

AdvantEdge Healthcare Solutions: 2012 Physician Quality Reporting System (PQRS) Manual

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DEFINITIONS

For the purposes of this manual, the following abbreviations will be used to be in sync with the CMS manuals and for simplification purposes:

EP – Eligible provider
QDC (Quality Data Code) – PQRS Code
GP – Group Practice

1 - ELIGIBLE PROFESSIONALS (EPs)

A listing of all providers eligible to participate in 2012 is located in Addendum A at the end of this newsletter. Included with physicians are PA’s, NPs, psychologists, social workers, therapists and other non-physician professionals. PQRS measures are analyzed by the individual NPI number even if the member is part of a group. The exception is if a group practice of 25 EPs or more reports their measures through the *Group Practice Reporting (GPRO)* method, in which case the group’s NPI number would be used in analyzing measure data.

2 - 2012 PQRI BASICS

Currently, PQRS is a voluntary individual reporting program to report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Medicare C (Medicare Advantage) beneficiaries are not included in claim-based reporting of individual measures or measure groups, GPRO reporting or HER Reporting.

- 2012 Incentive Payments will be **0.5% of a provider's total Medicare allowable** charges for successful reporting
 - 2011 was 1%
 - 0.5% will be applied to incentive payments for years 2013 - 2014
- All claims for service dates of January 1, 2012 – December 31, 2012 must be reported by February 22, 2013 to be included in the analysis for an incentive payment.
- Beginning in 2015, a payment adjustment will apply under the PQRS Incentive Program if the EP does not satisfactorily submit data on quality measures for covered professional services for the quality reporting period for the year. The fee schedule amount for services furnished by such EPs will be reduced by the following percentages:
 - 1.5 percent for 2015; and
 - 2.0 for 2016 and each subsequent year

Services not reported in the 12 month reporting period of January 1, 2013 through December 31, 2013 will result in the fee schedule reduction in the year 2015.

- There are a total of 210 measures, which includes 206 individual quality measure and the 4 measures in the Back Pain measures group, which are not reportable as individual PQRS quality measures.
- 32 new measure were introduced for 2012 (See Addendum B)
- Measures To Be Removed for 2012 and replaced with #110 – Preventive Care and Screening: Influenza Immunization
 - #79 – End Stage Renal Disease: Influenza Immunization in Patients with ESRD
 - #135 – Chronic Kidney Disease(CKD) – Influenza Immunization
 - #175 – Pediatric Stage Renal Disease (ESRD): Influenza Immunization
- Measures To Be Removed for 2012 and replaced with #241 – Ischemic Vascular Disease(IVD): Complete Lipid Panel and Low Density Lipoprotein (LDL-C) Control
 - #202 – Ischemic Vascular Disease(IVD): Complete Lipid Profile
 - #203 – Ischemic Vascular Disease (IVD) Low Density Lipoprotein (LDL-C) Control
- Measures To Be Removed Permanently in 2012
 - #94 – Otitis Media with Effusion(OME) Diagnostic Evaluation – Assessment of Tympanic Membrane Mobility (the measure
 - #153 – Chronic Kidney Disease(CKD):Referral for Arteriovenous (AVP) Fistula
- Measures to Be Removed for Claims-based and Registry – Only applicable to EHR Reporting
 - #200 – Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation

3 - 2011 PQRS REPORTING OPTIONS

There are 3 methods of reporting:

1. Individual Measure Reporting
2. Measures Groups Reporting
3. Group Practice Reporting Option (GPRO)

To participate in the 2012 PQRS program, individual EPs (Eligible Professionals) may choose to report information for **individual PQRS quality measures** or **measures groups** to CMS via:

1. Claim-based reporting - on Medicare Part B claims
2. A qualified PQRS Registry, or
3. A qualified electronic health record (EHR) product.

Reporting Periods

NEW: In 2012, there is only one reporting period of 12 months. CMS has eliminated the 6-month reporting period for claims-based, registry (individual measures via a registry) and EHR-based reporting. The 6-month reporting period is still available for reporting “measures groups” via a registry.

1. 12 months – Service dates of January 1, 2011 – December 31, 2011
2. 6 months – Service dates of July 1, 2011 – December 31, 2011 (*for reporting “measures groups” via a registry only*)

If a provider participated in the 2011 PQRS program and wants to report the same measures for the 2012 program, the provider must:

- determine if the measure is still available
- check the Release Notes to determine if the criteria for these measures changed in 2012.

The “Release Notes” manuals are specifically written to show only the changes from 2011 to 2012. The names of the manuals are listed below and can be found on our Public server in the PQRS folder or by clicking on the below [PQRS Measures](#) link.

[For Individual Measures – 2012_PhysQualRptg_MeasureSpecificationsManual_ReleaseNotes_11102011](#)

[For Measures Groups – 2012_PhysQualRptg_MeasuresGroups_ReleaseNotes_111010](#)

[For GPRO – Release Notes are not yet available on the CMS website](#)

[For EHR Reporting – 2012_EHR_MeasureSpec_ReleaseNotes_Nov2011.v3.1pdf](#)

PQRS Measures

A. INDIVIDUAL MEASURES REPORTING

Claims-based individual measures reporting remains similar to last year.

- EPs must report a minimum of 3 measures for at least **50%** of their Medicare patients eligible for each measure in order to qualify for the incentive payment unless the provider only performs less than 3 measures.
- Providers who report less than 3 measures will be subject to the measure-applicability validation (MVA) process. Should Medicare find that the provider submitted CPT and diagnosis codes that would qualify him/her for a 3rd measure, the provider will not be paid for the 2 measures or less submitted.
- Measures with a 0% performance rate will not be counted

For more information on how the measure-applicability validation process is calculated, see [Section 5 “Measure Applicability Validation”](#) of this Newsletter.

Registry Reporting

- EPs must report at least 3 measures for at least **80%** of their Medicare patients eligible for each measure in order to qualify for the incentive payment.
- Measures with a 0% performance rate will not be counted

B. “MEASURES GROUPS” REPORTING

With the “measure groups” option, providers may report on a group of clinically-related measures either through claims-based or registry-based submission.

