

PQRI Fact Sheet

<http://www.cms.hhs.gov/PQRI>

Changes to PQRI Reporting: Alternative Reporting Periods and Alternative Criteria for Satisfactorily Reporting for 2008: Measures Groups and Registry-Based Reporting

CMS has established new reporting options making it even easier for professionals to participate in PQRI. It is not too late for those who have not yet started reporting quality data to begin participation.

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) (P.L. 110-173), enacted on December 29, 2007, authorized CMS to establish *alternative reporting periods and alternative criteria for satisfactorily reporting* quality measures for the 2008 Physician Quality Reporting Initiative (PQRI). MMSEA provisions offer eligible professionals more options to report PQRI quality measures and potentially earn incentive payments for such reporting.

CMS has published a document that establishes the new alternative reporting criteria and periods for 2008 PQRI at <http://www.cms.hhs.gov/PQRI> on the CMS website. The alternatives, which are described below, supplement the reporting period and the reporting criteria previously established by the 2008 Physician Fee Schedule (PFS) Final Rule for satisfactory reporting 1-3 individual measures through claims-based data submission on services furnished during a January 1, 2008, through December 31, 2008, reporting period.

The January, 2008 PQRI Fact Sheet, located at [http://www.cms.hhs.gov/PQRI/Downloads/pqri2008_fact_sheet\(508\).pdf](http://www.cms.hhs.gov/PQRI/Downloads/pqri2008_fact_sheet(508).pdf) on the CMS website, provides a summary of the 2008 PFS provisions.

Measures Groups

New for 2008, there are four **measures groups**. “Measures groups” are subsets of PQRI measures that have in common a focus on a particular clinical condition or aspect of care. The denominator coding of the measures defines the condition or aspect of care. Eligible professionals electing to report a group of measures must report *all* measures within that group that are applicable to each patient in a minimum number of consecutive patients that varies by reporting period or 80% of Medicare patients. The four measures groups are: **Diabetes Mellitus**, **End Stage Renal Disease (ESRD)**, **Chronic Kidney Disease (CKD)**, and **Preventive Care**. Each of the measures groups contains at least four PQRI measures and may be reported through claims-based or registry-based data submission.

The measures groups are composed of the following PQRI measures:

Diabetes Mellitus:

Measure Number 1	Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus
Measure Number 2	Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus
Measure Number 3	High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus
Measure Number 117	Dilated Eye Exam in Diabetic Patient
Measure Number 119	Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients

End Stage Renal Disease (ESRD):

Measure Number 78	Vascular Access for Patients Undergoing Hemodialysis
Measure Number 79	Influenza Vaccination in Patients with ESRD
Measure Number 80	Plan of Care for ESRD Patients with Anemia
Measure Number 81	Plan of Care for Inadequate Hemodialysis in ESRD Patients

Chronic Kidney Disease (CKD):

Measure Number 120	ACE Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy in Patients with CKD
Measure Number 121	CKD: Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile)
Measure Number 122	CKD: Blood Pressure Management
Measure Number 123	CKD : Plan of Care: Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA)

Preventive Care:

Measure Number 39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
Measure Number 48	Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
Measure Number 110	Influenza Vaccination for Patients > 50 Years Old
Measure Number 111	Pneumonia Vaccination for Patients 65 Years and Older
Measure Number 112	Screening Mammography
Measure Number 113	Colorectal Cancer Screening
Measure Number 114	Inquiry Regarding Tobacco Use
Measure Number 115	Advising Smokers to Quit
Measure Number 128	Universal Weight Screening and Follow-Up

Alternative Reporting Periods and Criteria for Measures Groups

- (1) **Measures Groups using Claims-based Submission:** The claims-based reporting mechanism for measures groups will first be available July 1, 2008. The alternative reporting period for quality measures for measures groups submitted through claims-based reporting is *July 1, 2008 - December 31, 2008*.

Claims-based Reporting Only: The *alternative reporting criteria* for quality measures for measures groups reported for the July 1, 2008 - December 31, 2008 reporting period are:

- 15 consecutive Medicare patients for whom the measures of **one** measures group apply; or
- 80 percent of Medicare patients for whom the measures of the measures group apply without regard to whether the patients are consecutive.

