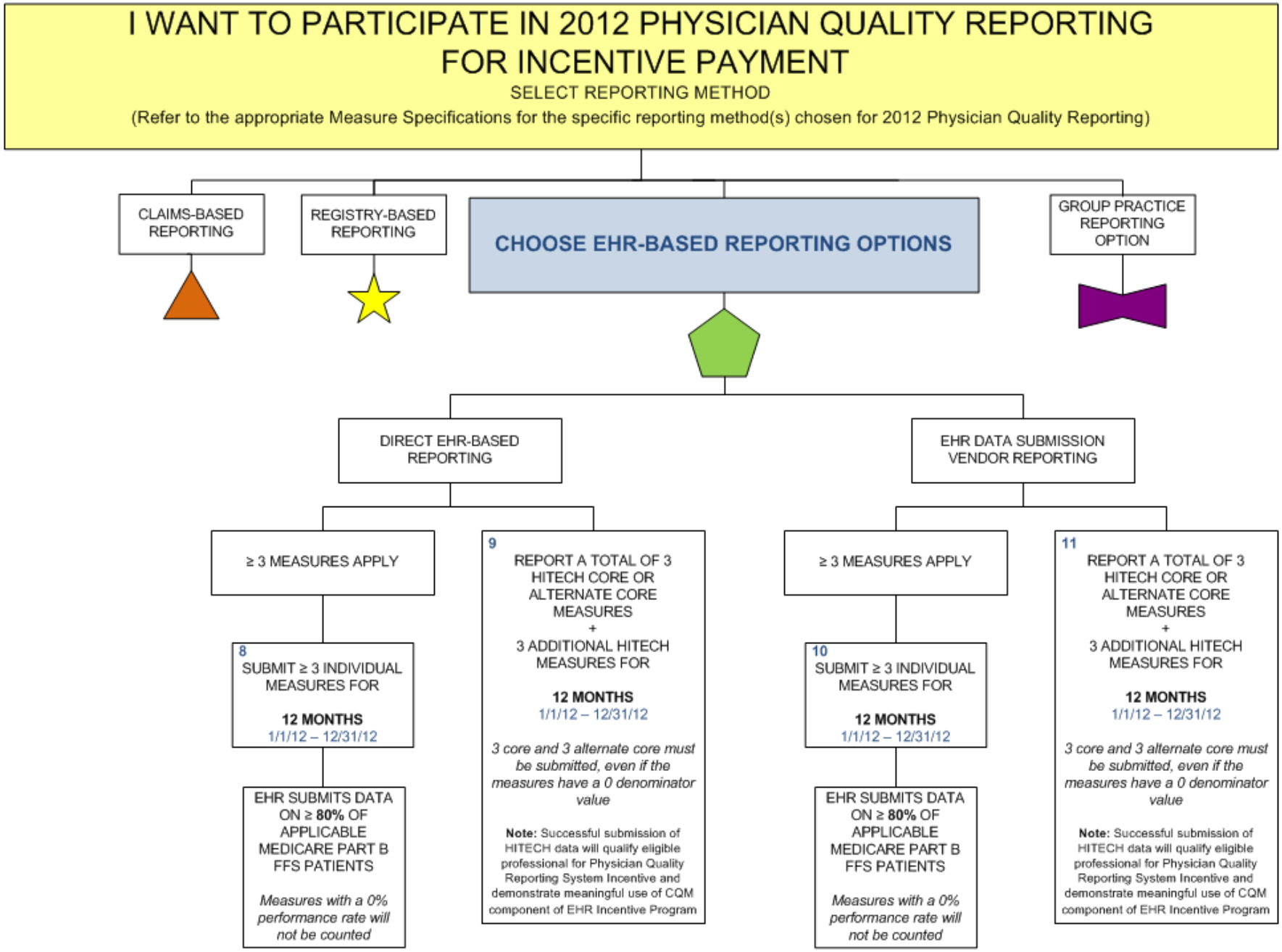
CMS-1500 Claim Example

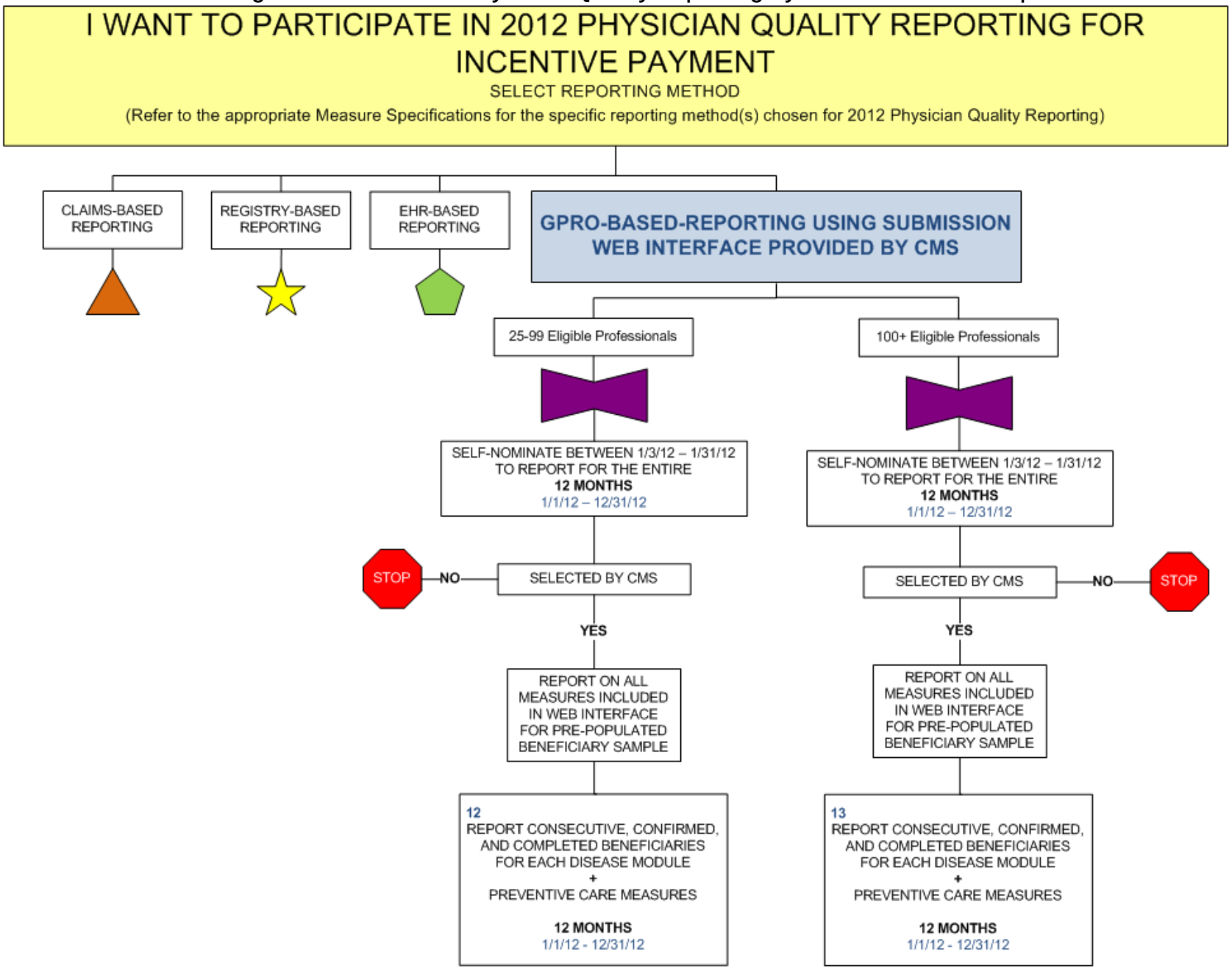
An example of a claim in CMS-1500 format that illustrates how to report measures groups is provided. See Appendix B.