- **Providers only need to report ONE measures group to qualify for PQRS payment.** More than one group measure may be reported but the EP will only earn a maximum of one incentive payment equal to 0.5% of the total estimated allowed charges furnished during the longest reporting period for which he or she satisfied reporting criteria..
- Each measure group has an **Intent G Code**. This code is used once to inform Medicare that the provider will be submitting via the Measures Group reporting method
- Each measure group has a **Composite Code**. This code is used if the EP is reporting on ALL measures within the measures group. This code is used instead of reporting each measure separately.
- There are 22 measures groups available for reporting in 2012. All 14 measures groups from 2011 will be available for 2012. There are 8 new measures groups for 2012. They are:
 - COPD MEASURES GROUP CLAIMS,REGISTRY
 - INFLAMATORY BOWEL DISEASE (IBD) MEASURES GROUP REGISTRY ONLY
 - SLEEP APNEA MEASURES GROUP REGISTRY ONLY
 - DEMENTIAL MEASURES GROUP REGISTRY ONLY
 - PARKINSON'S MEASURES GROUP REGISTRY ONLY
 - ELEVATED BLOOD PRESSURE MEASURES GROUP REGISTRY ONLY
 - CARDIOVASCULR PREVENTION MEASURES GROUP CLAIMS,REGISTRY
 - CATARACTS MEASURES GROUP REGISTRY ONLY

ADDENDUM E - lists all the Measures Groups, the measures within each group, the Intent Code, Composite Code and how the measures may be submitted.

Claims-based submission –

- The “intent G code” must be submitted only once. This alerts Medicare that the provider has chosen “measure group submission” of PQRS. As an example, G8485 (the first code) means: “I intend to report the Diabetes Mellitus Measures Group.”
- The PQRS analysis will be initiated when the intent G code is first submitted on a claim. However, all claims meeting the group measures criteria will be considered in the analysis regardless of the date of service the G code is initially submitted. As an example, if you submitted several claims with the measures group for service date of 1/1/2012 but you did not submit the intent G code claim until service date 1/8/12, the payment analysis will begin with the service dates of 1/1/2012 that were submitted before the intent G code.

Registry-based submission – The “intent G” code does not have to be submitted when reporting through a Registry unless the Registry will report via claims data. The Registry would inform the provider whether to submit one claim with the “intent G code”

There are 2 methods of submitting measure groups.

30 Patient Sample Method – If the provider feels he/she has a minimum of 30 separate Medicare patients that will fit one of the measure groups, he/she may choose to just submit information on those patients.

- 12-month reporting period only
- May report via claims-based or registry reporting
- Measure groups containing a measure with a 0% performance rate will not be counted

For **both claims-based** and **registry-based** reporting, all applicable measures within the group must be reported at least once for each patient within the sample population seen by the EP during the reporting period.

Percentage Patient Sample Method – If the EP does not have 30 patients that would fit into a methods group, then the Percentage Patient Sample method would be used.

- For Claims based reporting – 50% patient sample method
 - The EP must report on all applicable measures within the selected measures group for at least 50% of all patients during the selected reporting period
 - A minimum of 15 separate patients must meet the sample criteria
 - Measure groups containing a measure with a 0% performance rate will not be counted
- For Registry reporting – 80% patient sample method
 - The EP must report on all applicable measures within the selected measures group for at least 80% of all patients during the selected reporting period
 - 12 month reporting – a minimum of 15 patients must meet the sample criteria
 - 6 month reporting (July 1, 2012 – Dec. 31, 2012) – a minimum of 8 patients must meet the sample criteria
 - Measures groups containing a measure with a 0% performance rate will not be counted

Individual measures within the Measures groups may have different criteria and specifications than the same measure reported individually. Individual measures within the measures groups may have also changed since 2011. Therefore, it is important that the requirements for each measure are reviewed within the specifications and instructions for *measures group reporting*. These requirements are provided in a separate manual from the individual measures.

For information, *click below* to the “Measures Group” page on the CMS Website.

Measures Groups

For general information on Measures Groups:

[Getting_Started_with_2012_PhysQualRptg_Measures_Groups_111011](#)

For detailed information on each measure and how to report them:

[Group_Reporting:_CMS:_2012_PhysQualRptg_MeasuresGroup_SpecificationsManual_111011](#)

To review all changes from 2011:

[2012_PhysQualRptg_MeasuresGroups_ReleaseNotes_111011](#)

C. GROUP PRACTICE REPORTING (GPRO)

CMS’ definition of a group practice, for the purpose of submitting through the GPRO method, is a *practice with a single TIN with 25 or more Medicare eligible providers, as identified by their individual NPI, who have reassigned their billing rights to the TIN*. (This is a change from 2011 where there were 2 GRPO reporting options depending on the size of the group practice)

Methods for submitting:

- GPRO options can only submit through a web interface provided by CMS
- CMS will assign patients to participate by using Medicare Part B claims data for service dates on or after January 1, 2011 and claims submitted and processed by October 31, 2011. All patients will be Original Medicare patients and Medicare must be their primary payer.
- Submission requirements depend on the size of the Group Practice.
 - Groups 25-99 EPs
 - Must report via a submission web interface provided by CMS
 - Must report on all GPRO measures included in the web interface
 - Populate data field for the first 218 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample for each disease module or preventive care measure

- Groups 100+ EPs
 - Must report via a submission web interface provided by CMS
 - Must report on all GPRO measures included in the web interface
 - Populate data field for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each disease module or preventive care measure
- 12 month reporting period (Jan. 1, 2012 – Dec. 31, 2012)
- There are 29 measures available for GPRO reporting. (See ADDENDUM C)

GPRO Eligibility Criteria

- If a group has providers who are not established Medicare providers, the group may still participate as long as at least 25 providers are established Medicare providers.
- EPs, as classified by their NPIs, who do not submit Medicare Part B claims for PFS covered professional services during the reporting period will not be calculated in CMS' payment calculations.
- Providers/NPIs who are not established Medicare providers (must have billed Medicare for services dates between Jan, 1, 2011 – October 29, 2011), will not be included in the incentive payment calculations for the group.
- Individual EPs who are members of a GP selected to participate in the PQRS GPRO program are not eligible to separately earn a PQRS incentive payment as an individual EP under that same TIN. Once a GP's TIN is selected to participate in the GPRO, this is the only method of PQRS reporting available to the group and all individual NPIs who bill Medicare under the group's TIN number.
- As providers leave and join group practices through out the year, there could be a discrepancy between the number of EPs submitted by the practice during the self-nomination process and the number of EPs billing Medicare under the TIN.
 - If there are more NPIs in the Medicare claims than the number of NPIs submitted during self-nomination process, this could result in the practice being subject to different criteria for reporting, In this case, CMS will notify the practice of this finding as part of the self-nomination process. The practice will then have the option of:
 - either agreeing to being subject to the different criteria for satisfactory reporting or
 - opting out of participation as a group practice.

