Special Open Door Forum:
Physician Quality Reporting System for the Beginner – What You Need to Know to Succeed

(Physician Quality Reporting, previously known as PQRI)

March 22, 2011

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Agenda

- CMS Updates/Announcements
- Presentation
  - Physician Reporting for the Beginner, including Common Pitfalls to Avoid – Christine Estella
- Question and Answer Session

Physician Quality Reporting System –

Physician Reporting for the Beginner

Outline

- Physician Quality Reporting for the beginner focuses on:
  - A general overview of the Physician Quality Reporting System
  - Where to find resources for Physician Quality Reporting measures
  - Reporting options for the 2011 Physician Quality Reporting – Claims, Registries, EHR, GPRO I, and GPRO II
  - 2011 reporting and submission periods
  - Choosing measures to report including individual and measures groups
  - Common office processes for successful reporting
  - Finding your eligible population
  - Steps for reporting measures via claims

General Overview: 2011 Physician Quality Reporting

- Physician Quality Reporting is a voluntary reporting program that began in 2007 (originally called PQRI)
- Eligible professionals (or group practices) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries will qualify to earn an incentive payment
  - The incentive is a percentage of the eligible professional's (or group's) estimated total Medicare Part B PFS allowed charges
- Over time, the program has expanded the number of measures and reporting options to facilitate quality reporting by a broad array of eligible professionals

General Overview: 2011 Physician Quality Reporting (cont.)

- Eligible professionals
  - A list of eligible professionals who are able to participate in Physician Quality Reporting is available on the program website at http://www.cms.gov/PQRI
    - Not all entities are considered eligible as they may be reimbursed by Medicare under methods or fee schedules other than the Physician Fee Schedule (PFS)
      - e.g., Federally Qualified Health Centers are not eligible to report Physician Quality Reporting data because they are not reimbursed under the PFS
  - Eligible professionals include physicians, nurse practitioners, clinical nurse specialists, physician assistants, physical therapists, and many other health care professionals

General Overview: 2011 Physician Quality Reporting (cont.)

- 1% incentive payment
- Reporting mechanisms for individual eligible professionals
  - Claims
  - Qualified registry
  - Qualified EHR
- Reporting periods for individual eligible professionals
  - 12 months: January 1–December 31, 2011
  - 6 months: July 1-December 31, 2011 (claims and registry-based reporting only)
- Individual eligible professionals may report individual Physician Quality Reporting System measures or measures groups

General Overview: 2011 Physician Quality Reporting (cont.)

- Registration for Physician Quality Reporting is not required prior to submitting quality data
- Feedback reports and incentives (if eligible) will be made available during the following program year
- Do not confuse with other CMS programs!
  - eRx Incentive Program – http://www.cms.gov/ERxIncentive
  - EHR Incentive Program (aka Meaningful Use) – https://www.cms.gov/EHRIncentivePrograms/

Why Participate

- *Affordable Care Act* (ACA) (Section 10331, March 2010)
  - Provides Physician Quality Reporting incentives through 2014 and added PFS reductions starting in 2015
    - Authorized incentive payment amounts for each program year
      - 2007 – 1.5% subject to a cap
      - 2008 – 1.5%
      - 2009, 2010 – 2.0%
      - 2011 – 1%
      - 2012, 2013, 2014 – 0.5%
    - Authorized payment adjustment to fee schedule amount beginning in 2015 for those who do not satisfactorily report
      - 2015 – 98.5%
      - 2016 and subsequent years – 98.0%
  - Supports public reporting of quality data

Physician Quality Reporting Resources

- Visit the CMS Physician Quality Reporting webpage at http://www.cms.gov/PQRI for documents with additional participation information
  - How to Get Started section
  - Frequently Asked Questions
  - Sponsored Calls page
- Reminder – be sure to use the correct 2011 Physician Quality Reporting Measure Specifications as these documents are updated from year to year
  - *2011 Physician Quality Reporting Measure Specifications for Claims and Registry Reporting of Individual Measures*
  - *2011 Physician Quality Reporting Measures Groups Specifications*
  - *2011 Physician Quality Reporting EHR Measure Specifications*
  - *2011 Physician Quality Reporting GPRO I Narrative Measure Specifications*

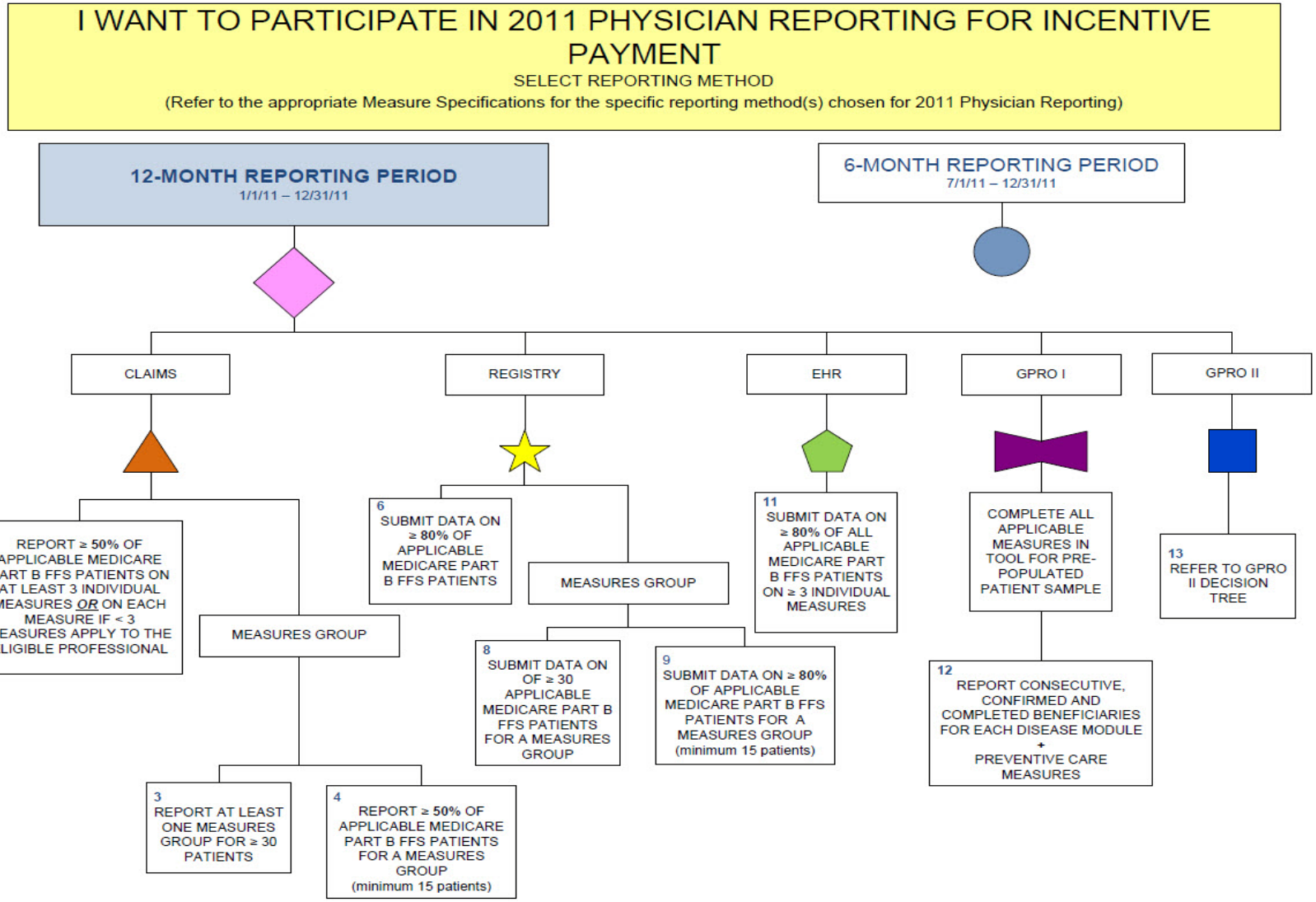
2011 Reporting Options

- Individual eligible professionals
  - Claims
  - Submission via a qualified registry
  - Submission via a qualified EHR product
- Selected group practices
  - Group Practice Reporting Option I (GPRO I)
  - GPRO II

