DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official CMS Information for Medicare Fee-For-Service Providers

2012 Physician Quality Reporting System:

Reporting the Preventive Care Measures Group Via Claims Made Simple

FACT SHEET http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS

Background

The Physician Quality Reporting System (Physician Quality Reporting) is a voluntary reporting program. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to **Medicare Part B Fee-For-Service (FFS) beneficiaries** (including Railroad Retirement Board and Medicare Secondary Payer).

A web page dedicated to providing all the latest news on Physician Quality Reporting is available at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS on the Centers for Medicare & Medicaid Services (CMS) website.

Purpose

This fact sheet provides guidance on satisfactorily reporting the Preventive Care Measures Group via claims for 2012 Physician Quality Reporting.

Is This Your Situation?

- You have not yet begun to participate in 2012 Physician Quality Reporting,
- You don't currently submit data to a registry, and
- You would like to participate in 2012 Physician Quality Reporting using claims-based reporting.

Solution

- Report on the Preventive Care Measures Group for 30 **unique** Medicare Part B FFS patients or 50 percent of applicable Medicare Part B FFS patients (with a minimum of 15 patients) between January 1 and December 31, 2012.

How to Start Using This Measures Group

- Select a start date to begin submitting quality data (e.g., January 1, 2012);
- Identify the next Medicare Part B FFS patient you will see who is 50 years of age or older and for whom you will bill an Evaluation and Management (E/M) Current Procedural Terminology (CPT) code in the ranges of 99201 – 99205 or 99212 – 99215. No specific International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code is required for this measures group;
- Report the measures group specific intent Healthcare Common Procedure Coding System (HCPCS) G-code (G8486) with your first patient; and
- Refer to Table 1 to see which measures apply to the patient based on the patient's age and gender.

Table 1. Preventive Measures Group Demographic Criteria

Age	Measures for Male Patients	Measures for Female Patients
< 50 years	Patient does not qualify for measures group analysis	Patient does not qualify for measures group analysis
50 – 64 years	110, 113, 128, 173, 226	110, 112, 113, 128, 173, 226
65 – 69 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 112, 113, 128, 173, 226
70 – 75 years	110, 111, 113, 128, 173, 226	39, 48, 110, 111, 113, 128, 173, 226
≥ 76 years	110, 111, 128, 173, 226	39, 48, 110, 111, 128, 173, 226

How to Report Using This Measures Group

- **When you identify your first patient, place intent G-code G8486 on the claim submitted for that patient. This signals CMS that you plan to submit the Preventive Care Measures Group for 30 unique Medicare Part B FFS patients or 50 percent of applicable Medicare Part B FFS patients (with a minimum of 15 patients) between January 1 and December 31, 2012.** Look at the "Data Collection Worksheet" in Appendix A for a brief description of the measures in the Preventive Care Measures Group and the codes to report depending on the quality action or service you provide to the patient. The appropriate Quality-Data Codes (QDCs) for the measures you report for each patient need to be included on the claim you submit for the patient during the 12-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. However, if a particular service has yet to be performed (e.g., a mammogram) you may report that measure at the time the patient returns post-procedure, if that patient is seen again prior to the end of the reporting period on December 31, 2012. If all quality actions for the patient have been performed for the Preventive Care Measures Group, the composite G-code G8496 (i.e., all quality actions for the applicable measures in the Preventive Care Measures Group have been performed for this patient) may be reported in lieu of the individual QDCs for each of the measures within the group.

- Check http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html on the CMS website for the full measures groups specifications.

Select Sample Method:

- **30-Patient Sample Method:** This method uses 30 **unique** Medicare Part B FFS patients meeting patient sample criteria for the measures group. (Note: The 30 patients do not have to be seen on consecutive dates.)
  - Use the "Worksheet to Track Unique Medicare Part B FFS Patients for Reporting Preventive Care Measures Group" in Appendix A to track each of your 30 unique patients. (Note: You may want to collect more than 30 as a safeguard.) You can list the measures that still need to be reported to help guide you during the patient's next visit. This is a suggested informal worksheet intended for your office's internal use only and should **not** be sent to CMS or your carrier or A/B Medicare Administrative Contractor (MAC).