Clients interested in participating as a GPRO *for the first time* must self-nominate themselves via a letter accompanied by an electronic file submitted in a format specified by CMS (such as Microsoft Excel) that includes the group practices' TIN(s) and name of the group practice, the name and email address of a single point of contact for handling administrative issues as well as the name and email address of a single point of contact for technical support purposes. (Once the CMS' web-tool is capable of accepting self-nomination statements that will be the only available method to self-nominate. The web tool is expected to be ready for the 2013 PQRS.

The self-nomination statement must also indicate the group practice's compliance with the following requirements:

- Agree to attend and participate in all mandatory GPRO training sessions
- Is an established Medicare provider that has billed Medicare Part B on or after January 1 and prior to October 29 of the year prior to the reporting period for the respective year. (For 2012, the group practice must have billed Medicare Part B on or after January 1, 2011 and prior to October 29, 2011)
- Agree to have the results on the performance of their PQRS measures publicly posted on the "Physician Compare" Web site.

- Obtain and/or have access to the identity management system specified by CMS (such as, but not limited to, the Individuals Authorized Access to CMS Computer Systems, or IACS) to submit Medicare clinical quality data to a CMS clinical data warehouse.
- Provider CMS access (upon request for health oversight purposes like validation) to review the Medicare beneficiary data on which PQRS GPRO submissions are founded or provide to CMS a copy of the actual data (upon request for health oversight purposes like validation)

CMS reserves the right to validate the data submitted by GPROs.

Groups who participated in the 2011 GPRO program would automatically be qualified to participate in the GPRO in 2012 and in future years. They will however, need to notify CMS in writing of their desire to continue participation in the PQRS program for 2012.

- The self-nomination letter must be *postmarked by January 31, 2012*.

4 - 2011 PQRS REPORTING MECHANISMS

The following are all the options for PQRS submission.

1. Claims-based reporting:

- individual measures (12 months)
- one measures group for 30 Medicare Part B FFS (Fee for service) patients (12 months)
- one measures group for 50 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients) (12 months)
- Measures with a 0 percent performance rate will not be counted

2. Registry-based reporting:

- at least 3 individual PQRS measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (12 months)
- one measures group for 30 patients (patients may include, but may not be exclusively non-Medicare patients) (12 months)
- one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 15 patients) (12 months)
- one measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (with a minimum of 8 patients) (6 months)
- Measures with a 0 percent performance rate will not be counted

3. GPRO based reporting:

- 25-99 EPs in a GPRO group – Report on all measures included in the web interface and populate data field for the first 218 consecutive ranked and assigned beneficiaries in the order in which they appear in the group’s sample. If the pool of eligible assigned beneficiaries is less than 218, then report on 100% of assigned beneficiaries
- 100+ EPs in the GPRO group – Report on all measures included in the web interface and populate data fields for the first 411 consecutively ranked and assigned beneficiaries in the order in which they appear in the group’s sample. If the pool of eligible assigned beneficiaries is less than 411, then report on 100% of assigned beneficiaries

4. EHR-based reporting ::

- at least 3 PQRS measures and report each measure for at least 80% of the EPs Medicare Part B FFS patients seen during the reporting period to which the measure applies (12 months)
- measures with a 0 percent performance rate will not be counted

A. CLAIMS-BASED REPORTING

PQRS measures are reported on each claim submitted to Medicare when the CPT and diagnosis combination qualifies for the PQRS measures the provider has chosen. Instructions for billing via this method are contained in Addendum F at the end of this Newsletter. Submission of PQRS may be by:

- Individual Measures
- Measures Groups

B. REGISTRY REPORTING

Professionals may submit their measures through a Registry. A registry is a third-party database that many professionals already use to report data to researchers about common care processes for diabetes, kidney disease and preventive medicine. An EP or group practice would be required to enter into and maintain an appropriate legal arrangement with a qualified PQRS registry. The Registry would act as a HIPAA Business Associate and agent of the EP.

CMS will post a list of qualified registries on their PQRS website. However, CMS does not anticipate making this list available prior to the start of the 2012 program year. The names of the qualified registries will be posted in phases as follows:

1. The registry's success in submitting PQRS quality measures data in a prior PQRS program year (2008, 2009, 2010, 2011)
2. The registry's submission of a letter indicating their continued interest in being a PQRS registry by October 31 of the year prior to the program year (October 31, 2011)
3. The registry's compliance with the 2010 PQRS registry requirements as indicated by CMS' vetting process..

You may access the current 2011 Qualified Registries by *clicking below, scrolling to **DOWNLOADS** and picking **2011 Qualified Registries PDF**.*

[2011 Qualified Registries](#)

C. EHR REPORTING (Electronic Health Records)

For 2012, EPs have the option of submitting quality measure data obtained from their PQRS qualified EHR to CMS either

1. Directly from the EPs qualified EHR in the CMS-specified manner , or
2. Indirectly from a qualified EHR data submission vendor (on the EP's behalf), in the CMS-specified manner.

Direct EHR Reporting

EPs who choose this method must ensure their system is qualified to submit PQRS measures. An EHR system certified for purposes of reporting under the Medicare and Medicaid EHR Incentive Programs may or may not be qualified for purposes of the 2012 PQRS program. The certification process for EHR technology does not test the EHR product's ability to output a file that meets the PQRS measure file specifications. CMS is currently exploring ways to further align the qualifications for both the PQRS and EHR Medicare/Medicaid Incentive Programs.

Testing for qualified direct EHR-based reporting products will occur in late 2012, immediately followed by the submission of the EP's actual 2012 PQRS data in early 2013. CMS expects to list the 2012 PQRS qualified EHR products by January 2012.