Claims-based Submission of Measures Groups

- The “G-code” required for claims-based submission of measures groups will not be implemented until July 1, 2008. Therefore, the July 1, 2008 - December 31, 2008 reporting period is the only available reporting period for measures groups submitted through claims.
- For measures groups submitted through the claims mechanism, an eligible professional must initiate reporting for the 15 consecutive Medicare patients beginning on or after July 1, 2008, by reporting a specific “G-code” on the initial claim for a measures group. This indicates the eligible professional’s intent to report a specific measures group starting with the first patient for whom the “G-code” is submitted. The measures groups specific “G-codes” are G8485 for Diabetes Mellitus, G8486 for Preventive Care, G8487 for Chronic Kidney Disease, and G8488 for End Stage Renal Disease.
- Reminder: Report all the applicable CPT II or “G-code” quality data codes for each of the measures in the measures group that are applicable to the patient.

- (2) **Measures Groups using Registry-based Submission:** The alternative reporting periods for reporting measures groups through clinical registry-based submission are *January 1, 2008 - December 31, 2008*, or *July 1, 2008 - December 31, 2008*.

Although quality measures information on consecutive patients reported through registry-based reporting for measures groups may include some non-Medicare patients, the string of consecutive patients must be established in such a way as to include Medicare patients. (Quality measures that are reported through the claims mechanism or under other registry-based reporting criteria can only include Medicare patients.)

Registry-based Reporting Only: The *alternative reporting criteria* for quality measures for measures groups reported for the January 1, 2008 - December 31, 2008 reporting period are:

- 30 consecutive patients for whom the measures of one measures group apply; or
- 80 percent of applicable Medicare patients seen during the year for whom the measures of the measures group apply without regard to whether the patients are consecutive.

Registry-based Reporting Only: The *alternative reporting criteria* for quality measures for measures groups reported for the July 1, 2008 - December 31, 2008 reporting period are:

- 15 consecutive patients for whom the measures of one measures group apply; or
- 80 percent of applicable Medicare patients seen during the six-month period for whom the measures of the measures group apply without regard to whether the patients are consecutive.

- (3) **Alternative Criteria Requirements for Both Claims-based and Registry-reporting of Measures Groups:** The following criteria for quality measures for measures groups apply regardless of whether the measures are reported through claims-based submission or through registry-based reporting:

- “*Medicare patients*” under these reporting criteria means Part B Medicare Fee-For-Service patients. Patients enrolled in Medicare Part C (also known as “*Medicare Advantage*”) plans may only be included in registry-based reporting, and then only under the consecutive-patients criterion. Medicare Advantage plans include but are not limited to Private Fee-For-Service Medicare plans.
- “*Non-Medicare*” patients are patients not enrolled in any part of Medicare and may only be included in registry-based reporting, and then only under the consecutive-patients criterion.
- “*Consecutive*” means next in order by date of service. Patients are considered consecutive without regard to gender even though some measures in a group (e.g., preventive care measures) may apply only to females or only to patients of over a specific age, while the majority of measures may apply to both males and females or to patients of a wider age range.
- “*Patients for whom the measures of one measures group apply*” means patients for whom services are furnished during the reporting period and for whom the measures of a particular group apply.
- Measures groups reporting requires that eligible professionals must report on **each** of the measures in the measures group that is applicable to each patient.

Alternative Criteria for Satisfactorily Reporting through Registry-based Submission: Individual Measures

- (1) The alternative reporting periods for registry-based reporting of individual measures are *January 1, 2008 - December 31, 2008 or July 1, 2008 - December 31, 2008*.
- (2) The alternative reporting criteria for registry-based reporting of individual measures are:
- a minimum of 3 PQRI measures applicable to the services furnished by the professional during the reporting period
 - for at least 80 percent of the Medicare cases in which each such measure is reportable.

Additional Requirements for Registry-based Reporting

- (1) To qualify to submit data under the registry-based reporting alternatives for 2008, a registry must have been in existence on January 1, 2008, and the registry also must meet certain technical and other requirements that CMS specifies. CMS will post those registry requirements by April 30, 2008 on the CMS website.
- (A) The requirements will include, but not be limited to, submission of a self-nomination by a certain date. Registries that participated and/or self-nominated for the 2008 registry testing process will need to submit a new self-nomination specific to this new process in order to be considered for potential qualification.
- (B) The requirements will include, but not be limited to, the registry having entered (or entering) into appropriate legal arrangements that provide for the registry’s receipt of patient-specific data from eligible professionals, as well as the registry’s disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program.
- (C) Each registry seeking to submit data described in (1)(B) will be required to meet all technical and other requirements CMS identifies for registries to submit such information.

