This document has been reprinted with permission from the Centers for Medicare and Medicaid Services (CMS) and can be found on the CMS website at www.cms.gov.

Information current as of January 2011 and is subject to change by CMS.
Introduction:

This document contains general implementation guidance for reporting 2011 Physician Quality Reporting System ("Physician Quality Reporting," formerly known as Physician Quality Reporting Initiative or PQRI)) 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. Fourteen measures groups have been established for 2011 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), and Asthma.

An eligible professional may choose to pursue more than one 2011 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 1.0% of their 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 reporting periods available for eligible professionals to report 2011 Physician Quality Reporting measures groups: a) 12-month reporting period from January 1 through December 31, 2011 (available for the 30 Patient Sample Method, 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, 2011 (available only for the 50% Patient Sample Method via Claims and 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 1.0% 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 2011 Physician Quality Reporting System Measures Groups Specifications Manual, which can be found at http://www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage, 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 2011 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 below) 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: 2011 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, 2011) for each of the 30 unique Medicare Part B FFS patients.

OR

50% Patient Sample Method via Claims or 80% Patient Sample Method via Registry – 12-month and 6-month reporting periods available

- All Medicare Part B FFS patients seen during the reporting period (either January 1 through December 31, 2011 OR July 1 through December 31, 2011) who meet patient sample criteria (see Patient Sample Criteria Table below) 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. A minimum of 80% of this patient sample must be reported for all applicable measures within the measures group according to each measures group’s reporting instructions contained within each group’s overview section.

- 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 the minimum number of patients does not meet the measures group patient sample criteria, the eligible professional is not incentive eligible.

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

<table>
<thead>
<tr>
<th>Measures Group</th>
<th>CPT Patient Encounter Codes</th>
<th>ICD-9-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Mellitus</td>
<td>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, 99346, 99348, 99349, 99350, G0270, G0271</td>
<td>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</td>
</tr>
<tr>
<td>Chronic Kidney Disease (CKD)</td>
<td>99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215</td>
<td>585.4, 585.5</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215</td>
<td></td>
</tr>
<tr>
<td>Coronary Artery Bypass Graft (CABG)</td>
<td>33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536</td>
<td></td>
</tr>
<tr>
<td>Rheumatoid Arthritis (RA)</td>
<td>99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99341, 99342, 99343, 99344, 99345, 99346, 99348, 99349, 99350</td>
<td>714.0, 714.1, 714.2, 714.81</td>
</tr>
<tr>
<td>Measures Group</td>
<td>CPT Patient Encounter Codes</td>
<td>ICD-9-CM Diagnosis Codes</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Perioperative Care</td>
<td>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, 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</td>
<td></td>
</tr>
<tr>
<td>18 years and older</td>
<td>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.</td>
<td></td>
</tr>
</tbody>
</table>
## Patient Sample Criteria Table

<table>
<thead>
<tr>
<th>Measures Group</th>
<th>CPT Patient Encounter Codes</th>
<th>ICD-9-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Back Pain</strong></td>
<td></td>
<td>Diagnosis codes for CPT 9XXXX codes:</td>
</tr>
<tr>
<td></td>
<td>Diagnosis codes with CPT codes:</td>
<td>97001, 97002, 99201, 99202, 99203, 99205, 99212, 99213, 99214, 99215</td>
</tr>
<tr>
<td></td>
<td>22210, 22214, 22220, 22222, 22224, 22226, 22532, 22533, 22534, 22548, 22554, 22556, 22558, 22565, 22590, 22596, 22600, 22612, 22614, 22630, 22632, 22636, 22638, 22680, 22682, 22684, 22686, 22688, 22690, 22692, 22694, 22696, 22698, 22699, 22700</td>
<td></td>
</tr>
<tr>
<td></td>
<td>OR</td>
<td>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</td>
</tr>
<tr>
<td><strong>Hepatitis C</strong></td>
<td>99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215</td>
<td>070.54</td>
</tr>
<tr>
<td>18 years and older</td>
<td></td>
<td>Diagnosis codes for CPT codes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215</td>
</tr>
<tr>
<td><strong>Heart Failure (HF)</strong></td>
<td>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</td>
<td>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, 428.22, 428.23, 428.30, 428.31, 428.32, 428.33, 428.40, 428.41, 428.42, 428.43, 428.9</td>
</tr>
<tr>
<td>18 years and older</td>
<td></td>
<td>Diagnosis codes for CPT codes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215</td>
</tr>
<tr>
<td><strong>Coronary Artery Disease (CAD)</strong></td>
<td>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</td>
<td>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, 414.08, 414.09, 414.8, 414.9, V45.81, V45.82</td>
</tr>
</tbody>
</table>
### Patient Sample Criteria Table

