

PQRI Made Simple

For Reporting the Preventive Care Measures Group

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

Is This Your Situation?

- You have not begun to participate in PQRI in 2008.
- You don't currently submit data to a registry.
- You would like to participate in PQRI in 2008 using claims.

Solution:

- Report on the Preventive Care Measures Group for 15 consecutive Medicare Fee-For-Service (FFS) (non-Medicare Advantage) patients between 7/1/08 and 12/31/08.

How to Start Using this Measures Group:

- Select a start date on which you want to begin submitting quality data (e.g., 7/15/08).
- Identify your next Medicare FFS patient that you will be seeing who is 50 years of age or older and for whom you will bill an evaluation and management (E/M) code of 99201-99205 or 99212-99215. No specific diagnosis is required for this measures group. This will be your first consecutive patient.
- Report the measures group specific G-code (G8486) with your first patient in the consecutive patient group.
- Look at the following table to see which measures apply to the patient based on their age and gender:

Preventive Measures Group Demographic Criteria		
Age	Measures for <u>Male</u> Patients	Measures for <u>Female</u> Patients
<50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50-64 years	110, 113, 114, 115	110, 112, 113, 114, 115
65-69 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 112, 113, 114, 115, 128
70-80 years	110, 111, 113, 114, 115, 128	39, 48, 110, 111, 113, 114, 115, 128
≥81 years	110, 111, 114, 115, 128	39, 48, 110, 111, 114, 115, 128

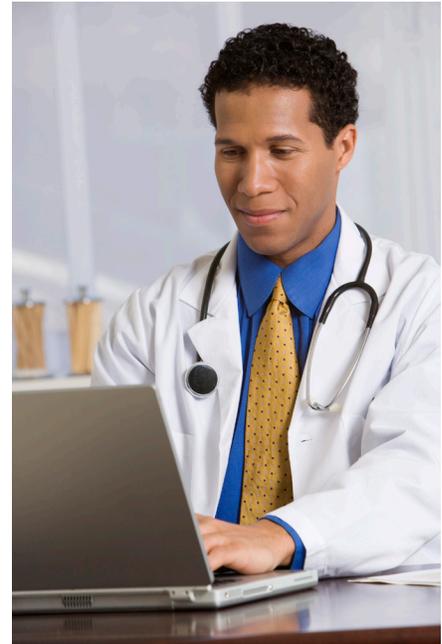
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ICN# 900963

How to Report Using this Measures Group:

- When you identify your first patient, place G-code G8486 on the claim that you submit for that patient. This signals CMS that you plan to submit the Preventive Care Measures Group on 15 consecutive Medicare FFS patients.
- Look at the **Data Collection Worksheet** (see next page) for a brief description of the measures in the Preventive Care Measures Group and the codes to report depending on the action or service you provide to the patient. The appropriate Quality Data Codes (QDCs) for the measures you are reporting on for each patient will need to be included on a claim that you submit for the patient during the 6 month reporting period. It is generally easier to report all of the applicable measures at one time on the same claim when the patient is seen in the consecutive patient sequence. However, if a particular service has yet to be performed (e.g., a mammogram) and you expect to see that patient again before the end of the reporting period (12/31/08) at which time the patient will have had her mammogram, you can report the mammography measure when the patient returns for her next visit later in the year. Check the measures section of the PQRI website for the full measure specifications at <http://www.cms.hhs.gov/pqri> on the CMS website.
- Report *all* of the *applicable* measures (using the appropriate QDCs) on the claim you submit for each patient. To help you keep track, you might consider photocopying the **Data Collection Worksheet** and highlighting or circling the appropriate measures (for the patient you are seeing) and the measure codes (QDCs) that you need to submit and then staple the worksheet to your superbill. Your billing staff or company can use this information to report the appropriate measures codes on the patient's claim.
- Repeat this process 14 more times. Remember that the patients must be consecutive. Medicare will determine the consecutive patient sequence by date of service on the claim you submit. Each patient counts as a unique patient. That is, you need 15 different patients to qualify. You cannot count the same patient twice even if they return the following day or week and you are still in the process of collecting and reporting on your 15 consecutive patients.
- *Note:* You do not need to resubmit the measures group specific G-code (G8486) on any patient after the first patient. You only need to report the QDCs for the measures that apply to your next 14 consecutive Medicare patients on each of those 14 patients' claim form.
- Use the worksheet on the last page of this tip sheet to track each of your 15 consecutive patients. You can list the measures which still need to be reported to help guide you at the patient's next visit. This worksheet is for your office's internal use only and should not be sent to CMS or your Medicare billing carrier / Medicare Administrative Contractor (MAC).