EHR Data Submission Vendors

CMS mandates the following requirements for individual EPs associated with indirect EHR based reporting-based reporting:

- Selection of a PQRS qualified EHR data submission vendor, and
- Submission of Medicare clinical quality data extracted from the EHR to a qualified "EHR data submission vendor", which may include some current registries, EHR vendors, and other entities that are able to receive and transmit clinical quality data extracted from an EHR to CMS

CMS expects to list the entities that are EHR submission vendors qualified to submit 2012 PQRS measures by mid-2012.

More information is available on EHR reporting by **clicking on** the following CMS website, scrolling to DOWNLOADS and clicking on 2012 EHR Documents for Eligible Professionals PDF. This file will contain two good resources:

Alternative Reporting Mechanisms

CMS: 2012_2012_EHR_MeasuresSpecs_ReleaseNotes_Nov2011_v3.1.pdf

CMS: 2012_EHR_MeasureSpecifications_Nov 2011_v2.1.pdf.

5. CERTIFICATE OF MAINTENANCE

To be completed at a later date.

6. VALIDATION OF SATISFACTORY REPORTING

When an EP reports on fewer than 3 measures, CMS will perform a review to determine whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of EP). If an EP who reports on fewer than 3 measures in 2012 and reports on a measure that is part of an identified cluster of closely related measures and does not report on any other measure that is part of that identified cluster, then the eligible professional will not qualify as a satisfactory reporter in the 2012 PQRS program. The EP will then NOT earn an incentive payment on the less than 3 measures reported.

Measure-applicability validation applies to providers:

- who submit QDC for only one or only two PQRS measures for at least 50% of their patients or encounters eligible for each measure and who do not submit any QDCs for any other measure – reports less than 3 measures
- who submit PQRS codes via **claim-based submissions**

Those who fail the validation process will not earn the PQRS incentive payments.

Measures reported via REGISTRY, GPRO or EHR are NOT subject to MVA.

CMS will apply a two-step process to operationalize the MVA.

1. Clinical Relation Test
2. Minimum Threshold Test

Step 1: Clinical Relation Test.

This test is based on:

1. A presumption that if a provider submits data for a measure, then that measure applies to her/his practice and
2. The concept that if one measure in a cluster of measures related to a particular clinical topic or professional service is applicable to a provider's practice, then other closely-related measures (measures in that same *cluster*) may also be applicable.

The following is an example of how the clinical relation test will be applied:

A provider submitted PQRS codes for one of the PQRS measures related to pneumonia. (pneumonia has 4 separate measures) That professional's claims will then be analyzed using the minimum threshold test described below to determine whether another pneumonia measure (or two more pneumonia measures) could also have been submitted.

Clusters of clinically related measures are listed in the "download" section at the bottom of the article in the [below link labeled CMS MVA Information](#). Click on [2011 Physician Quality Reporting System Applicability Validation Documents](#) and you will find 3 documents; a flow chart, full description of the process and Release Notes showing only changes from last year.

Step 2: Minimum Threshold Test.

The minimum threshold test is based on the concept that only if, during the 2012 reporting period, a provider treated more than a certain number of Medicare patients with a condition to which a certain measure applied, then that EP should be accountable for submitting the QDC(s) for that measure.

For the 2011 reporting period, the common minimum threshold, based on statistical and clinical frequency considerations, will not be less than 15 patients or encounters for the 12-month reporting period.

CMS examples of how the minimum threshold test will be applied:

An emergency department (ED) physician treated 20 Medicare patients with pneumonia during the 2012 12-month reporting period. If that ED physician is subject to validation and was found to have submitted a PQRS code for at least one of the pneumonia measures under the clinical relation test, then the physician would be deemed responsible for submitting PQRS codes for at least one other PQRS pneumonia measure. If the additional codes were not submitted, the provider will not earn the 2011 incentive payment.

Alternatively, if an internist was subject to validation and was found to have submitted a PQRS code for at least one of the pneumonia measures under the clinical relation test but treated only 2 Medicare patients with pneumonia during the same period, then the internist would not be responsible for submitting the additional pneumonia measures and would not be precluded from receiving an incentive payment.

During the reporting period, CMS will determine a minimum threshold for each individual PQRS measure based on analysis of Part B claims data. However, no threshold will fall below the common threshold of 15 patients or encounters described above.

CMS may determine that it is necessary to modify the measure-applicability validation process after the start of the reporting periods. However, any changes will result in the process being applied more leniently, thereby (1) allowing a greater number of professionals to pass validation and (2) causing no professional who would otherwise have passed to fail.

Information concerning the Validation Process along with a listing of the validation clusters can be found by *clicking below and scrolling to DOWNLOADS to 2012 PQRS Measure Applicability Validation Documents*. You will find 3 documents:

[2012_PhysQualRptg_MAV_ProcessforclaimsbasedReporting_111011.pdf](#)

[2012_PhysQualRptg_MAV_ReleaseNotes_111011.pdf](#)

[2012_PhysQualRptg_MAV_Flow_111011.pdf](#)

[PQRS Validation](#)

ADDENDUM A

Eligible Professionals to report 2011 PQRS Measures

1. Medicare physicians

Doctor of Medicine
Doctor of Osteopathy
Doctor of Podiatric Medicine
Doctor of Optometry
Doctor of Oral Surgery
Doctor of Dental Medicine
Doctor of Chiropractic

2. Practitioners

Physician Assistant
Nurse Practitioner
Clinical Nurse Specialist
Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
Certified Nurse Midwife
Clinical Social Worker
Clinical Psychologist
Registered Dietician
Nutrition Professional
Audiologists (as of 1/1/2009)

3. Therapists

Physical Therapist
Occupational Therapist
Qualified Speech-Language Therapist (as of 7/1/2009)

Eligible But Not Able to Participate

The following professionals are eligible to participate but are not able to participate for one or more reasons:

1. Providers paid under the Medicare PFS billing Medicare fiscal intermediaries/MACs. The FI/MAC claims processing systems currently cannot accommodate billing at the individual physician or practitioner level:

- Critical access hospital (CAH), method II payment, where the physician or practitioner has reassigned his or her benefits to the CAH. In this situation, the CAH bills the regular FI for the professional services provided by the physician or practitioner.
- All institutional providers that bill for outpatient therapy provided by physical and occupational therapists and speech language pathologists (for example, hospital, skilled nursing facility Part B, home health agency, comprehensive outpatient rehabilitation facility, or outpatient rehabilitation facility). This does not apply to skilled nursing facilities under Part A.