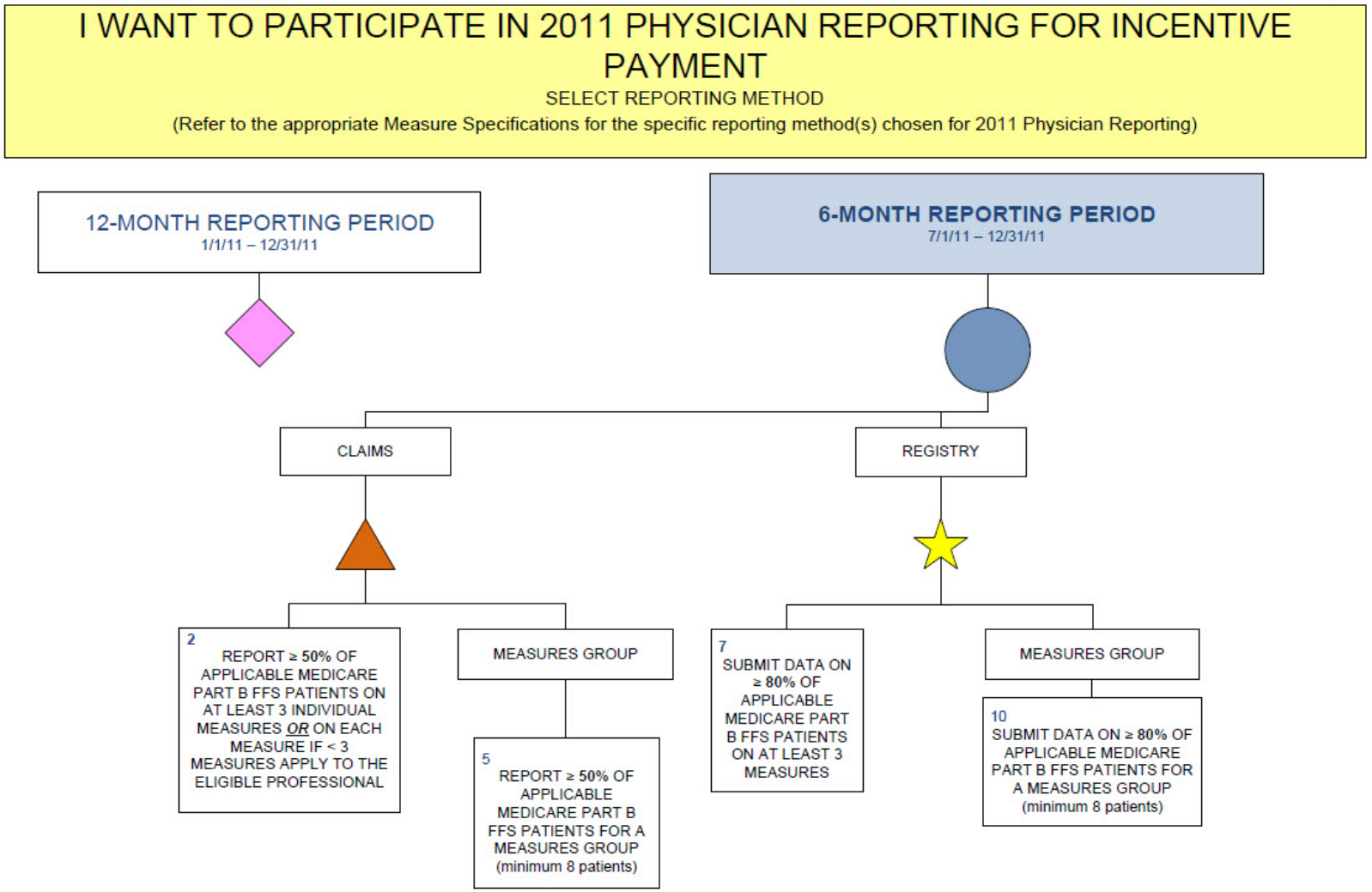
2011 Reporting Options (cont.)

- Determine which reporting option best fits your practice (claims-based, registry-based, or EHR-based reporting of either individual measures or measures groups) as well as the reporting period (12 months or 6 months where applicable) which may vary with the reporting option selected
  - Already past GPRO deadline
- Refer to 2011 Physician Quality Reporting Participation Decision Tree in Appendix C of the *2011 Physician Quality Reporting System Implementation Guide* - available as a download in the Measures Codes section of the CMS Physician Quality Reporting website at http://www.cms.gov/PQRI