Data Collection Worksheet: PQRI Preventive Care Measures Group

Measures in the Preventive Care Measures Group (G8486) and the Quality Data Codes to be Reported on Patient Claim Depending on Action/Service Performed

Patient Name:	Date of Service:	Physician:	
Measure number and title*	Action performed	Action not performed / Reason documented	Action not performed / Reason not documented
39: Screening or Therapy for Osteoporosis (females only)	G8399 DXA ordered, documented or patient on Rx treatment	G8401 DXA not ordered or patient not on meds for documented reason	G8400 DXA not ordered. No Rx treatment. No reason noted.
48: Assessment of Presence or Absence of Urinary Incontinence (females only)	1090F Incontinence assessed within past 12 months	1090F-1P Medical reason for not assessing incontinence	1090F-8P Not assessed. No reason noted.
110: Flu Vaccination (September through February)	G8482 Vaccine ordered or given	G8483 Vaccine not given for documented reason (e.g., wrong season)	G8484 Vaccine not given. No reason noted.
111: Pneumonia Vaccination	4040F Vaccination given or previously received	4040F-1P Vaccine not given for medical reason	4040F-8P Vaccine not given or received. No reason noted.
112: Screening Mammography (females only)	3014F Results documented and received	3014F-1P Not performed for medical reason (e.g., mastectomy)	3014F-8P Not performed. No reason noted.
113: Colorectal Cancer Screening	3017F Screening done and results reviewed	3017F-1P Not done for medical reason	3017F-8P Not done. No reason noted.
114: Inquiry Regarding Tobacco Use	1000F Tobacco use assessed AND either: • 1034F Current Smoker OR • 1035F Current Smokeless Tobacco OR • 1036F Current Non-smoker	/	1000F-8P Tobacco use not assessed. No reason noted.
115: Advising Smokers to Quit	G8455 Smoker AND G8402 Cessation intervention performed	G8456 Smokeless Tobacco User OR G8457 Tobacco Non-user	G8455 Smoker AND G8403 Not counseled
128: Universal Weight Screening and Follow-Up	G8420 BMI < 30 and ≥ 22 OR G8417 BMI ≥ 30 with follow-up plan documented OR G8418 BMI < 22 with follow-up plan documented	G8422 Patient not eligible for BMI calculation	G8421 BMI not calculated, no reason noted OR G8419 BMI ≥ 30 or < 22 calculated but no follow-up plan documented

* Note: Medicare coverage may differ from PQRI measures specification.

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Worksheet to Track Consecutive Medicare FFS Patients for Reporting Preventive Care Measures Group

Consecutive Patient #	Date of Service	Patient Identifier	All Applicable Measures Submitted for this Patient?	Measure Numbers that still need to be submitted for this Patient (if any)
Example A	07/15/2008	MS	No	112
Example B	07/16/2008	PF	Yes	None
1*				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				

* When you identify your first patient, place G-code G8486 (in addition to QDCs) on the claim that you submit for that patient. This signals CMS that you plan to submit the preventive care measures group on 15 consecutive Medicare FFS patients. You do not need to resubmit the measures group specific G-code (G8486) on any patient after the first patient. You only need to report the QDCs for the measures that apply to your next 14 consecutive Medicare patients on each of those 14 patients' claim form.