<table>
<thead>
<tr>
<th>Measures Group</th>
<th>CPT Patient Encounter Codes</th>
<th>ICD-9-CM Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic Vascular Disease (IVD)</td>
<td>Diagnosis codes with CPT codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99216, 99217, 99218, 99219, 99220, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456</td>
<td>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, 414.8, 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, 444.0, 444.1, 444.21, 444.22, 444.81, 444.89, 444.9, 445.01, 445.02, 445.81, 445.89</td>
</tr>
<tr>
<td>18 years and older</td>
<td><strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>33140, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33533, 33534, 33535, 33536, 92980, 92982, 92995</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215</td>
<td>042, 079.53, V08</td>
</tr>
<tr>
<td>13 years and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-Acquired Pneumonia (CAP)</td>
<td>99201, 99202, 99203, 99204, 99205, 99211, 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.</td>
<td>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</td>
</tr>
<tr>
<td>18 years and older</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td>99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215</td>
<td>493.00, 493.02, 493.10, 493.12, 493.20, 493.22, 493.82, 493.90, 493.92</td>
</tr>
<tr>
<td>5 through 50 years</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
Getting Started with 2011 Physician Quality Reporting of Measures Groups

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

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

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 QDCs as instructed in the 2011 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 2011 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/PQRI/15_MeasuresCodes.asp#TopOfPage.

An eligible professional is only required to report QDCs on those individual measures in the measures group that meet the criteria (e.g., age or gender) according to the 2011 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 seven measures out of ten apply. See the Preventive Measures Group Demographic Criteria table on the table below.

<table>
<thead>
<tr>
<th>Age</th>
<th>Measures for Male Patients</th>
<th>Measures for Female Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50 years</td>
<td>Patient does not qualify for measures group analysis</td>
<td>Patient does not qualify for measures group analysis</td>
</tr>
<tr>
<td>50-64 years</td>
<td>110, 113, 128, 173, 226</td>
<td>110, 112, 113, 128, 173, 226</td>
</tr>
<tr>
<td>70-75 years</td>
<td>110, 111, 113, 128, 173, 226</td>
<td>39, 48, 110, 111, 113, 128, 173, 226</td>
</tr>
</tbody>
</table>
### Preventive Measures Group Demographic Criteria

<table>
<thead>
<tr>
<th>Age</th>
<th>Measures for Male Patients</th>
<th>Measures for Female Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥76 years</td>
<td>110, 111, 128, 173, 226</td>
<td>39, 48, 110, 111, 128, 173, 226</td>
</tr>
</tbody>
</table>

### 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 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 or QDCs 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/contractor, 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/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.

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/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 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.
Submission through Carriers/MACs
QDCs shall be submitted to Carriers/MACs either through:

Electronic submission, which is accomplished using the ASC X 12N Health Care Claim Transaction (Version 4010A1).

CPT Category II and/or temporary G-codes should be submitted in the SV101-2 “Product/Service ID” Data Element on the SV1 “Professional Service” Segment of the 2400 “Service Line” Loop.

- It is also necessary to identify in this segment that a HCPCS code is being supplied by submitting the HC in data element SV101-1 within the SV1 “Professional Service” Segment.
- Diagnosis codes are submitted at the claim level, Loop 2300, in data element HI01, and if there are multiple diagnosis codes, in HI02 through HI08 as needed with a single reference number in the diagnosis pointer.
- In general for group billing, report the NPI for the rendering provider in Loop 2310B (Rendering Provider Name, claim level) or 2420A (Rendering Provider Name, line level), using data elements NM109 (NM108=XX).

OR

Paper-based submission, which is accomplished by using the CMS-1500 claim form (version 08-05). Relevant ICD-9-CM diagnosis codes are entered in Field 21. Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in Field 24D with a single reference number in the diagnosis pointer Field 24E that corresponds with the diagnosis number in Field 21.

- For group billing, the National Provider Identifier (NPI) of the rendering provider is entered in Field 24J.
- The Tax Identification Number (TIN) of the employer is entered in Field 25.

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.
I WANT TO PARTICIPATE IN 2011 PHYSICIAN QUALITY REPORTING FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD
(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2011 Physician Quality Reporting)

CLAIMS-BASED REPORTING

EHR-BASED REPORTING

GPRA I-BASED REPORTING

GPRA II-BASED REPORTING

CHOOSE REGISTRY-BASED REPORTING OPTIONS

≥ 3 MEASURES APPLY

INDIVIDUAL MEASURES

6. SUBMIT ≥ 3 INDIVIDUAL MEASURES FOR
12 MONTHS
1/1/11 – 12/31/11

7. SUBMIT ≥ 3 INDIVIDUAL MEASURES FOR
6 MONTHS
7/1/11 – 12/31/11

MEASURES GROUP

8. FOR ≥ 30 APPLICABLE MEDICARE PART B
FFS PATIENTS FOR A MEASURES GROUP

9. SUBMIT DATA ON ≥ 80% OF APPLICABLE
MEDICARE PART B FFS PATIENTS FOR A
MEASURES GROUP (minimum 15 patients)

10. SUBMIT DATA ON ≥ 80% OF APPLICABLE
MEDICARE PART B FFS PATIENTS FOR A
MEASURES GROUP (minimum 8 patients)
I WANT TO PARTICIPATE IN 2011 PHYSICIAN QUALITY REPORTING FOR INCENTIVE PAYMENT
SELECT REPORTING METHOD
(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2011 Physician Quality Reporting)