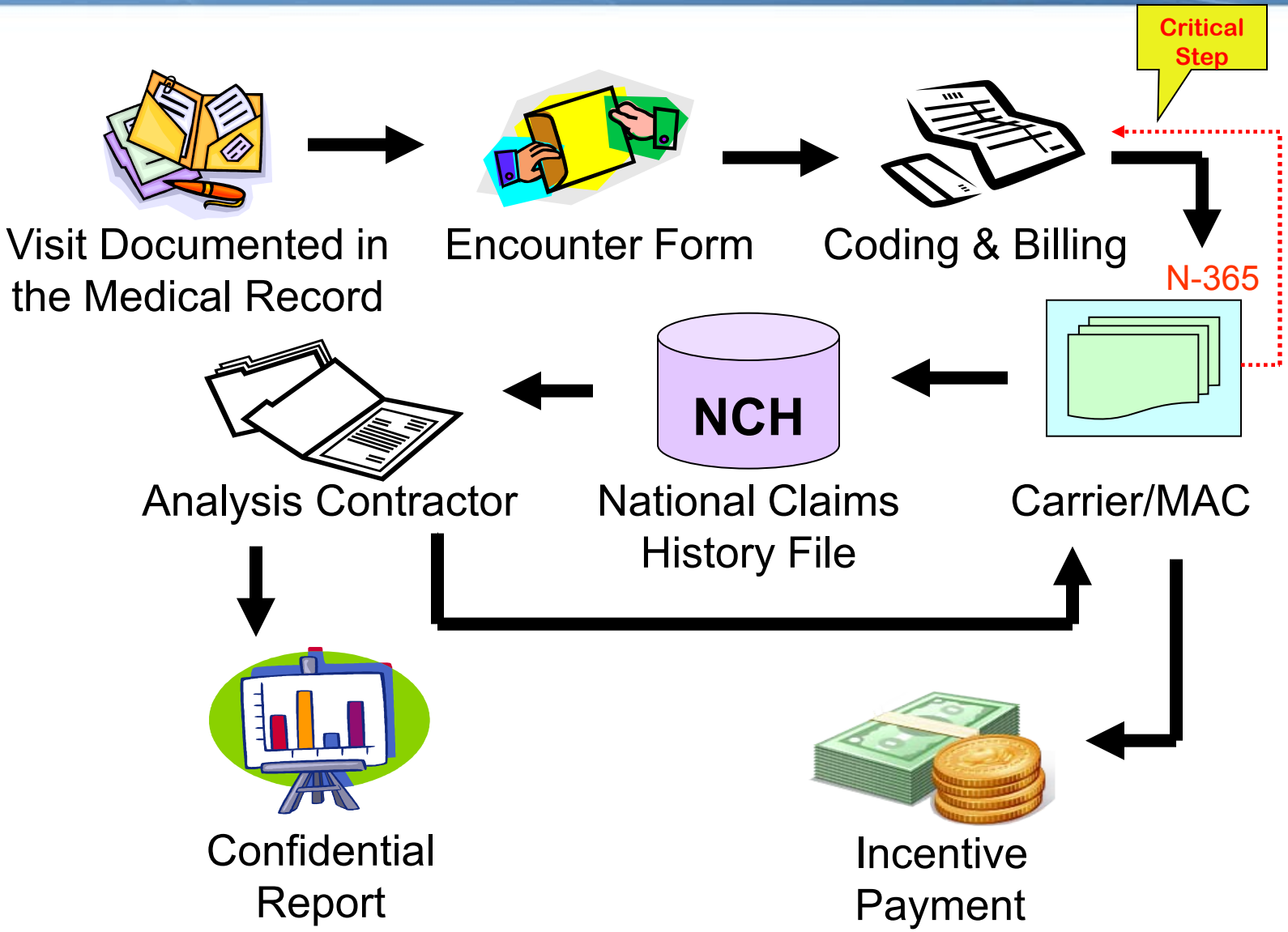
2011 Decision Tree



2011 Decision Tree (cont.)



Claims-based Process



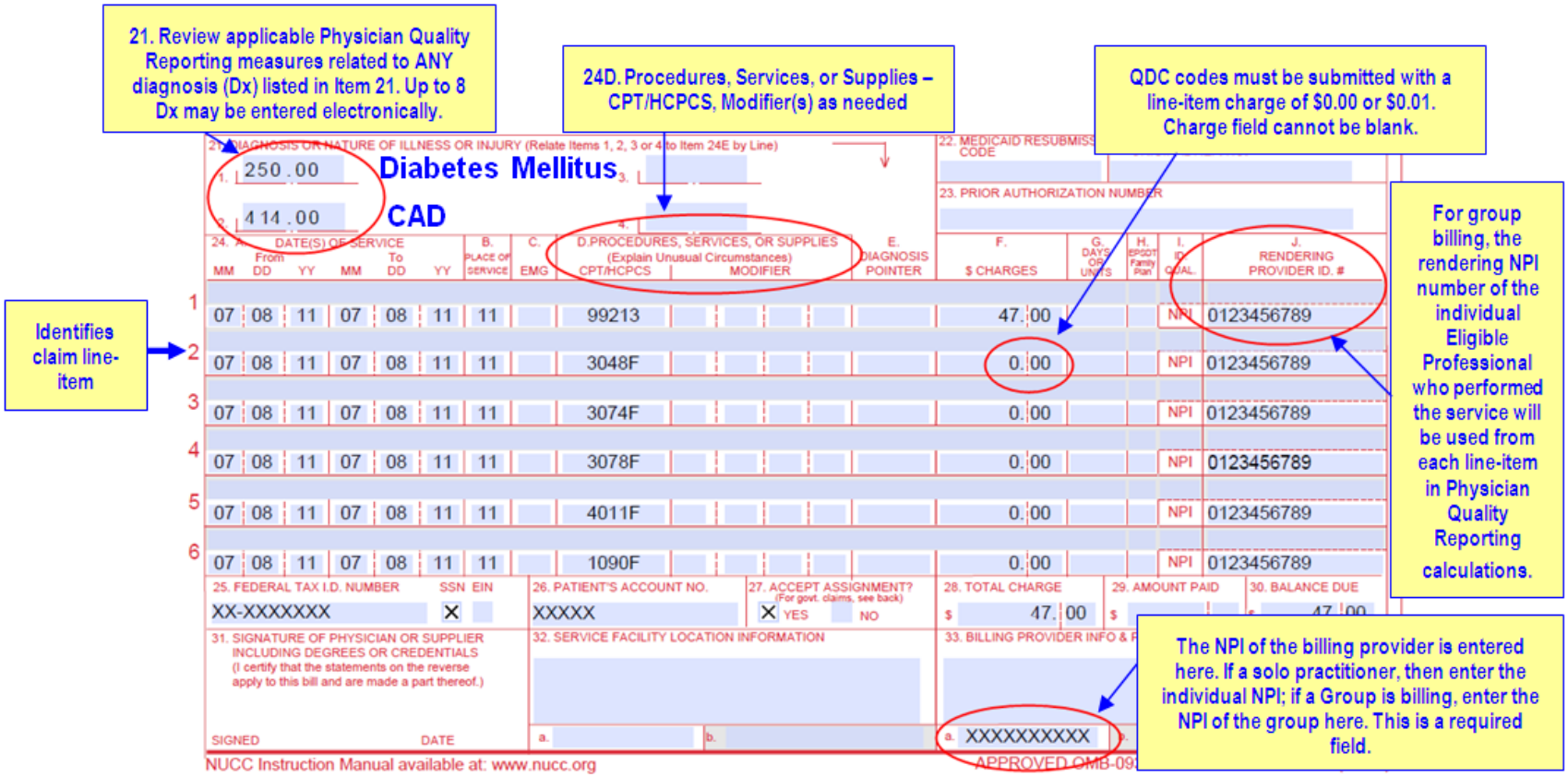
Claims-based Reporting

- When reviewing the measure specifications and reporting instructions for individual measures and measures groups, notice that each measure has a QDC (which consists of a Current Procedural Terminology [CPT] II code or a G-code) associated with it
  - Note that several measures allow the use of CPT II modifiers: 1P, 2P, 3P, and the 8P reporting modifier
  - Only allowable CPT II modifiers may be used with a CPT II code
- Eligible professionals should use the 8P modifier judiciously for applicable measures and measures groups they have selected to report
  - 8P modifier may not be used indiscriminately in an attempt to meet satisfactorily reporting criteria without regard to meeting quality improvement goals

Claims-based Reporting (cont.)