Providers not defined as eligible professionals in the Tax Relief Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRS and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the PFS are not included in PQRS (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, portable x-ray suppliers, independent laboratories, hospitals [including critical access], rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRS since DME is not paid under the PFS.

Eligible professionals participating in the PQRS should familiarize themselves and their office staff with the PQRS measures that appear to apply to their patients for the relevant program year

ADDENDUM B - New Individual Measures for 2012

- 245 - Chronic Wound Care: Use of wound surface culture technique in patients with Chronic Skin Ulcers - *Claims, Registry*
- 246 - Chronic Wound Care: Use of Wet to Dry Dressings in Patients with Chronic Skin Ulcers - *Claims, Registry*
- 247 - Substance Use Disorders: Counseling Regarding Psychosocial and Pharmacologic Treatment Options for Alcohol Dependence - *Claims, Registry*
- 248 - Substance Use Disorders: Screening for Depression among Patients with Substance Abuse or Dependence - *Claims, Registry*
- 242 - Coronary Artery Disease (CAD): Symptom Management - *Registry Only*
- 243 - Cardiac Rehabilitation Patient Referral From an Outpatient Setting – *Registry Only*
- 244 - Hypertension: Blood Pressure Control – *Registry Only*
- 249 - Barrett's Esophagus: - *Claims, Registry*
- 250 - Radical Prostatectomy Pathology Reporting: *Claims, Registry*
- 251 - Immunohistochemical Evaluation of HER2 for Breast Cancer Patients – *Claims, Registry*
- 252 - Anticoagulation for Acute Pulmonary Embolus Patients- *Claims, Claims, Registry*
- 253 - Pregnancy Test for Female Abdominal Pain Patients – *Claims, Registry*
- 254 - Ultrasound Determination of Pregnancy Location for Pregnant Patients with Abdominal Pain – *Claims, Registry*
- 255 - Rh Immunoglobulin (Rhogam) for Rh Negative Pregnant Women at Risk of Fetal Blood Exposure – *Claims, Registry*
- 256 - Surveillance after Endovascular abdominal Aortic Aneurysm Repair (EVAR) – *Registry Only*
- 257 - Statin Therapy at Discharge after Lower Extremity Bypass (LEB) – *Registry Only*
- 258 - Rate of Open AAA Repair without Major Complications (discharged to home no later than post-operative day #7) – *Registry Only*
- 259 - Rate of EVAR without Major Complications (discharged to home no later than POD #2) - *Registry Only*
- 260 - Rate of Carotid Endarterectomy for Asymptomatic Patients, without Major Complications (discharged to home no later than post-operative day #2) - *Registry Only*
- 261 - Referral for Otology Evaluation for Patients with Acute or Chronic Dizziness – *Claims, Registry*
- 262 - Image Confirmation of Successful Excision of Image-Localized Breast Lesion – *Claims, Registry*
- 263 - preoperative Diagnosis of Breast Cancer – *Claims, Registry*
- 264 - Sentinel Lymph Node Biopsy for Invasive Breast Cancer – *Registry Only*
- 265 - Biopsy Follow-up – *Registry Only*
- 266 - Epilepsy: Seizure Type(s) and Current Seizure Frequency(ies) – *Claims, Registry*
- 267 - Epilepsy: Documentation of Etiology or Epilepsy or Epilepsy Syndrome – *Claims, Registry*
- 268 - Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy - *Claims, Registry*
- 303 - Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery – *Registry Only*
- 304 - Patient Satisfaction within 90 Days Following Cataract Surgery - *Registry Only*
- Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100 - *Claims, Registry*
- 317 - Preventive Care and Screening: Blood Pressure Measurement - *Claims, Registry*
- ??Preventive Care: Cholesterol-LDL test performed - *Claims, Registry*
- 241 - Ischemic Vascular Disease(IVD): Complete Lipid Profile and LDL Control <100 - *Claims, Registry*

ADDENDUM C – GPRO MEASURES

- 1 - Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus(>9%)**
- 2 - Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus**
- 3 - Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus**
- 5 - Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- 6 - Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
- 8 - Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)*
- 46 - Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility*
- 52 - Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
- 110 - Preventive Care and Screening: Influenza Immunization*
- 111 - Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older*
- 112 - Preventive Care and Screening: Screening Mammography*
- 113 - Preventive Care and Screening: Colorectal Cancer Screening*
- 117 - Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- 118 - Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)*
- 128 0 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up*
- 163 - Diabetes Mellitus: Foot Exam
- 197 - Coronary Artery Disease (CAD): Lipid Control*
- 198 - Heart Failure: Left Ventricular Ejection Fraction (LVEF) Assessment
- 199 - Heart Failure: Patient Education
- 204 - Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic*
- 226 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention*
- 228 - Heart Failure: Left Ventricular Function (LVF) Testing
- 236 - Hypertension (HTN): Controlling High Blood Pressure*
- 241 - Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low-Density Lipoprotein (LDL-C) Control *
- 317 - Preventive Care and Screening: Screening for High Blood Pressure*
- Diabetes: Daily Aspirin Use for Patients with Diabetes and Ischemic Vascular Disease*
- Falls: Screening for Fall Risk*
- Diabetes Mellitus: Tobacco Non-Use*
- Diabetes Mellitus: Hemoglobin A1c Control (<8%)*

* Measure also available for reporting under the Medicare Shared Savings Program

** Measure is part of NQF #0729, Optimal Diabetes Care composite, under the Medicare Shared Savings Program

ADDENDUM D – EHR MEASURES

EHR MEASURES THAT ARE ALSO EHR INCENTIVE PROGRAM CORE MEASURES

- 128 - Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-up
- 237* - Hypertension (HTN): Blood Pressure Measurement
- 226 - Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

EHR MEASURES THAT ARE ALSO EHR INCENTIVE PROGRAM ALTERNATE CORE MEASURES

- 110 - Preventive Care and Screening: Influenza Immunization
- 239* - Weight Assessment and Counseling for Children and Adolescents