Appendix A: 2012 Physician Quality Reporting Participation Decision Tree





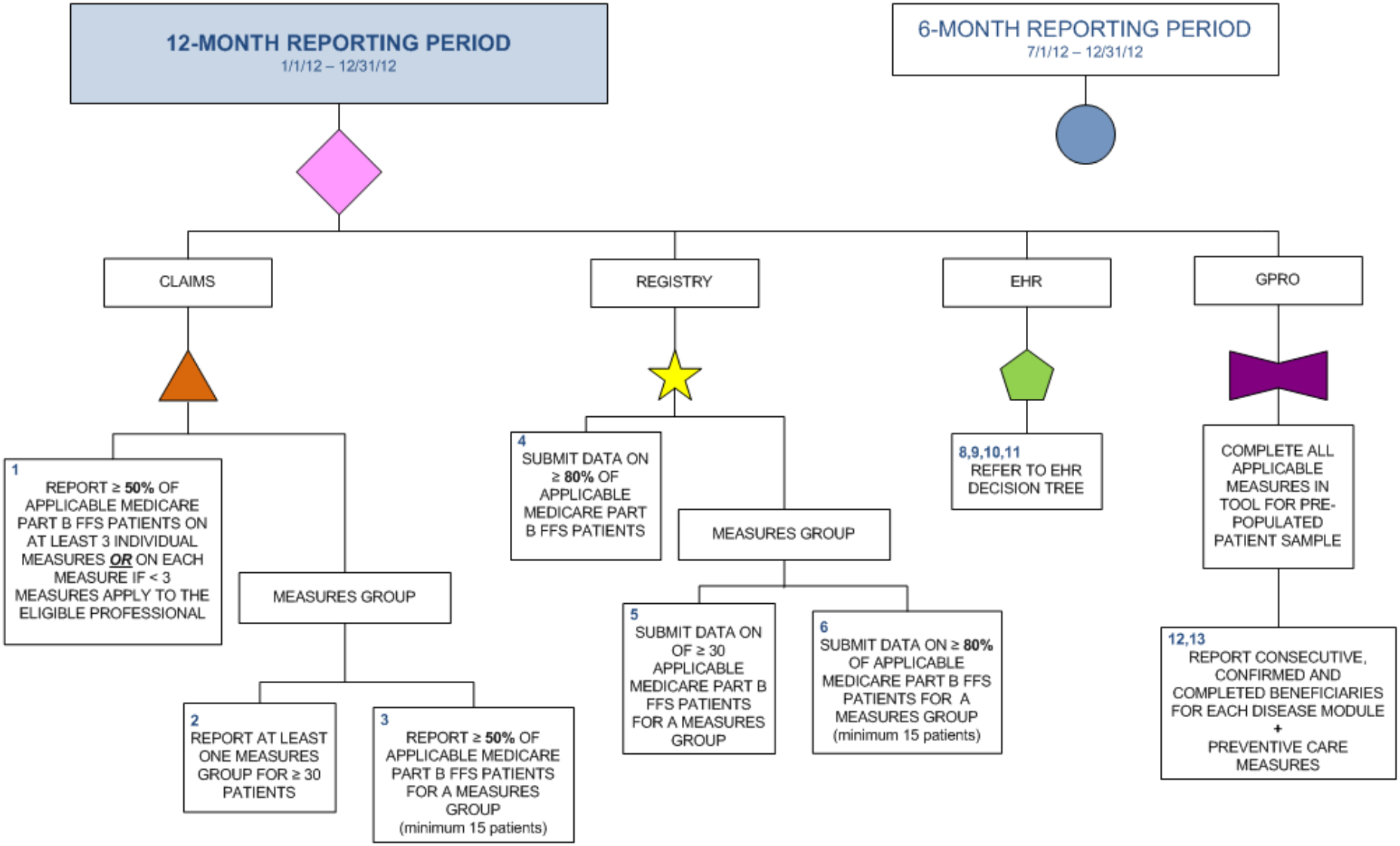




I WANT TO PARTICIPATE IN 2012 PHYSICIAN QUALITY REPORTING FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2012 Physician Quality Reporting)