- Reporting QDCs for Physician Quality Reporting measures
  - CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
    - on the same claim as the denominator billing code(s)
    - for the same beneficiary
    - by the same Eligible Professionals (individual National Provider Identifier or NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the *denominator*
    - for the same date of service (DOS)
  - Claims can not be re-submitted just to add QDCs

CMS-1500 Claim Example



- The patient was seen for an **office visit (99213)**. The provider is reporting **several measures related to diabetes, coronary artery disease (CAD),** and **urinary incontinence:**
- Measure **#2** (LDL-C) with **QDC 3048F** + diabetes line-item diagnosis (24E points to **DX 250.00** in **Item 21**);
- Measure **#3** (BP in Diabetes) with **QDCs 3074F + 3078F** + diabetes line-item diagnosis (24E points to **Dx 250.00** in **Item 21**);
- Measure **#6** (CAD) with **QDC 4011F** + CAD line-item diagnosis (24E points to **Dx 414.00** in **Item 21**); and
- Measure **#48** (Assessment - Urinary Incontinence) with **QDC 1090F**. **For Physician Quality Reporting, there is no specific diagnosis associated with this measure.** Point to the appropriate diagnosis for the encounter.
- **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.
- 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. Physician Quality Reporting analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

Measures Groups

- As an alternative to reporting individual measures, you may select to report one or more measures groups
- Eligible professionals choosing to report 2011 Physician Quality Reporting measures groups should select at least one measures group on which to submit in an attempt to qualify for a Physician Quality Reporting incentive payment
- Refer to the *Measures Groups Specifications Manual*, located on the Measures Codes section of the CMS Physician Quality Reporting website to review measures groups applicable to your practice

Claims-based Reporting of Measures Groups

- There are two reporting methods for submission of measures groups that involve a patient sample selection: 30-patient sample method and 50% patient sample method
- An “intent G-code” must be submitted for either method to initiate intent to report measures groups via claims
- If a patient selected for inclusion in the 30-patient sample did not receive all the quality actions and that patient returns at a subsequent encounter, QDC(s) may be added (where applicable) to the subsequent claim to indicate that the quality action was performed during the reporting period
- Physician Quality Reporting analysis will consider all QDCs submitted across multiple claims for patients included in the 30-patient samples

Claims-based Reporting of Measures Groups (cont.)

- Eligible professionals only need to report the applicable measures for each patient meeting denominator inclusion in the patient sample
- Eligible professionals who have contracted with Medicare Advantage (MA) health plans should not include their MA patients in **claims-based** reporting of measures groups using the 30 unique patient sample method
- Only Medicare Part B FFS patients should be included in claims-based reporting of measures groups

Measures Groups: Supporting Documents

- Once you have selected a measures group(s) to report, carefully review the following documents:
  - *2011 Physician Quality Reporting System Measures Groups Specifications Manual* for claims-based or registry-based reporting of measures groups
    - Note: The specifications for a measures group are different from those for individual measures because they identify a common denominator across the measures group. Be sure you use the correct specifications.
  - *Getting Started with 2011 Physician Quality Reporting System Reporting of Measures Groups* is the implementation guide for reporting measures groups
- Available as downloads from Measures Codes section of the CMS Physician Quality Reporting website

Measures Groups: Supporting Documents (cont.)

- *2011 Physician Quality Reporting System Fact Sheet: Physician Quality Reporting System Made Simple for Reporting the Preventive Care Measures Group*
  - Provides a useful worksheet to keep track of each unique patient reported when using the 30-patient sample method to report a measures group
  - Available as download in the Educational Resources section of the CMS Physician Quality Reporting website

Registry Submission

- What is a registry?
  - Captures and stores clinically related data submitted by the eligible professional (or group practice)
  - Registry submits information on Physician Quality Reporting System individual measures or measures groups (or eRx measure) to CMS on behalf of eligible professionals (or group practice)
- Registries provide CMS with calculated reporting and performance rates at the end of the reporting period
  - Data must be submitted to CMS via defined .xml specifications
- CMS qualifies registries annually
  - A list of qualified registries for 2011 Physician Quality Reporting/eRx will be available by summer 2011 at: http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp

Registry–based Reporting of Individual Measures or Measures Groups

- Must submit three individual measures or at least one measures group
- The qualified registry is responsible for providing their clients with instructions on how to submit the selected measures or measures group(s) through the registry
- Information regarding qualified registries can be found in the Alternative Reporting Mechanisms section of the CMS Physician Quality Reporting website

EHR Submission

- CMS qualifies EHR vendors annually
  - List of ***Qualified EHR Vendors for the 2011 Physician Quality Reporting and eRx Incentive Programs*** (including the specific product(s) and version(s) that are qualified) is available at: http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage > ***Downloads***
- Using a qualified EHR, eligible professionals submit raw clinical data to CMS and measures are calculated by CMS

EHR-based Reporting

- Eligible professionals who choose to report on EHR measures must select **at least three** EHR measures to be eligible for the Physician Quality Reporting incentive payment
  - Review the *2011 Physician Quality Reporting System EHR Measure Specifications* to determine if three measures apply to your practice
- Determine if your EHR product is a 2011 Physician Quality Reporting System qualified EHR system
  - A list of qualified 2011 EHR vendors and their product version(s) is available as a download in the Alternative Reporting Mechanisms section of the CMS Physician Quality Reporting website at http://www.cms.gov/PQRI

EHR References

- Note: Do not confuse with *EHR Incentive Program*, a separate program with a different website, resources, and help desk
- Reference documents on CMS Physician Quality Reporting website:
  - *2011 EHR Measure Specifications* – located in a zip titled *2011 EHR Documents for Eligible Professionals* on the Alternate Reporting Mechanisms page
  - *2011 Physician Quality Reporting EHR Reporting Made Simple* – Educational Resources page
- User Guides posted on the Portal sign-in page:
  - *Physician Quality Reporting/eRx Submission User Guide*
  - *Physician Quality Reporting/eRx Submission Report User Guide*
  - *Portal User Guide*
  - *Submission Engine Validation Tool (SEVT) User Guide*
  - *EHR Submitter Role – Quick Reference Guide*

Group Practice Reporting Options (GPRO)

- To participate, a group practice must:
  - Submit self-nomination letter to CMS – information is posted on the Group Practice Reporting Option section of the Physician Quality Reporting website
  - Meet certain technical and/or other requirements
  - Be selected to participate

2011 GPRO I

- GPRO I: self-nominated group practices with 200 or more eligible professionals
  - Must have self-nominated by January 31, 2011
  - Complete pre-populated data collection tool for an assigned set of Medicare beneficiaries
    - 26 total measures (4 disease modules + 4 individual preventive care measures)
    - Access to tool no later than first quarter of 2012
      - 2011 data submitted in 2012

2011 GPRO II

- GPRO II: group practices with 2-199 eligible professionals (new for 2011)
  - Must have self-nominated by January 31, 2011
  - CMS will select approximately 500 groups meeting the eligibility requirements
    - Reported via claims (unless only applicable measures group(s) is registry-only)
  - No data collection tool; will use:
    - *2011 Physician Quality Reporting System Individual Measure Specifications for Claims and Registry*
    - *2011 Physician Quality Reporting System Measures Groups Specifications Manual*

GPRO (cont.)