Childhood Immunization Status

EHR MEASURES THAT ARE ALSO EHR INCENTIVE PROGRAM MEASURES

- 1 - Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
- 2 - Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
- 3 - Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
- 5 - Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- 6 - Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
- 7 - Coronary Artery Disease (CAD): Beta-Blocker Therapy- Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40 percent)
- 8 - Heart Failure (HF): Beta-blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- 9 - Anti-depressant medication management: (a) Effective Acute Phase Treatment, (b) Effective Continuation Phase Treatment
- 12 - Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
- 18 - Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- 19 - Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- 53 - Asthma: Pharmacologic Therapy for Persistent Asthma
- 64 - Asthma: Assessment of Asthma Control
- 66 - Appropriate Testing for Children with Pharyngitis
- 71 - Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
- 72 - Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
- 102 - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
- 112 - Preventive Care and Screening: Screening Mammography
- 113 - Preventive Care and Screening: Colorectal Cancer Screening
- 308* - Smoking and Tobacco Use Cessation, Medical Assistance: a. Advising Smokers to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies
- 117 - Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- 119 - Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
- 163 - Diabetes: Foot Exam
- 197 - Coronary Artery Disease (CAD): Lipid Control
- 200* - Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation
- 201 - Ischemic Vascular Disease (IVD): Blood Pressure Management Control
- 204 - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic

- 305* - Initiation and Engagement of Alcohol and Other Drug Dependence
Treatment: (a) Initiation, (b) Engagement
- 306* - Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
- 307* - Prenatal Care: Anti-D Immune Globulin
- 236* - Hypertension: Controlling High Blood Pressure
- 309* - Cervical Cancer Screening
- 310* - Chlamydia Screening for Women
- 311* - Use of Appropriate Medications for Asthma
- 312* - Low Back Pain: Use of Imaging Studies
- 241 -Ischemic Vascular Disease (IVD): Complete Lipid Panel and Low-Density (LDL-C) Control
- 313* - Diabetes: Hemoglobin A1c Control (<8.0%)

OTHER PHYSICIAN QUALITY REPORTING SYSTEM EHR MEASURES

- 39 - Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- 47 - Advance Care Plan
- 48 - Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- 173 - Preventive Care and Screening: Unhealthy Alcohol Use – Screening
- 238* - Drugs to be Avoided in the Elderly
- 316* - Preventive Care: Cholesterol-LDL test performed
- 317 - Preventive Care and Screening: Blood Pressure Measurement

* Measures are not part of the PQRS Individual Measures Option

ADDENDUM E - 2012 PQRS REPORTING OPTIONS FOR MEASURES GROUPS

DIABETES MELLITUS MEASURES GROUP:

Intent Code: G8485 **Composite Code: G8494** **CLAIMS, REGISTRY**

- # 1. Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus
- # 2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
- # 3. Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus
- #117. Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- #119. Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
- #163. Diabetes Mellitus: Foot Exam

ADULT KIDNEY DISEASE MEASURES GROUP: (Formerly called (Chronic Kidney Disease)

Intent Code: G8487 **Composite Code: G8495** **CLAIMS, REGISTRY**

- #121. Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
- #122. Chronic Kidney Disease (CKD): Blood Pressure Management
- #123. Chronic Kidney Disease (CKD): Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis - Stimulating Agents (ESA)
- #153.. ~~Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula~~
- #110.. Preventive Care and Screening: Influenza Immunization - NEW

THE PREVENTIVE CARE MEASURES GROUP:

Intent Code: G8486 **Composite Code: G8496** **CLAIMS, REGISTRY**

- # 39. Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- # 48. Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- #110. Preventive Care and Screening: Influenza Immunization for Patients \geq 50 Years Old
- #111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older
- #112. Preventive Care and Screening: Screening Mammography
- #113. Preventive Care and Screening: Colorectal Cancer Screening
- #128. Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up
- #173. Preventive Care and Screening: Unhealthy Alcohol Use – Screening
- #226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (new)

CORONARY ARTERY BYPASS GRAFT (CABG) MEASURES GROUP:

Intent Code: G8544 **Composite Code: G8497** **REGISTRY ONLY**

- # 43. Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery
- # 44. Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery
- #164. Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation)
- #165. Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate
- #166. Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA)
- #167. Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency
- #168. Coronary Artery Bypass Graft (CABG): Surgical Re-exploration
- #169. Coronary Artery Bypass Graft (CABG): Anti-platelet Medications at Discharge
- #170. Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge
- #171. Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling

ADDENDUM E - 2011 PQRS REPORTING OPTIONS FOR MEASURES GROUPS

(cont'd)

RHEUMATOID ARTHRITIS MEASURES GROUP:

Intent Code: G8490 Composite Code: G8499 CLAIMS, REGISTRY

- #108. Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy
- #176. Rheumatoid Arthritis (RA): Tuberculosis Screening
- #177. Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity
- #178. Rheumatoid Arthritis (RA): Functional Status Assessment
- #179. Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis
- #180. Rheumatoid Arthritis (RA): Glucocorticoid Management

PERIOPERATIVE CARE MEASURES GROUP:

Intent Code: G8492 Composite Code: G8501 CLAIMS, REGISTRY

- #20. Perioperative Care: Timing of Antibiotic Prophylaxis – Ordering Physician
- #21. Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
- #22. Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
- #23. Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)

BACK PAIN MEASURES GROUP:

Intent Code: G8493 Composite Code: G8502 CLAIMS, REGISTRY

- #148. Back Pain: Initial Visit
- #149. Back Pain: Physical Exam
- #150. Back Pain: Advice for Normal Activities
- #151. Back Pain: Advice Against Bed Rest

HEPATITIS C MEASURES GROUP:

Intent Code: G8545 Composite Code: G8549 CLAIMS, REGISTRY

- # 84. Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment
- # 85. Hepatitis C: HCV Genotype Testing Prior to Treatment
- # 86. Hepatitis C: Antiviral Treatment Prescribed
- # 87. Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment
- # 89. Hepatitis C: Counseling Regarding Risk of Alcohol Consumption
- # 90. Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy
- #183. Hepatitis C: Hepatitis A Vaccination in Patients with HCV
- #184. Hepatitis C: Hepatitis B Vaccination in Patients with HCV