OR

- **50 Percent Patient Sample Method:** This method uses all patients meeting patient sample criteria for the measures group during the entire reporting period (January 1 – December 31, 2012). For the 12-month reporting period, a minimum of 15 Medicare Part B FFS patients must meet the measures group patient sample criteria to report satisfactorily.
  - **All applicable measures within the group must be reported** using the appropriate QDCs on the claim you submit for each Medicare Part B FFS patient. To assist with tracking, consider photocopying the "Data Collection Worksheet" in Appendix A. Highlight or circle the appropriate measures and measures codes (QDCs) you need to submit for that patient's visit and staple the worksheet to your encounter form. Your clinical support staff can use this information to report the appropriate measures codes on the patient's claim. Your system may also help you select those patients eligible for this measure by identifying the appropriate ICD-9-CM and CPT codes for each measure.

Resources

- For more information about what's new for 2012 Physician Quality Reporting, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html on the CMS website.
- For more information about reporting via claims, refer to the "2012 Physician Quality Reporting System: Claims Reporting Made Simple" document at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/EducationalResources.html on the CMS website.
- For answers to frequently asked questions, visit https://questions.cms.gov on the CMS website.
- The Medicare Learning Network® (MLN) Educational Web Guides MLN Guided Pathways to Medicare Resources help providers gain knowledge on resources and products related to Medicare and the CMS website. For more information applicable to you, refer to the section about your provider type in the "MLN Guided Pathways to Medicare Resources Provider Specific" booklet at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website. For all other "Guided Pathways" resources, visit http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Guided_Pathways.html on the CMS website.

Appendix A: Data Collection Worksheet

Data Collection Worksheet: Physician Quality Reporting System 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 for Women Aged 65 Years and Older	**G8399** Patient with central Dual-energy X-Ray Absorptiometry (DXA) results documented or ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis prescribed	**G8401** Clinician documented that patient was not an eligible candidate for screening or therapy for osteoporosis for women measure	**G8400** Patient with central Dual-energy X-Ray Absorptiometry (DXA) results not documented or not ordered or pharmacologic therapy (other than minerals/vitamins) for osteoporosis not prescribed
48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older	**1090F** Presence or absence of urinary incontinence assessed (within past 12 months)	**1090F-1P** Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence	**1090F-8P** Presence or absence of urinary incontinence **not** assessed, reason not otherwise specified
110: Preventive Care and Screening: Influenza Immunization	**G8482** Influenza immunization administered or previously received	**G8483** Influenza immunization was not ordered or administered for reasons documented by clinician **OR** **G0919** Influenza immunization ordered or recommended (to be given at alternate location or alternate provider); vaccine not available at time of visit	**G8484** Influenza immunization was **not** ordered or administered, reason not specified

Data Collection Worksheet: Physician Quality Reporting System 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**
111: Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older	**4040F** Pneumococcal vaccine administered or previously received	**4040F-1P** Documentation of medical reason(s) for not administering or previously receiving pneumococcal vaccination	**4040F-8P** Pneumococcal vaccine was not administered or previously received, reason **not** otherwise specified
112: Preventive Care and Screening: Screening Mammography	**3014F** Screening mammography results documented and reviewed	**3014F-1P** Documentation of medical reason(s) for not performing a mammogram (i.e., women who had a bilateral mastectomy or two unilateral mastectomies)	**3014F-8P** Screening mammography results were **not** documented and reviewed, reason not otherwise specified
113: Preventive Care and Screening: Colorectal Cancer Screening	**3017F** Colorectal cancer screening results documented and reviewed	**3017F-1P** Documentation of medical reason(s) for not performing a colorectal cancer screening	**3017F-8P** Colorectal cancer screening results were **not** documented and reviewed, reason not otherwise specified
128: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow Up	**G8420** Calculated BMI within normal parameters and documented in the medical record **OR** **G8417** Calculated BMI above the upper parameter and a follow-up plan was documented in the medical record **OR** **G8418** Calculated BMI below the lower parameter and a follow-up plan was documented in the medical record	**G8422** Patient not eligible for BMI calculation	**G8421** BMI **not** calculated **OR** **G8419** Calculated BMI outside normal parameters, no follow-up plan documented in the medical record