- For more information regarding reporting 2011 Physician Quality Reporting via GPRO I or II, please see documents in the Downloads section of the Group Practice Reporting Option page of the CMS Physician Quality Reporting website

Reporting and Submission Periods

- 2011 reporting periods:
  - 12 months (January 1-December 31, 2011)
  - 6 months (July 1-December 31, 2011)
- Submission period for 2011 data:
  - Registry – 1st quarter 2012
  - EHR – 1st quarter 2012

Choosing Measures

- Steps for selecting measures
  1. Choose measures based on your method of reporting (Claims, Registry & EHR reporting options)
  2. Determine if measures are applicable to your practice by reviewing:
     - Clinical conditions usually treated
     - Types of care typically provided (e.g., preventive, chronic, acute)
     - Applicable clinical settings
     - Supports the practice's quality improvement goals

Claims-based Reporting of Individual Measures

- Review the *2011 Physician Quality Reporting System Measures List*, available as a download in the Measures Codes section of the CMS Physician Quality Reporting website and determine which Physician Quality Reporting measures apply to your practice
- Eligible professionals who choose to report 2011 Physician Quality Reporting individual measures should select <u>at least</u> three applicable measures to submit to attempt to qualify for a Physician Quality Reporting incentive payment
  - If fewer than three measures are reported, CMS will apply a measure-applicability validation (MAV) process when determining incentive eligibility
    - Additional information on MAV can be found on the Analysis and Payment section of the Physician Quality Reporting webpage

Claims-based Reporting of Individual Measures (cont.)

- If you participated in Physician Quality Reporting in 2010, you may choose to report on the same measures for 2011 (if available) or you may select different measures on which to report
- Eligible professionals should review the 2011 measure specifications in detail including noting any revisions from the prior program year

Claims-based Reporting of Individual Measures (cont.)

- Individual Physician Quality Reporting measures
  - Once you have selected the measures (at least three) on which you will report, carefully review the following documents:
    - *2011 Physician Quality Reporting Implementation Guide,* which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in Form CMS-1500 format
    - *2011 Physician Quality Reporting Measure Specifications Manual for Claims and Registry Reporting of Individual Measures and Release Notes,* which includes codes and reporting instructions for the measures
  - These can be found as downloads in the Measures Codes section of the CMS Physician Quality Reporting website

2011 Physician Quality Reporting Measures Groups

- Measures groups include reporting on a group of clinically-related measures identified by CMS for use in Physician Quality Reporting, either through claims-based and/or registry-based submission
- A complete list of Measures Groups is available at: http://www.cms.gov/PQRI/15_MeasuresCodes.asp

2011 Physician Quality Reporting Measures Groups (cont.)

- 14 measures groups
  - Diabetes Mellitus
  - Chronic Kidney Disease (CKD)
  - Preventive Care
  - Rheumatoid Arthritis
  - Perioperative Care
  - Back Pain
  - Hepatitis C
  - Ischemic Vascular Disease (IVD)
  - Community-Acquired Pneumonia (CAP)
  - Asthma (new)
  - Coronary Artery Bypass Graft (CABG) (registry only)
  - Heart Failure (HF) (registry only)
  - Coronary Artery Disease (CAD) (registry only)
  - HIV/AIDS (registry only)

Helpful Common/Office Processes

- Medical record documentation must support what is reported
- Ensure the practice has a method to flag denominator-eligible cases when billing Medicare Part B, including Medicare as a secondary payer, so that QDCs on those cases are also reported
  - i.e., visits for services listed in the denominator coding section of each measure specification
  - Add ticklers to files
  - Consider implementing data collection worksheets
  - Edits to billing software
- Ensure you identify and capture **all** eligible claims for the measure denominator for each measure selected

Finding Your Eligible Population

- For measures selected to report, carefully review all ICD-9-CM diagnoses (if applicable) and CPT service (encounter) codes that will qualify claims for inclusion in Physician Quality Reporting measurement calculations (i.e., claims that are denominator-eligible)

NUMERATOR

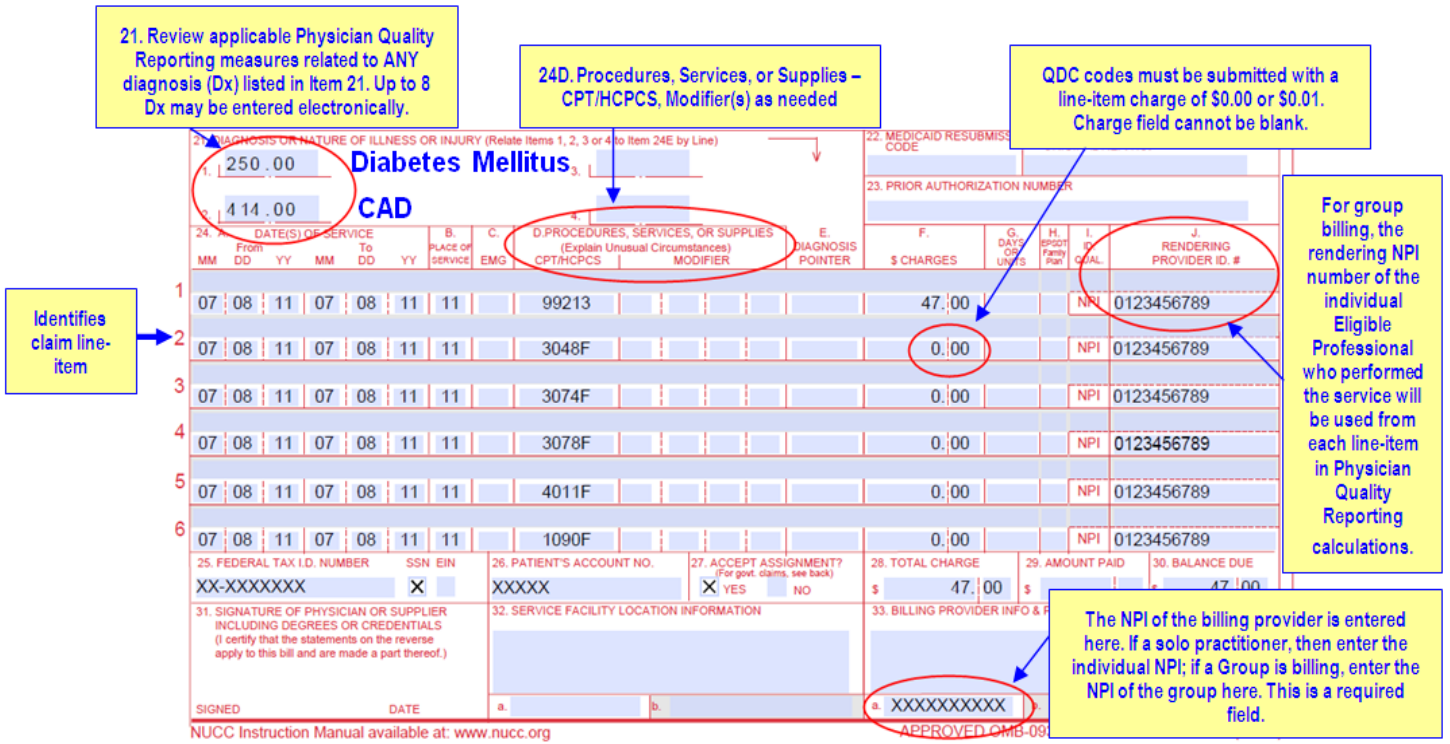
(**Clinical action** required for performance)