CHOOSE EHR-BASED REPORTING OPTIONS

≥ 3 MEASURES APPLY

11 SUBMIT ≥ 3 INDIVIDUAL MEASURES FOR
12 MONTHS
1/1/11 – 12/31/11

EHR SUBMITS DATA ON ≥ 80% OF APPLICABLE MEDICARE PART B FFS PATIENTS
Getting Started with 2011 Physician Quality Reporting of Measures Groups

I WANT TO PARTICIPATE IN 2011 PHYSICIAN QUALITY REPORTING FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD
(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2011 Physician Quality Reporting)

CLAIMS BASED REPORTING
REGISTRY-BASED REPORTING
EHR-BASED REPORTING
GPRO I BASED REPORTING
GPRO II BASED REPORTING VIA CLAIMS AND REGISTRY

SELF-NOMINATE BETWEEN 1/2/2011 – 1/31/2011 TO REPORT FOR THE ENTIRE 12 MONTHS 1/1/11 – 12/31/11

SELECTED BY CMS

NO

STOP

YES

GROUP SIZE 2-10
1 MEASURES GROUP + 3 INDIVIDUAL MEASURES NOT IN MEASURES GROUP REPORTED

13 REPORT ≥ 35 PATIENTS FOR MEASURES GROUP AND REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FPS PATIENTS

GROUP SIZE 11-25
1 MEASURES GROUP + 3 INDIVIDUAL MEASURES NOT IN MEASURES GROUP REPORTED

14 REPORT ≥ 35 PATIENTS FOR MEASURES GROUP AND REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FPS PATIENTS

GROUP SIZE 26-50
2 MEASURES GROUPS + 4 INDIVIDUAL MEASURES NOT IN MEASURES GROUP REPORTED

13 REPORT ≥ 50 PATIENTS FOR MEASURES GROUP AND REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FPS PATIENTS

GROUP SIZE 51-100
3 MEASURES GROUPS + 5 INDIVIDUAL MEASURES NOT IN MEASURES GROUP REPORTED

14 REPORT ≥ 60 PATIENTS FOR MEASURES GROUP AND REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FPS PATIENTS

GROUP SIZE 101-100
4 MEASURES GROUPS + 6 INDIVIDUAL MEASURES NOT IN MEASURES GROUP REPORTED

13 REPORT ≥ 100 PATIENTS FOR MEASURES GROUP AND REPORT ≥ 50% OF APPLICABLE MEDICARE PART B FPS PATIENTS

Version 5.0

11/15/2010

Page 15 of 21
2011 Program Reporting Options
Number assigned coordinates with appropriate box on the Appendix A: 2011 Physician Quality Reporting Participation Decision Tree.

1. Claims-based reporting of individual measures (12 months)
2. Claims-based reporting of individual measures (6 months)
3. Claims-based reporting of one measures group for 30 Medicare Part B FFS patients (12 months)
4. Claims-based reporting of one measures group for 50% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients) (12 months)
5. Claims-based reporting of one measures group for 50% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 8 patients) (6 months)
6. Registry-based reporting of at least 3 individual Physician Quality Reporting measures for 80% of applicable Medicare Part B FFS patients of each eligible professional (12 months)
7. Registry-based reporting of at least 3 individual Physician Quality Reporting measures for 80% of applicable Medicare Part B FFS patients of each eligible professional (6 months)
8. Registry-based reporting of one measures group for 30 Medicare Part B FFS patients (12 months)
9. Registry-based reporting of one measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients) (12 months)
10. Registry-based reporting of one measures group for 80% of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 8 patients) (6 months)
11. EHR-based reporting of at least 3 individual Physician Quality Reporting measures for 80% of applicable Medicare Part B FFS patients of each eligible professional (12 months)
12. GPRO I-based reporting of all applicable measures in CMS provided tool for consecutive, confirmed, and completed patients for each disease module and preventive care measures (12 months)
13. GPRO II-based reporting via claims of individual measures and measures groups depending on the group size (12 months)
14. GPRO II-based reporting via registry of individual measures and measures groups depending on the group size (12 months)
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.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage 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);

For group billing, the rendering NPI number of the individual eligible professional who performed the service will be used from each line-item in the Physician Quality Reporting.
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.

21. Review and determine if ANY diagnosis (Dx) listed in Item 21 meets the patient sample criteria for the RA measures group.

RA–Physician Quality Reporting #178
Identifies claim line-item
Rheumatoid Arthritis (RA)

RA–Physician Quality Reporting #179
Report ALL measures’ QDCs within the RA measures group

RA–Physician Quality Reporting #180

QDC(s) must be submitted with a line-item charge of $0.00 or $0.01. Charge field cannot be blank.

For group billing, the rendering NPI number of the individual eligible professional who performed the service will be used from each line-item in the Physician Quality Reporting calculations.

Solo practitioner - Enter individual NPI here

- 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.
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/PQRI/15_MeasuresCodes.asp#TopOfPage](http://www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage) for more information.

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

#### Objective

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.