Data Collection Worksheet: Physician Quality Reporting System 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**
173: Preventive Care and Screening: Unhealthy Alcohol Use – Screening	**3016F** Patient screened for unhealthy alcohol use using a systematic screening method	**3016F-1P** Documentation of medical reason(s) for not screening for unhealthy alcohol use (e.g., limited life expectancy)	**3016F-8P** Unhealthy alcohol use screening **not** performed, reason not otherwise specified
226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	**4004F** Patient screened for tobacco use AND received tobacco cessation (intervention, counseling, pharmacotherapy, or both), if identified as a tobacco user **OR** **1036F** Current tobacco non-user	**4004F-1P** Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy)	**4004F-8P** Tobacco Screening **not** performed, reason not otherwise specified

Worksheet to Track Unique Medicare Part B FFS Patients for Reporting Preventive Care Measures Group				
Unique 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	02/15/2012	MS	No	112
Example B	02/16/2012	PF	Yes	None
1				
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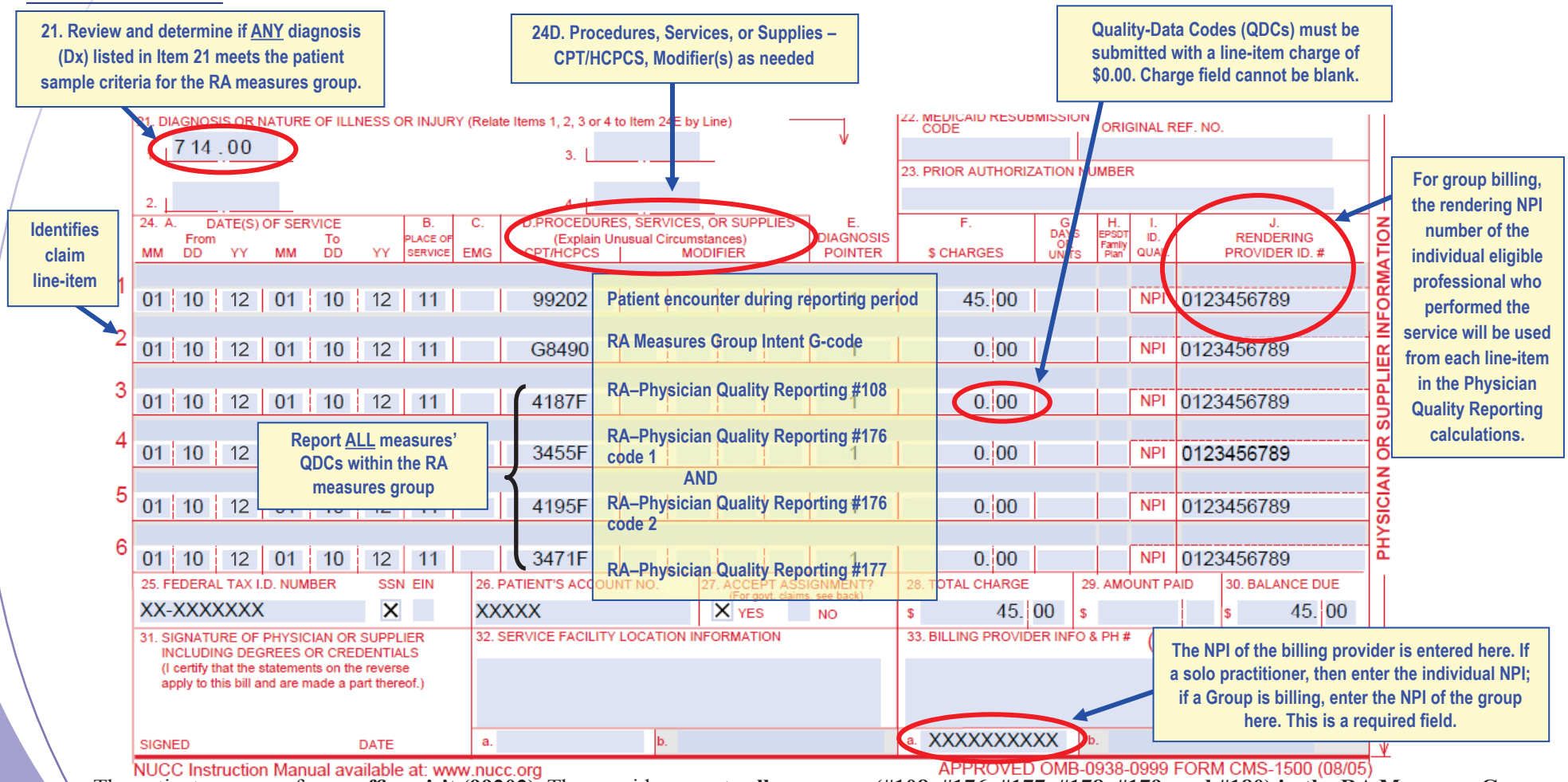
Appendix B: Form CMS-1500 Claim [Detailed Measures Group] – Sample 1 (continues on next page)