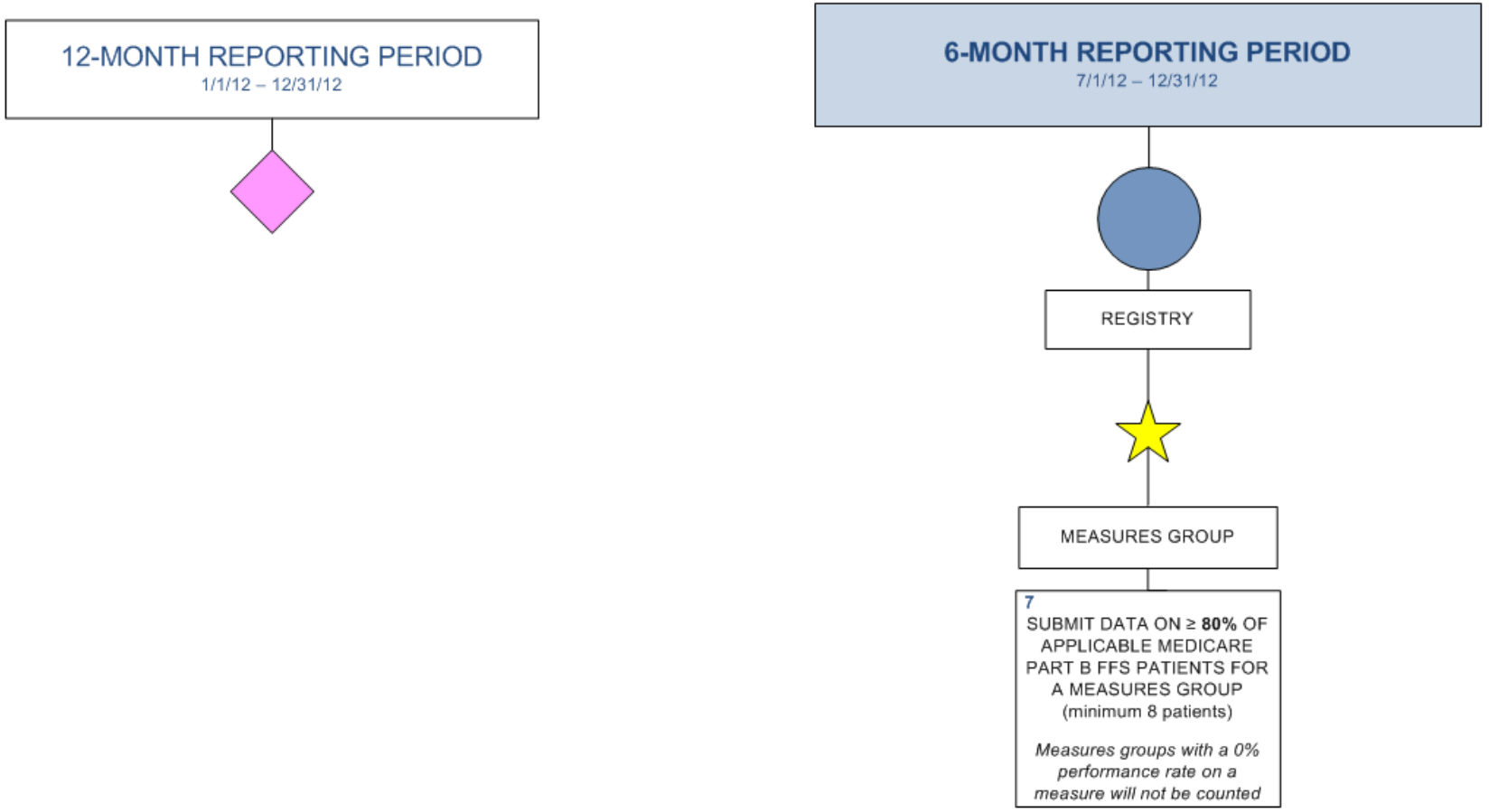


Note: *Measures with a 0% performance rate and Measures Groups containing a measure with a 0% performance rate will not be counted*

I WANT TO PARTICIPATE IN 2012 PHYSICIAN QUALITY REPORTING FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2012 Physician Quality Reporting)