DENOMINATOR

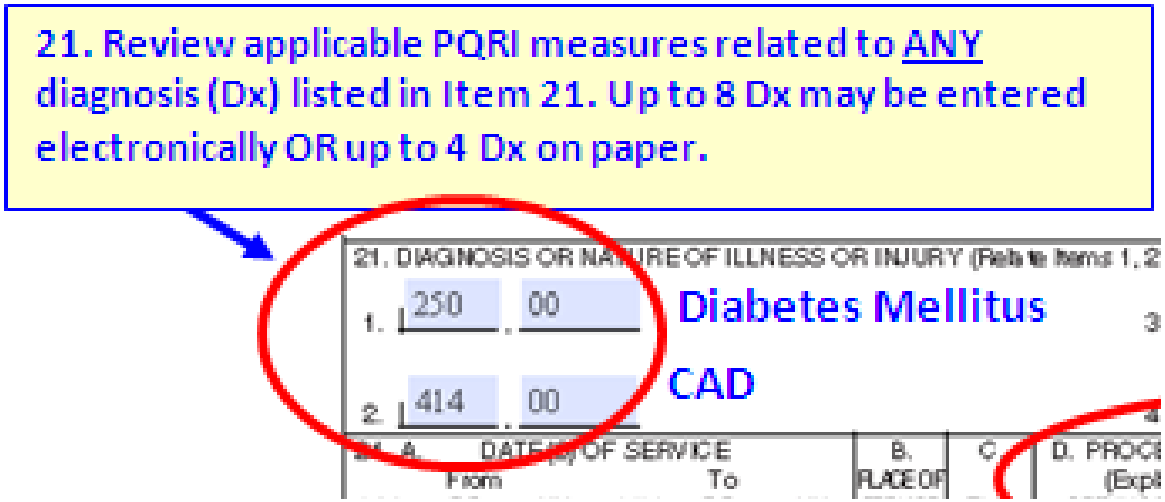
(Describes **eligible cases** for which a **clinical action** was performed: the eligible patient population as defined by denominator specification**)**

5 Steps for Reporting via Claims

- File a Medicare claim as you normally would, with the addition of extra quality-data codes (QDCs) to indicate the quality action



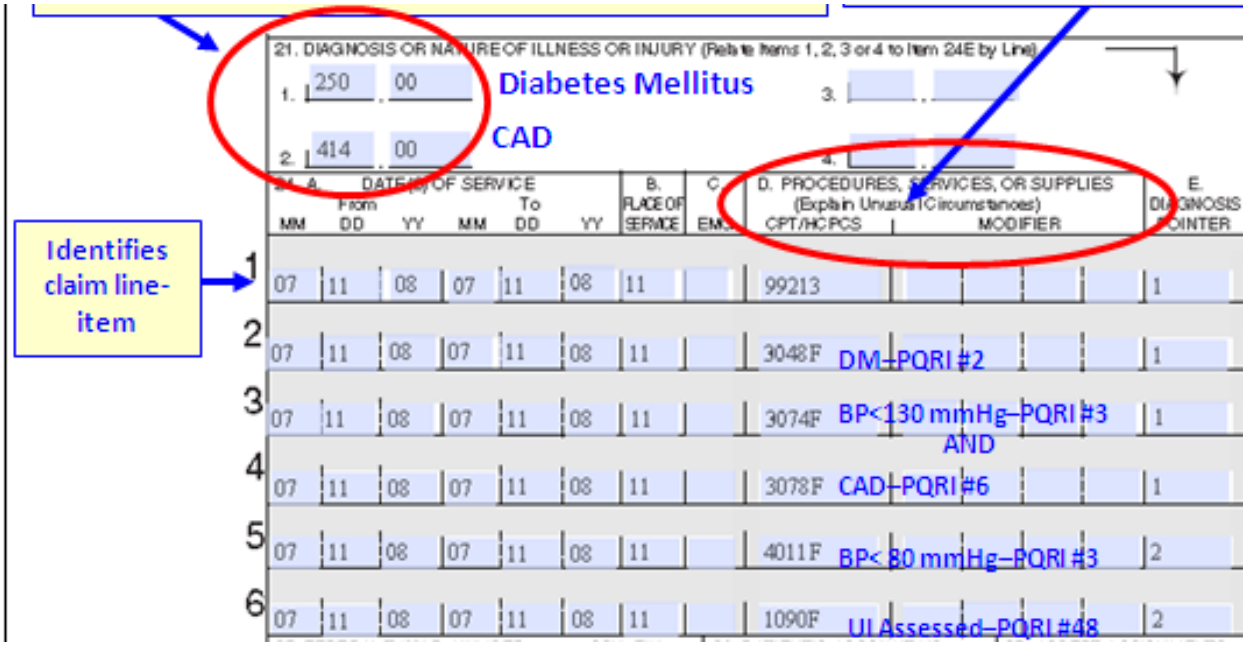
Reporting via Claims: Step 1



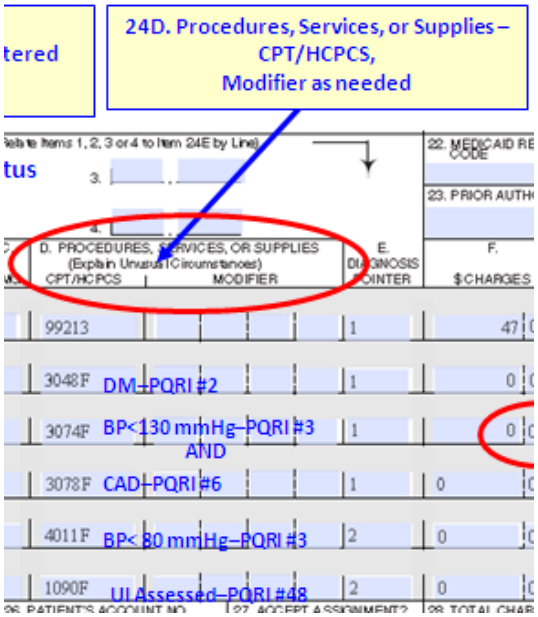
- Relevant ICD-9-CM diagnosis codes are entered in **Field 21**
  - Up to 8 diagnoses may be entered electronically OR up to 4 diagnoses may be included on paper
- **All base claim diagnoses and valid QDCs reported are considered for the analysis of reporting and apply to all rendering providers on the claim reporting the measures**

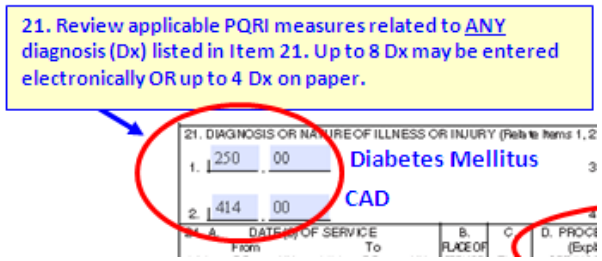
Reporting via Claims: Step 2

- The numbers 1 through 6 by each line identify the **claim line-item**
  - Only one diagnosis can be linked to each line item, whether billing on paper or electronically