HEART FAILURE (HF) MEASURES GROUP:

Intent Code: G8548 Composite Code: G8551 REGISTRY ONLY

- # 5. Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- # 8. Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- # 198. Heart Failure: Left Ventricular Function (LVF) Assessment
- ~~# 199. Heart Failure: Patient Education~~
- #226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

CORONARY ARTERY DISEASE (CAD) MEASURES GROUP:

Intent Code: G8489 Composite Code: G8498 REGISTRY ONLY

- # 6. Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
- # 196. Coronary Artery Disease (CAD): Symptom and Activity Assessment
- # 197. Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
- #226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

ADDENDUM E - 2011 PQRS REPORTING OPTIONS FOR MEASURES GROUPS (cont'd)

ISCHEMIC VASCULAR DISEASE (IVD) MEASURES GROUP:

Intent Code: G8547 Composite Code: G8552 CLAIMS, REGISTRY

- #114. Inquiry Regarding Tobacco Use (Preventive Care and Screening)
- #115. Advising Smokers and Tobacco Users to Quit (Preventive Care and Screening)
- #201. Ischemic Vascular Disease (IVD): Blood Pressure Management Control
- #202. Ischemic Vascular Disease (IVD): Complete Lipid Profile
- #203. Ischemic Vascular Disease (IVD): Low Density Lipoprotein (LDL-C) Control
- #204. Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic
- #226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

HIV/AIDS MEASURES GROUP:

Intent Code: G8491 Composite Code: G8500 REGISTRY ONLY

- # 159. HIV/AIDS: CD4+ Cell Count or CD4+ Percentage
- # 160. HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis
- # 161. HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy
- # 162. HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy
- # 205. HIV/AIDS: Sexually Transmitted Diseases – Chlamydia and Gonorrhea Screenings
- # 206. HIV/AIDS: Screening for High Risk Sexual Behaviors
- # 207. HIV/AIDS: Screening for Injection Drug Use
- # 208. HIV/AIDS: Sexually Transmitted Diseases – Syphilis Screening

COMMUNITY-ACQUIRED PNEUMONIA (CAP) MEASURES GROUP:

Intent Code: G8546 Composite Code: G8550 CLAIMS, REGISTRY

- #56. Community-Acquired Pneumonia (CAP): Vital Signs
- #57. Community-Acquired Pneumonia (CAP): Assessment of Oxygen
- #58. Community-Acquired Pneumonia (CAP): Assessment of Mental Status
- #59. Community-Acquired Pneumonia (CAP): Empiric Antibiotic

ASTHMA MEASURES GROUP

Intent Code: G8645 Composite Code: G8646 CLAIMS, REGISTRY

- #53. Asthma: Pharmacologic Therapy
- #64. Asthma: Asthma Assessment
- #231. Asthma: Tobacco Use: Screening – Ambulatory Care Setting
- #232. Asthma: Tobacco Use: Intervention – Ambulatory Care Setting

COPD MEASURES GROUP

Intent Code: G8898 Composite Code: CLAIMS, REGISTRY

- #110. Preventive Care and Screening: Influenza Immunization
- #111. Preventive Care and Screening: Pneumonia Vaccination for Patients 65 years and Older
- #51. Chronic Obstructive Pulmonary Disease (COPD); Spirometry Evaluation
- #52. Chronic Obstructive Pulmonary Disease (COPD); Bronchodilator Therapy
- #226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

INFLAMMATORY BOWEL DISEASE (IBD) MEASURES GROUP

Intent Code: G8899 Composite Code REGISTRY ONLY

- #269. IBD: Type, Anatomic Location and Activity All Documented
- #270. IBD: Preventive Care: Steroid Sparing Therapy
- #271. IBD: Preventive Care: Steroid Related Iatrogenic Injury-Bone Loss Assessment
- #272. IBD: Preventive Care: Influenza Immunization
- #273. IBD: Preventive Care: Pneumococcal Immunization
- #274. IBD: Screening for Latent TB Before Initiating Anti-TNF Therapy
- #275. IBD: Hepatitis B Assessment Before Initiating Anti-TNF Therapy
- #226. IBD: Preventive Care: Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention

ADDENDUM E - 2011 PQRS REPORTING OPTIONS FOR MEASURES GROUPS

(cont'd)

SLEEP APNEA MEASURES GROUP

REGISTRY ONLY

Intent Code: G8900 Composite Code

- #276. Assessment of Sleep Symptoms
- #277: Severity Assessment at Initial Diagnosis
- #278: Positive airway Pressure Therapy Prescribed
- #279: Assessment of Adherence to Positive Airway Pressure Therapy

DEMENTIAL MEASURES GROUP

REGISTRY ONLY

Intent Code: G8902 Composite Code

- #280. Dementia: Staging of Dementia
- #281. Dementia: Cognitive Assessment
- #282. Dementia: Functional Status Assessment
- #283: Dementia: Neuropsychiatric Symptom Assessment
- #284. Dementia: Management of Neuropsychiatric Symptoms
- #285. Dementia: Screening for Depressive Symptoms
- #286. Dementia: Counseling Regarding Safety Concerns
- #287 Dementia: Counseling Regarding Risks of Driving
- #288. Dementia: Caregiver Education and Support

PARKINSON'S MEASURES GROUP

REGISTRY ONLY

Intent Code: G8903 Composite Code

- #289. Annual Parkinson's Disease Diagnosis Review
- #290. Psychiatric Disorders or Disturbances Assessment
- #291. Cognitive Impairment of Dysfunction Assessment
- #292. Querying about Sleep Disturbances
- #293. Parkinson's Disease Rehabilitative Therapy Options
- #294. Parkinson's Disease Medical and Surgical Treatment Options Reviewed

HYPERTENSION MEASURES GROUP

REGISTRY ONLY

Intent Code: G8904 Composite Code

- #295. Aspirin or Other Anti-Platelet or anti-Coagulant Therapy
- #296. Complete Lipid Profile
- #297. Urine Protein Test
- #298. Annual Serum Creatinine Test
- #299. Diabetes Documentation or Screen Test
- #300. Blood Pressure Control
- #301. LDL Control
- #302. Counseling for Diet and Physical Activity