2012 Program Reporting Options

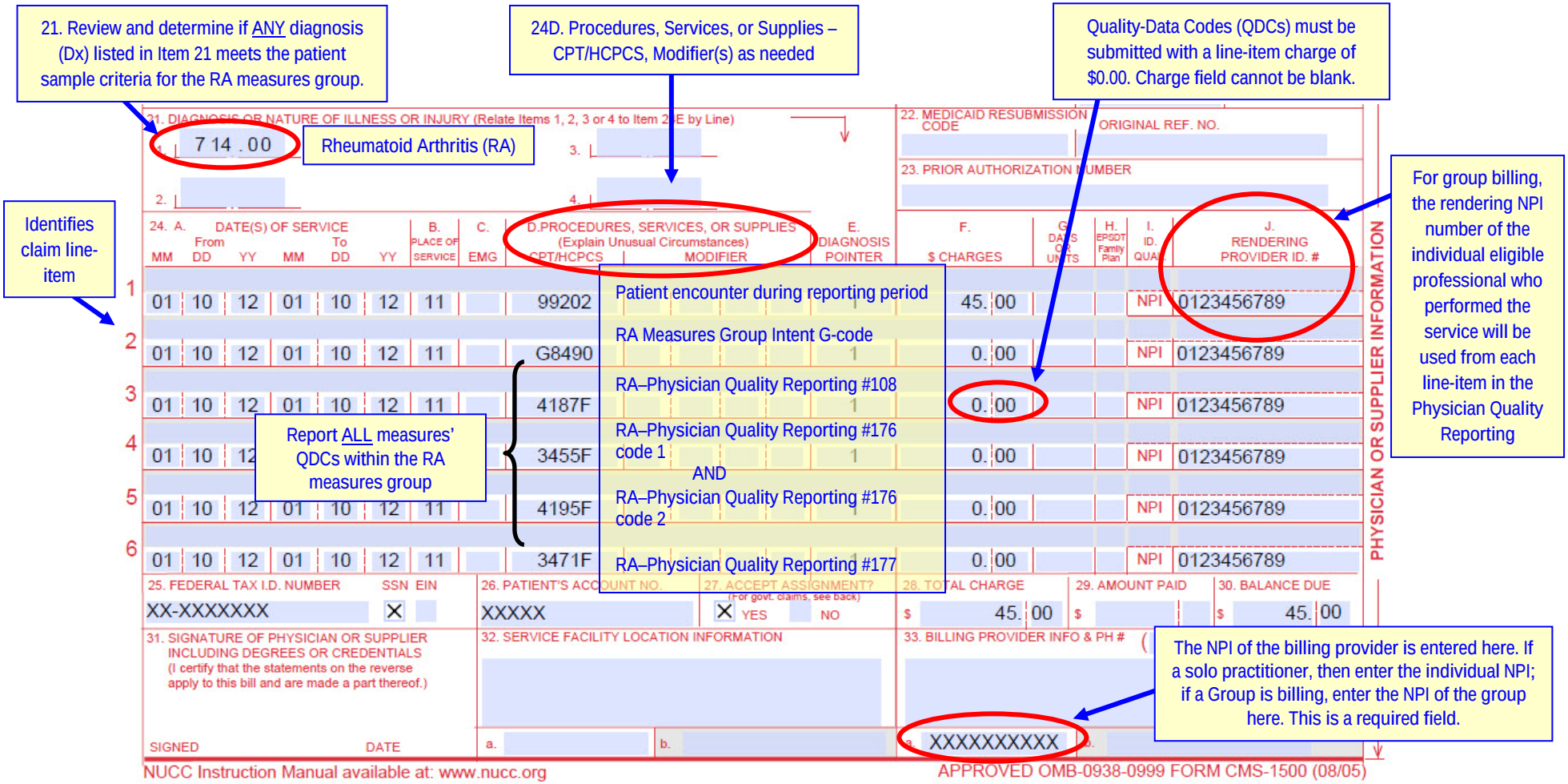
Number assigned coordinates with appropriate box on the Appendix C: 2012 Physician Quality Reporting Participation Decision Tree.

1. Claims-based reporting of individual measures (12 months)
2. Claims-based reporting of at least one measures group for 30 unique Medicare Part B FFS patients (12 months)
3. Claims-based reporting of at least one measures group for 50% or more of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients) (12 months)
4. Registry-based reporting of at least 3 individual Physician Quality Reporting measures for 80% or more of applicable Medicare Part B FFS patients of each eligible professional (12 months)
5. Registry-based reporting of at least one measures group for 30 unique Medicare Part B FFS patients (12 months)
6. Registry-based reporting of at least one measures group for 80% or more of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients) (12 months)
7. Registry-based reporting of at least one measures group for 80% or more of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 8 patients) (6 months)
8. Direct EHR-based reporting of at least 3 individual Physician Quality Reporting measures for 80% or more of applicable Medicare Part B FFS patients of each eligible professional (12 months)
9. Direct EHR-based reporting of a total of 3 HITECH core or alternate core measures AND at least 3 additional HITECH measures (12 months)
10. EHR Data Submission Vendor reporting of at least 3 individual Physician Quality Reporting measures for 80% or more of applicable Medicare Part B FFS patients of each eligible professional (12 months)
11. EHR Data Submission Vendor reporting of a total of 3 HITECH core or alternate core measures AND at least 3 additional HITECH measures (12 months)
12. GPRO-based reporting (25-99 eligible professionals) of all applicable measures included in the submission web interface provided by CMS for consecutive, confirmed, and completed patients for each disease module and preventive care measures (12 months)
13. GPRO-based reporting (100+ eligible professionals) of all applicable measures included in the submission web interface provided by CMS for consecutive, confirmed,and completed patients for each disease module and preventive care measures (12 months)