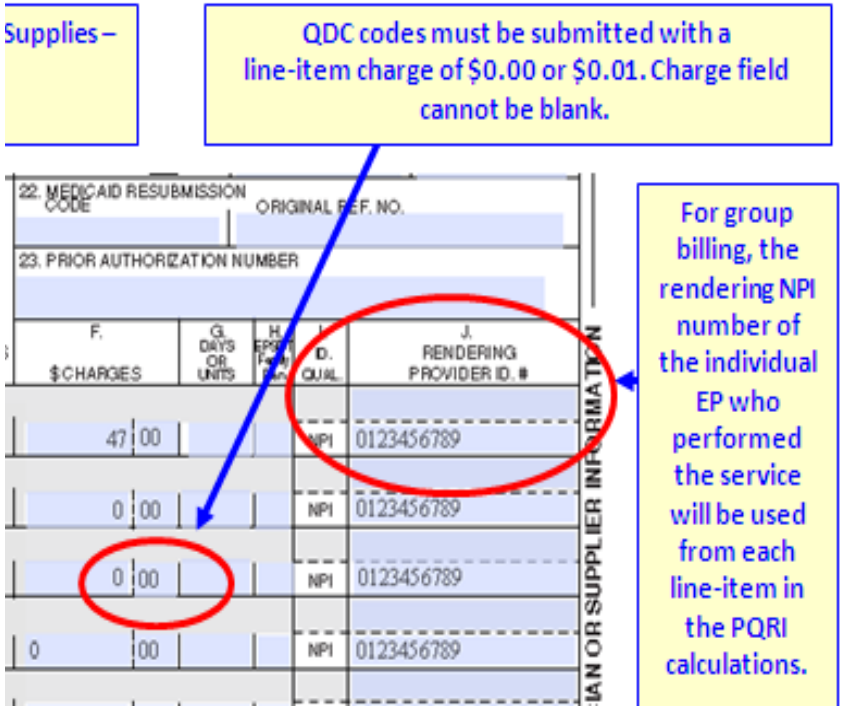
Reporting via Claims: Step 3





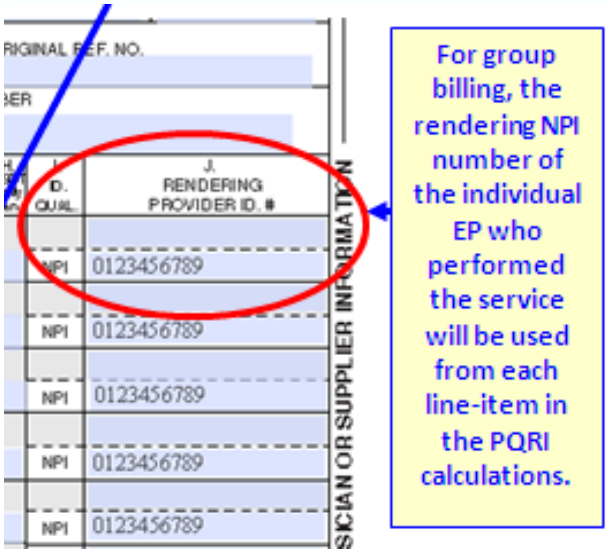
- In **24D**, include Procedures, Services, or Supplies - Enter the **service codes** (including CPT, HCPCS, CPT Category II, and/or G-codes) with any associated modifiers (as indicated in the measure's specification)
- Be sure to include a single reference number in the **diagnosis pointer Field 24E** that corresponds with the diagnosis pointer number in **Field 21**
  - 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
  - Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in Physician Quality Reporting analyses
  - Eligible professionals should review ALL diagnosis and encounter codes listed on the claim to ensure they are capturing ALL reported measures applicable to that patient's encounter

Reporting via Claims: Step 4

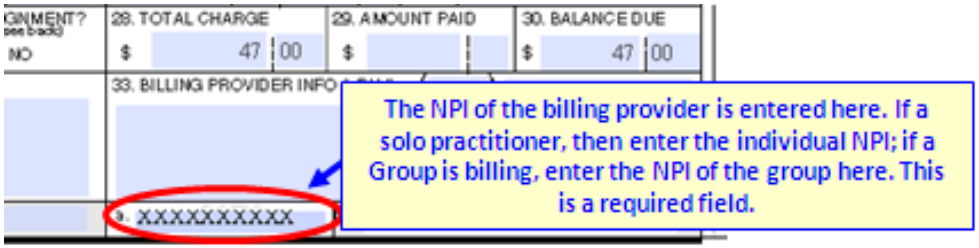


- **Important!** QDCs must be submitted with a line-item charge of $0.00 or $0.01 (The beneficiary is not liable for this nominal amount.)
  - If your billing software limits claim line items, add a nominal amount to one of the QDC line items on the second claim
  - The charge field cannot be blank
  - Analyses will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI, and analyze them as one claim
- The QDC must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in analysis
  - The total claim cannot be $0.00
  - Entire claims with a zero charge will be rejected
  - Please note that **claims may NOT be resubmitted solely to add QDCs**

Reporting via Claims: Step 5



- For group billing, the **rendering NPI** of the individual eligible professional who performed the service will be used from each line-item in calculations
- This NPI should be entered in **Field 24J**



- The **Tax Identification Number (TIN)** of the employer is entered in **Field 25**
- The NPI of the **billing provider** is entered in **Field 33A**
  - Submit for solo practitioner or group billing appropriately

Physician Quality Reporting System –

Watch for Common Pitfalls

Outline

- Common pitfalls with Physician Quality Reporting
  - Missing your eligible population
  - Reporting incorrect information
    - Using incorrect specifications
    - Quality-data codes
    - Individual National Provider Identification numbers
  - Missing the reporting frequency
  - Confusing with other CMS programs (Meaningful Use)
  - Knowing who to call for help

Missing Eligible Population

- For measures selected to report, carefully review all ICD-9-CM diagnoses (if applicable) and CPT service (encounter) codes that will qualify claims for inclusion in Physician Quality Reporting measurement calculations (i.e., claims that are denominator-eligible)
  - Some measures have specified patient demographics, such as age parameters, and gender, for denominator inclusion
- For measures that require capturing clinical values for coding, make sure these clinical values are available to those who are coding claims for Physician Quality Reporting (i.e., HgA1c value)

Reporting Incorrect Info

- Be sure to use correct measure specifications for current program year and reporting method
- For measures that require more than one QDC (CPT II or G-code), please ensure that **all** codes are captured on the claim
- Ensure that each claim includes the appropriate QDC(s) or QDC with the allowable CPT II modifier with the individual eligible professional's NPI in the rendering provider ID field on the claim
- Be sure to include the individual *rendering* NPI number(s) on the claim
- If all billable services on the claim are denied for payment by the Carrier/MAC, the QDCs will not be included in Physician Quality Reporting analysis
- QDCs should be submitted on the line item of the claim as a zero charge
  - A nominal amount such as a penny may be entered if billing software does not permit a zero charge line item
  - The submitted charge field ($charges) cannot be left blank