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CARDIOVASCULAR PREVENTION MEASURES GROUP

CLAIMS, REGISTRY

Intent Code: Composite Code

- #2. Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus
- #204. Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
- #226. Measure pair: a. Tobacco Use Assessment, b. Tobacco Cessation Intervention
- #236. Controlling High Blood Pressure
- #241: Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL Control <100
- #317. Preventive Care and Screening; Blood Pressure Measurement

CATARACTS MEASURES GROUP

REGISTRY ONLY

Intent Code: G8906 Composite Code:

- #191. Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery
- #192. Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures
- #303. Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery
- #304. Cataracts: Patient Satisfaction within 90 Days Following Cataract Surgery

ADDENDUM F - STEPS TO BILLING PQRS MEASURES

How to choose which Measures will be included

1. Review the listing of Measures for 2011 to see if they cover services provided by our clients
 - a. 2011 PQRS QDC Categories
 - b. 2011 List of 2010 Measures
2. Client must choose the measures applicable to the practice.
 - a. Review the “Clusters Listing” in the MVA (Section 6) to ensure the provider, if reporting less than 3 measures, will not fail the measures validity test
 - b. If client is reporting the same measures as 2010, they must read the PQRS Measures Specifications **RELEASE NOTES** to review for any changes to the criteria for these measures (i.e., addition, deletion of CPT or DX codes, etc.)s

Basics of Reporting

1. Print the pages of the measures that will be reported (PQRS Measures Specifications)
2. See 2011 PQRS implementation guide for instructions on how to interpret the measures
3. Each measure has:
 - a. QDC (Quality Data code) – Non-payable HCPCS codes comprised of specified CPT Category II (CPTII) codes and/or G-codes that describe the clinical action associated with each measure
 - i. CPTII codes consist of 5 alphanumeric characters with the string ending in the letter “F”
 - ii. CPTII codes are not modified or updated during the reported period remaining valid for the entire year
 - b. Each measure will have modifiers that are unique to CPTII codes. They describe Performance Measure Exclusion modifier due to:
 - i. 1P –Medical reasons
 1. Not indicated (absence of organ/limb, already received/performed, other)
 2. Contraindicated (patient allergy history, potential adverse drug interaction, other)
 3. Other medical reasons
 - ii. 2P –Patient reasons
 1. Patient declined
 2. Economic, social, or religious reasons
 3. Other patient reasons
 - iii. 3P – System reasons
 1. Resources to perform the services not available (e.g., equipment, supplies)
 2. Insurance coverage or payer-related limitations
 3. Other reasons attributable to health care delivery system
 - iv. 8P – Action not performed, reason not otherwise specified
 1. For use when an action described in a measure is not performed and the reason is not specified. Instructions of how to use this code is included in each measure.
 - c. Each measure will have a reporting frequency or timeframe requirement for each eligible patient seen during the reporting period by each eligible provider.
 - i. Patient Process: Minimum of once per reporting period
 - ii. Patient Intermediate: Minimum of once per reporting period
 - iii. Patient Periodic: Report once per timeframe specified in the measure during the reporting period
 - iv. Episode: Report once for each occurrence of a particular illness/condition per reporting period
 - v. Procedure: Report each time a procedure is performed during the reporting period
 - vi. Visit: Report each time the patient is seen during the reporting period
 - vii. All information must be captured in the clinical record
 - d. Other reporting requirements
 - i. Some measures may not have associated diagnoses and will have to report the measure as specified in the measure (examples: 110-influenza immunization, 154-Falls risk assessment, 47 – Advance Care Plan, etc.

- ii. Settings of care: office, hospitals, nursing homes and home health agencies
- iii. Specified patient demographics, such as age parameters and sex
- e. For measures that require more than one QDC, ensure that all codes are captured for the measure and reported on the claim form in the same encounter as the billed CPT code associated with the measures – See Measure 3

How to Read a Measure

1. Number and Narrative of the Measure
2. Reporting Options – Claims, Registry, EHR
3. DESCRIPTION – description of the patient and diagnoses of patients
4. INSTRUCTIONS – describes how often and criteria of patients (age) and who might report it
5. MEASURE REPORTING
 - a. Via Claims – instructions for claims – CPT, DX, modifier
 - b. Registry requirements
6. NUMERATOR – clinical action counted as meeting the measure’s requirement (patients receive a particular service or obtained a particular outcome that is being measured) This are the CPT Category II and G-codes
 - a. Communication
 - b. Numerator Note
 - c. Listing of Numerator Quality Data Code (QDC) for this measure (5010F type code or G code and possible modifiers to append
7. DENOMINATOR –
 - a. Statement of diagnosis
 - b. Acceptable Diagnosis codes
 - c. Acceptable CPT codes
 - d. Patient Demographics (age, gender) and POS (if applicable)
8. RATIONALE
 - a. A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results
9. CLINICAL RECOMMENDATION STATEMENTS
 - a. Summary of clinical recommendations based on best practices

CLAIMS

1. If billable services on the claims are denied for payment, the QDCs will not be included in the PQRS analysis
 - a. If the claim is corrected and paid through an adjustment, reopening, or the appeals process with accurate codes that correspond to the numerator and denominators specifications, the QDCs will now be counted
2. The ORIGINAL claim must have all the correct QDCs listed on the claim. A claim can not be resubmitted only to add or correct QDCs.
3. Claims with ONLY the QDCs on them (without the CPT code) may not be resubmitted to the carrier
4. EPs may submit multiple codes for more than one measure on a claim.
5. All diagnoses reported on the base claim will be included in PQRS analysis as some measures require reporting more than one diagnosis
6. Up to 8 diagnoses can be reported in the header on electronic claims and 4 diagnoses on paper claims.
7. Appeals of denials must reach the Medicare claims system by February 24, 2010 to be included in the analysis
8. QDC codes should be submitted with \$0 or \$.01 as the fee depending on system requirements. The field can not be left blank.
9. All PQRS QDC lines will deny with denial code N365. This code indicates that the code has been passed on to the NCH file for use in calculating incentive eligibility. *N365 = This procedure code is not payable. It is for reporting/information purposes only.*

10. It is suggested that N365 denials are matched to claims submitted to ensure all QDCs were passed to the NCH system.
11. Group Billing – individual EP’s NPI number must be on all claim lines including the QDC line.