

## Reporting on Individual PQRI Measures

A physician must report on the number of individual quality measures applicable to his or her practice up to a maximum of three measures to receive the 2% bonus payment under this reporting option. While it is possible to report on fewer than three quality measures and still qualify for the bonus payment, general internists and internal medicine subspecialists typically will need to report on three measures. This is because the PQRI program contains numerous measures that pertain to the patient conditions that internists often treat. Internists should choose the three measures that are most relevant to their practice and report on those.

The CMS list of 153 individual PQRI measures is available at <http://www.cms.hhs.gov/PQRI/Downloads/2009PQRIMeasuresList.pdf>. An example of a PQRI quality measure is:

Low Density Lipoprotein Control in Diabetes Mellitus: Percentage of patients aged 18-75 years with diabetes who had most recent LDL-C level in control (less than 100mg/dl)

Physicians are to report quality measures through the claims process, using the quality codes that pertain to each measure for each eligible patient and encounter. To illustrate, below are the code specifications for the Low Density Lipoprotein Control in Diabetes Mellitus quality measure mentioned above.

The specifications state that a physician is expected to report this measure a minimum of once during a 12-month period.

To report most recent LDL-C performed, select:

- CPT II 3048F: Most recent LDL-C < 100 mg/dL;
- CPT II 3049F: Most recent LDL-C 100-129 mg/dL; or
- CPT II 3050F: Most recent LDL-C  $\geq$  130 mg/dL.
- Append modifier “8P” to CPT II 3048F to report that LDL-C was not performed in past 12 months for reasons not otherwise specified.

Eligible patients are those with diabetes as indicated by International Classification of Diseases (ICD-9) codes 250.00-250.93, 357.2, 362.01-362.07, 366.41, 648.00-648.04.

Eligible encounters are:

- New patient office visits, 99201-99205;
- Established patient office visits, 99212-99215;
- Nursing facility services, 99304-99310;
- Domiciliary services, 99324-99337;
- Home services, 99341-99345; and

- Medical nutrition therapy services, 97802-97804, and HCPCS G0270-G0271.

CMS instructs physicians to report the applicable quality measure code using the same claim form used to bill the Medicare payable, medically necessary service to which the quality measure pertains. A charge must be listed for the quality measure code on the claim form. You should enter the charge of \$0.00. If your billing system/clearinghouse system will not accept a \$0.00 charge, enter a nominal charge of \$0.01.

The National Provider Identifier (NPI) for the physician who performed the service to which reported quality measure code(s) is associated must be listed on the claim form. CMS has required physicians to use their NPI since May 2007. Use of the NPI enables CMS to determine a reporting and performance score for each physician and to determine the amount of the bonus payment to be made to each successful physician participant.

A physician must report on each selected measure for at least 80% of the applicable encounters from January 1 through December 31, 2009. For example, an internist who selected three quality measures would qualify for the 2% bonus if CMS determined that he or she reported on: measure 1 – 90%; measure 2 – 87%; and measure 3 – 95%.

ACP maintains a coding tool template for reporting individual measures common to internal medicine. The template—which specifically includes diabetes, coronary artery disease, and geriatric measures—can be used in its current form or modified to reflect the selection of different measures. The template is meant to assist internists and their staff with proper reporting of the individual measures they select. The College is currently updating this template to reflect the 2009 specifications for the individual measures included on the form.

### **Detailed Information for Each Individual PQRI Measure**

CMS makes the specifications for the individual PQRI measures available at [http://www.cms.hhs.gov/PQRI/15\\_MeasuresCodes.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage). You can access the following documents by clicking the “2009 PQRI Quality Measure Specifications Manual and Release Notes [ZIP 1MB]” link under the “Downloads” heading at the bottom of the page:

- A 442 page specifications document that describes the complete information for each of the 153 PQRI measures. The specifications for each measure include: detailed measure definition; the quality measure codes that are to be reported on claims; and Current Procedural Terminology (CPT) and ICD-9 codes that indicate an eligible encounter. While this document is extremely large, you only need to focus on the measures you select. The document contains about three pages of description per individual measure.
- A 16 page document that describes the specification changes for the 2008 PQRI measures that were modified for the 2009 program, e.g. CPT code 99211, the lowest level established patient office visit, is no longer an encounter during

which you report quality code for the Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus measure.