Frequency of Reporting

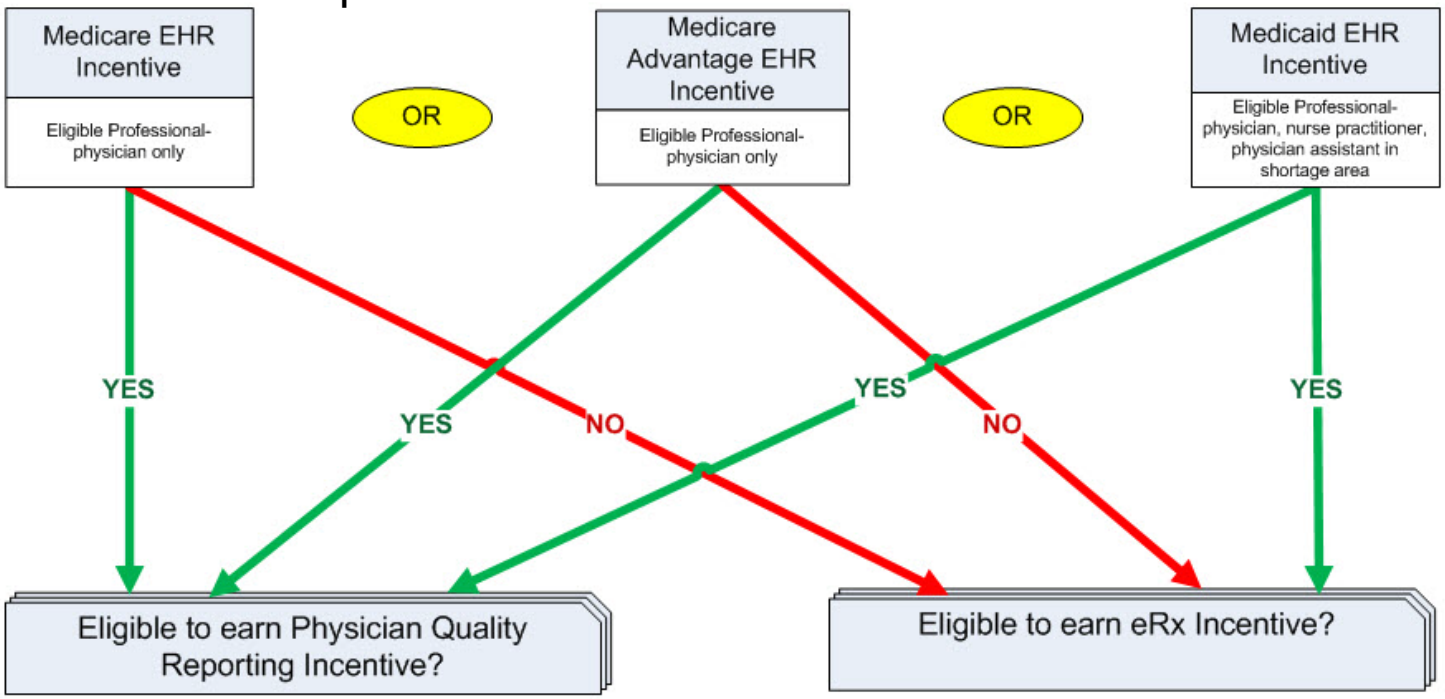
- Each measure has a reporting frequency or timeframe requirement (called a “measure tag” in Physician Quality Reporting analysis) for each eligible patient seen during the reporting period for each individual eligible professional (NPI)
  - Found in the Instructions section of each measure specification for individual measures and measures groups
  - Ensure that all members of the team understand and capture this information in the clinical record to facilitate reporting

Frequency of Reporting (cont.)

- Physician Quality Reporting measure tag examples include:
  - Report one-time per patient, per NPI/TIN combo per reporting period – **patient-level**
  - Report once for **each procedure** performed
  - Report for each acute **episode**
  - Report for each **visit**

Confusing with Other Programs

- Physician Quality Reporting is separate from the Medicare & Medicaid EHR Incentive Program (aka Meaningful Use)
  - Different program year materials/requirements
  - Different Help Desk



NOTE: Although an eligible professional may not earn an incentive for both Medicare EHR and eRx during 2011, he/she must report 10 eligible eRx instances via claims between January 1 and June 30, 2011 in order to avoid the 2012 payment adjustment.

Who to Call for Help

- Please contact the **QualityNet Help Desk** at **866-288-8912** (available 7:00 a.m. to 7:00 p.m. CST Monday through Friday) or via e-mail at qnetsupport@sdps.org (or TTY 1-877-715-6222)
- For questions regarding **EHR Incentive Programs**:
  - EHR Incentive Program website, including FAQs and educational materials http://www.cms.gov/EHRIncentivePrograms/
  - Contact the Electronic Health Record (EHR) Information Center 8:30 a.m. – 4:30 p.m. (CT) Monday through Friday (except federal holidays)
    1-888-734-6433 (primary) or 888-734-6563 (TTY)

Reporting Tips

- Check the CMS website for updated FAQs and educational documents
- Remittance Advice (RA) with denial code N365 is your indication that Physician Quality Reporting codes were passed into the National Claims History (NCH) file for use in calculating incentive eligibility
  - Check RA notices regularly to ensure receipt of a remark code N365 for each QDC submitted denoting that QDCs for individual measures and/or measures groups were passed into the NCH
    - This remark does not confirm QDC accuracy

Reporting Tips (cont.)

- Several reporting errors can be avoided! Please report carefully, since all diagnoses listed on the CMS-1500 (or electronic equivalent) at an encounter during the reporting period will be counted in analysis
  - In other words, you may unintentionally report measures you did not anticipate
- Once you report one valid QDC for a measure, you will be included in analysis whether you selected to report that measure or not
- Under-reporting may result if QDCs are not reported on claims where billed codes match a measure's denominator
- Review the specs closely for patient demographics, such as age parameters and gender, for denominator inclusion
- Capture all codes on the claim
  - e.g., When submitting codes for Measure #3 - High Blood Pressure Control in Diabetes Mellitus, be sure to include codes for both the systolic and diastolic blood pressure

Reporting Tips (cont.)

- Note: If the diagnosis or encounter code is different than those listed in the Physician Quality Reporting denominator for a measure, it is not necessary to report a QDC
  - Only report QDCs when the codes billed match the denominator coding specified in the measure you are reporting
- Review *all* denominator codes affecting *claims-based* reporting, particularly those measures that do not have an associated diagnosis (for example, #110 Influenza Immunization, #154 Falls Risk Assessment, #47 Advance Care Plan, etc.)
  - Report on each eligible claim as instructed in the measure specifications
- Review all diagnoses (if applicable) and CPT service (encounter) codes for denominator inclusion in Physician Quality Reporting (i.e., claims that are denominator-eligible)

Reporting Tips (cont.)

- All denominator-eligible claims must have the appropriate QDC(s) or QDC with the allowable CPT II modifier along with the individual eligible professional's NPI
- Report more than what is required (i.e., for 30 patient sample may want to report on 35-40, etc.)
- Report under individual NPI (as shown in CMS-1500 example-Item 24J must contain the NPI of the individual provider who rendered the service when a group is billing)
- If reporting on measures groups, report on all applicable measures within the measures group
- Only include reporting modifiers (1P, 2P, 3P) or performance modifier (8P) if they are included in the measure's specifications

Thank you

Questions?