Getting Started with 2012 Physician Quality Reporting System Measures Groups

Appendix B: CMS-1500 Claim [Detailed Measures Group] – Sample 1 (continues on next pg)

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:

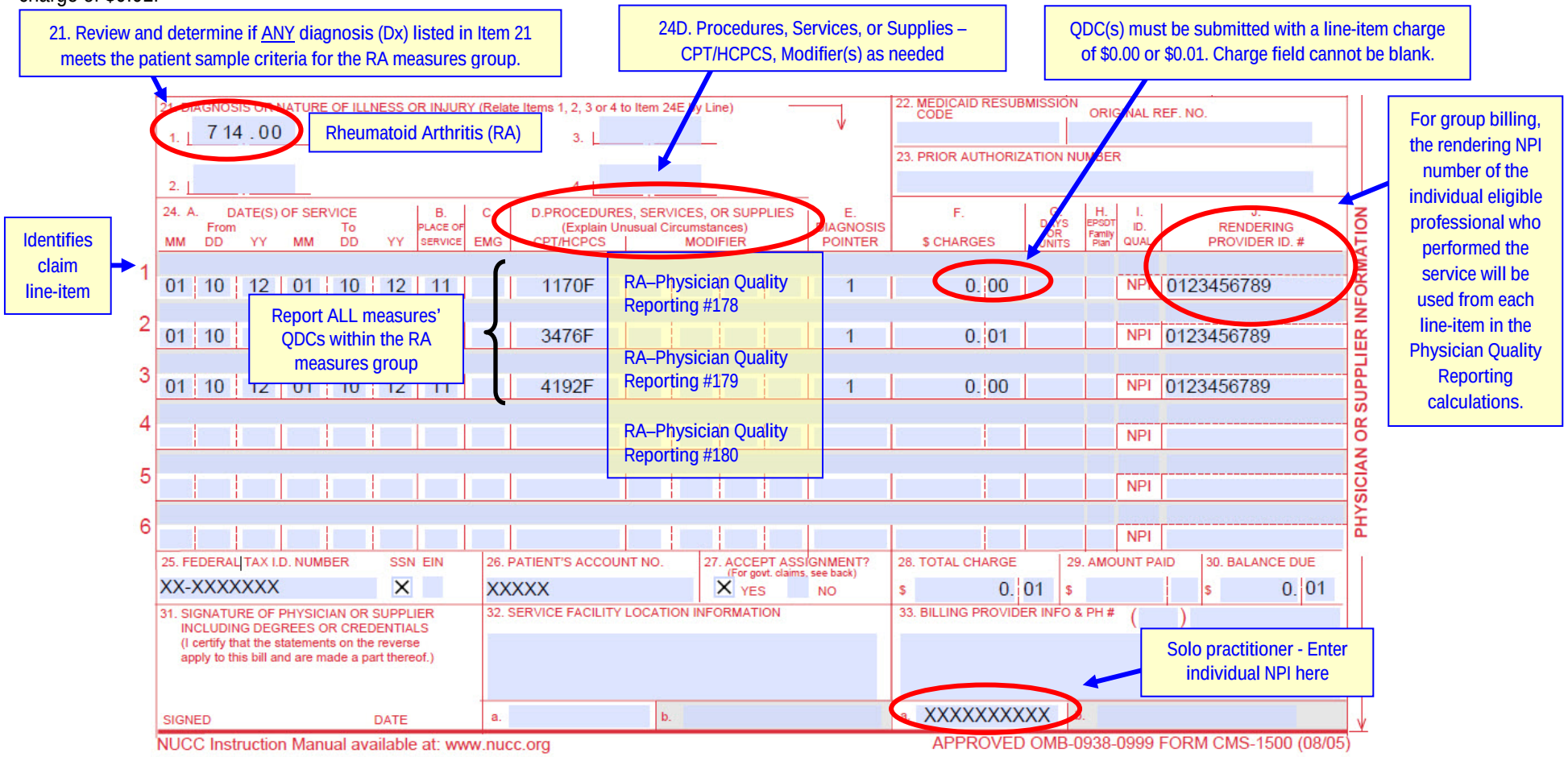
- Intent G-code (G8490) was submitted to initiate the eligible professional's submission of the RA Measures Group.
- Measure #108 (RA-DMARD Therapy) with QDC 4187F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21);
- Measure #176 (RA-Tuberculosis Screening) with QDCs 3455F + 4195F + RA line-item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

Getting Started with 2012 Physician Quality Reporting System Measures Groups

Appendix B: 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.