The following is a claim sample for reporting the Rheumatoid Arthritis (RA) Measures Group on a Form CMS-1500 claim, and it continues on the next page. Two samples are included: one is for reporting of individual measures for the RA measures group; the second sample shows reporting performance of all measures in the group using a composite G-code. For more information, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html on the CMS website.



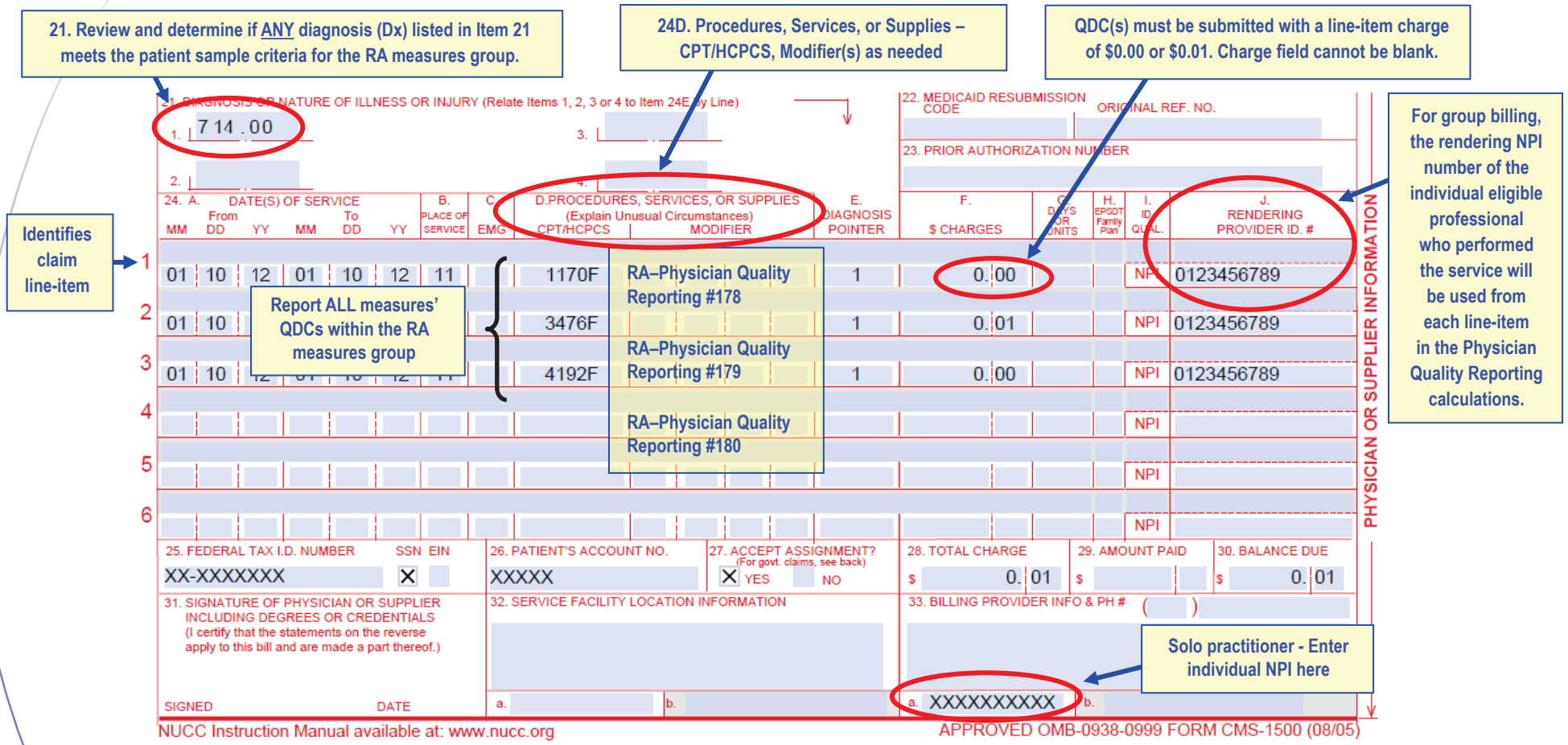
The patient was seen for an **office visit (99202)**. The provider reports **all measures (#108, #176, #177, #178, #179, and #180) in the RA Measures Group:**

- Intent **G-code (G8490)** was submitted to initiate the eligible professional's submission of the RA Measures Group.
- Measure **#108** (RA-DMARD Therapy) with **QDC 4187F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);
- Measure **#176** (RA-Tuberculosis Screening) with **QDCs 3455F + 4195F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);
- Measure **#177** (RA-Periodic Assessment of Disease Activity) with **QDC 3471F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);

RA Measures Group Sample 1 continues on the next page.

Appendix B: Form CMS-1500 Claim [Detailed Measures Group] – Sample 1 (cont.)