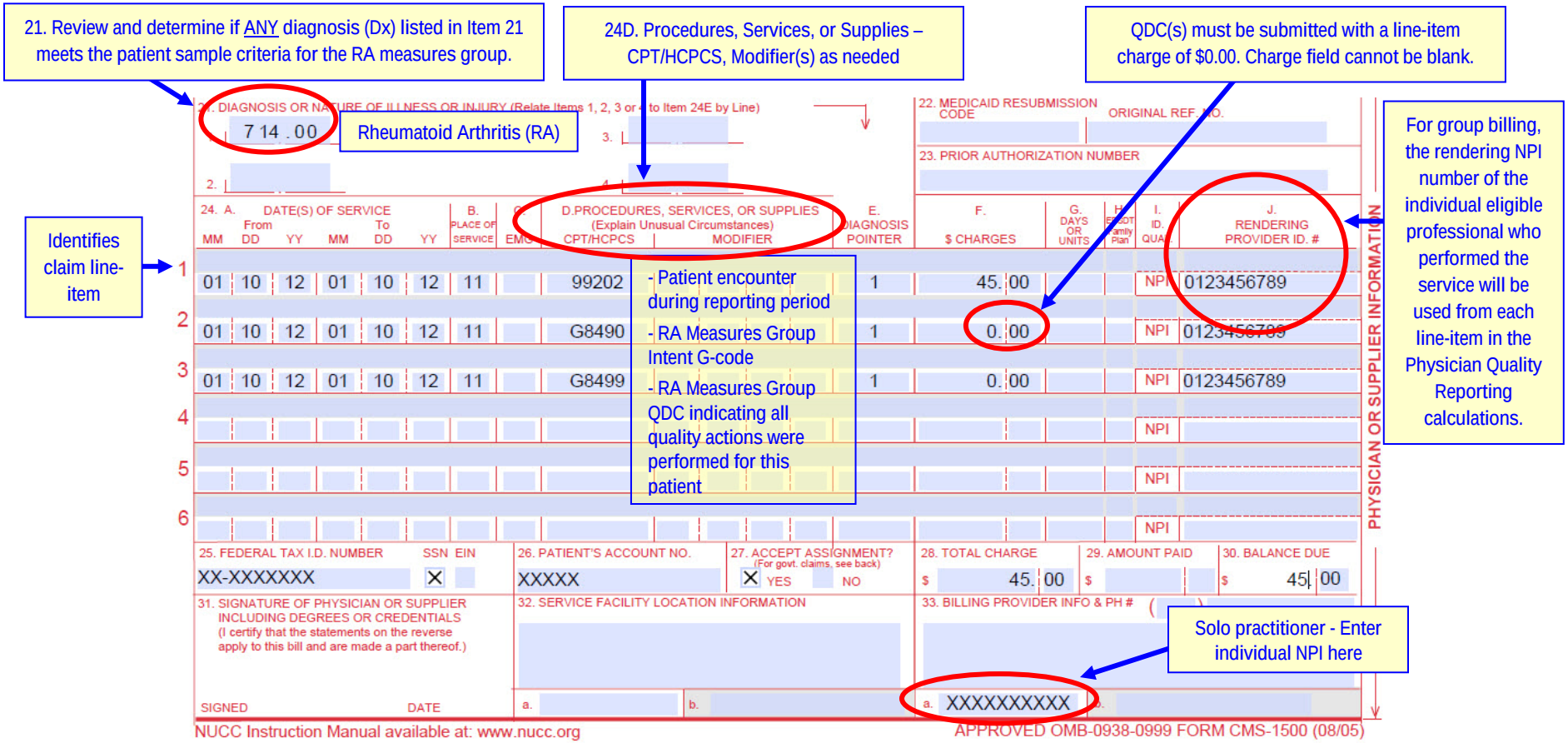


- Measure #178 (RA-Functional Status Assessment) with QDC 1170F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21);
- Measure #179 (RA-Assessment & Classification) with QDC 3476F + RA line-item diagnosis (24E points to Dx 714.0 in Item 21); and
- Measure #180 (RA-Glucocorticoid Management) 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.

Getting Started with 2012 Physician Quality Reporting System Measures Groups

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.