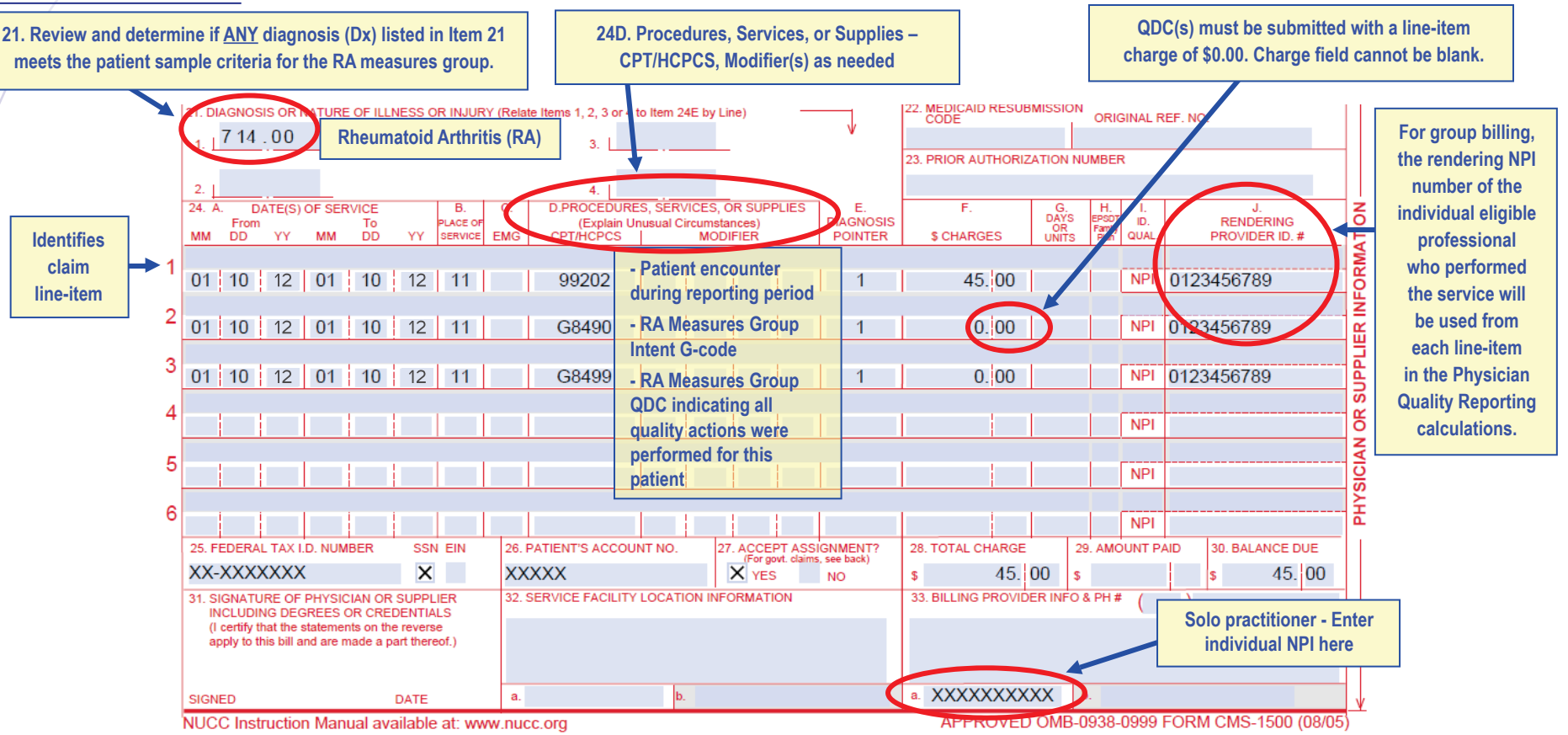
If billing software limits the line items on a claim, you may add a nominal amount such as a penny to one of the QDC line items on that second claim for a total charge of $0.01.



- Measure **#178** (RA-Functional Status Assessment) with **QDC 1170F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);
- Measure **#179** (RA-Assessment & Classification) with **QDC 3476F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**); and
- Measure **#180** (RA-Glucocorticoid Management) with **QDC 4192F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**).
- **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 a 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.

Appendix B: Form CMS-1500 Claim [Sample Measures Group] – Sample 2

A detailed sample of an individual NPI reporting the RA Measures Group on a related Form CMS-1500 claim is shown below. This sample shows reporting performance of **all** measures in the group using a composite G-code. For more information, visit http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html on the CMS website.



The patient was seen for an **office visit (99202)**. The provider reports **all measures (#108, #176, #177, #178, #179, and #180) in the RA Measures Group:**

- Intent **G-code (G8490)** was submitted to initiate the eligible professional's submission of the RA Measures Group.
- Measures Group **QDC Composite G-code G8499** (indicating all quality actions related to the RA Measures Group were performed for this patient) + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**). The composite G-code G8499 may not be used if performance modifiers (1P, 2P, 3P, or G-code equivalent) or the 8P reporting modifier apply.
- **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.

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