

Appendix A: Glossary of Terms

Terms	Definitions
Base Claim Diagnosis	PQRI refers to all diagnoses listed (Item 21 of the CMS-1500 claim form) associated with physician office, outpatient, and inpatient visits for reporting in PQRI.
CPT Category II Codes	<p>A set of supplemental CPT codes intended to be used for performance measurement. These codes may be used to facilitate data collection about the quality of care rendered by coding certain services, test results or clinical actions that support nationally established performance measures and that the evidence has demonstrated to contribute to quality patient care.²</p> <p>For PQRI, CPT Category II codes are used to report quality measures on a claim for measurement calculation.</p>
Denominator (Eligible Cases)	<p>The lower part of a fraction used to calculate a rate, proportion, or ratio.</p> <p>The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements.</p> <p>PQRI measure denominators are identified by ICD-9-CM, CPT Category I, and HCPCS codes, as well as patient demographics (age, gender, etc), and place of service (if applicable).</p>
Denominator Statement	A statement that describes the population eligible for the performance measure. For example, "Patients aged 18 through 75 years with a diagnosis of diabetes."
Diagnosis Pointer	<p>Item 24E of the CMS-1500 claim form or electronic equivalent. For PQRI, the line item containing the quality-data code (QDC) for the measure should point to one diagnosis (from Item 21) per measure-specific denominator coding.</p> <p>To report a QDC for a measure that requires reporting of multiple diagnoses, enter the reference number in the diagnosis pointer field that corresponds to one of the measure's diagnoses listed on the base claim. Regardless of the reference number in the diagnosis pointer field, both primary and all secondary diagnoses are considered in PQRI analysis.</p>
Eligible Professional	<p>Refer to http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage for a list of EPs eligible to participate in 2010 PQRI.</p> <p>Providers not defined as EPs in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRI and do not qualify for an incentive. Services payable under fee schedules or methodologies other than the Medicare Physician Fee Schedule (PFS) are not included in PQRI (for example, services provided in federally qualified health centers, portable x-ray suppliers, independent laboratories, independent diagnostic testing facilities, hospitals, rural health clinics, ambulance providers, and ambulatory surgery center facilities). In addition, suppliers of durable medical equipment (DME) are not eligible for PQRI since DME is not paid under the PFS.</p>
Encounter	Encounters with patients during the reporting period which include: CPT Category I E/M service codes, CPT Category I procedure codes, or HCPCS codes found in a PQRI measure's denominator. These codes count as eligible to meet a measure's inclusion requirements when occurring during the reporting period.
G-codes for PQRI	A set of CMS-defined temporary HCPCS codes used to report quality measures on a claim. G-codes are maintained by CMS.
ICD-9-CM Diagnosis Codes	The International Classification of Diseases, 9th Revision, Clinical Modification ⁵ is used in assigning codes to diagnoses associated with inpatient, outpatient, and physician office visits for reporting in PQRI.

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Line-Item Diagnosis	Six service lines in Section 24 of the CMS-1500 claim form to accommodate submission of the rendering NPI and supplemental information to support the billed service, including the pointed diagnosis from Item 21. QDCs are submitted on the line item in section 24 for PQRI reporting.
Measure	Performance Measure <ul style="list-style-type: none"> • A quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process or outcome. • See also process measure and outcome measure.^{1,6} Types of Measures <ul style="list-style-type: none"> • Process measure: A measure which focuses on a process which leads to a certain outcome, meaning that a scientific basis exists for believing that the process, when executed well, will increase the probability of achieving a desired outcome.⁶ • Outcome measure: A measure that indicates the result of the performance (or non-performance) of a function(s) or process(es).⁶ • Structure measure: A measure that assesses whether organizational resources and arrangements are in place to deliver health care, such as the number, type, and distribution of medical personnel, equipment, and facilities.⁶
Measure Reporting Timeframes (Frequency)	<ul style="list-style-type: none"> • Patient-Process: Report a minimum of once per reporting period per individual eligible professional (NPI). <ul style="list-style-type: none"> ○ If the measure is reported more than once during the reporting period, performance rates are calculated using the most advantageous QDC submitted. ○ Reflect quality actions performed throughout the reporting period or other timeframe. • Patient-Intermediate: Report a minimum of once per reporting period per individual eligible professional (NPI). <ul style="list-style-type: none"> ○ If the measure is reported more than once during the reporting period, performance rates are calculated using the most recent QDC submitted. ○ Often reflect lab or other test value, so the most recent measurement is desired. • Patient-Periodic: Report once per timeframe specified in the measure for each individual eligible professional (NPI) during the reporting period. <ul style="list-style-type: none"> ○ Examples include once per month and three times per year. • Episode: Report once for each occurrence of a particular illness/condition by each individual eligible professional (NPI) during the reporting period. <ul style="list-style-type: none"> ○ Usually reflect a clinical episode, difficult to determine from a single Part B claim. ○ Require specialized analytics to determine the episode. • Procedure: Report each time a procedure is performed by the individual eligible professional (NPI) during the reporting period. • Visit: Report each time the patient is seen by the individual eligible professional (NPI) during the reporting period.
MIPPA	Medicare Improvements for Patients and Providers Act of 2008.
MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007.
NPI	National Provider Identifier of the individual eligible professional billing under the Tax ID (“NPI within the Tax ID”).

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Numerator	<p>The upper portion of a fraction used to calculate a rate, proportion, or ratio.</p> <p>A clinical action to be counted as meeting a measure's requirements (i.e., patients who received the particular service or obtained a particular outcome that is being measured).⁶</p> <p>PQRI measure numerators are CPT Category II codes and G-codes.</p>
Numerator Statement	<p>A statement that describes the clinical action that satisfies the conditions of the performance measure.</p> <p>For example, "Patients who were assessed for the presence or absence of urinary incontinence."</p>
Performance Timeframe	<p>A designated timeframe within which the action described in a performance measure should be completed. This timeframe is generally included in the measure description and may or may not coincide with the measure's data reporting frequency requirement.</p>
Performance Measure Exclusion Modifiers	<p>Modifiers developed exclusively for use with CPT Category II codes to indicate documented medical (1P), patient (2P), or system (3P) reasons for excluding patients from a measure's denominator.²</p>
Performance Measure Reporting Modifier 8P	<p>The 8P reporting modifier is intended to be used as a "reporting modifier" to allow the reporting of circumstances when an action described in a measure's numerator is not performed and the reason is not otherwise specified.</p> <p>8P Performance measure reporting modifier - action not performed, reason not otherwise specified (AMA)</p>
Place of Service	<p>References Place of Service Codes (POS) from the list provided in section 10.5 of the Medicare Claims Processing Manual.</p>
Quality-Data Code (QDC)	<p>Specified CPT Category II codes with or without modifiers and G-codes used for submission of PQRI data. The 2010 PQRI Measure Specifications Manual for Claims and Registry contains all codes associated with each PQRI measure and instructions for data submission through the administrative claims system.</p>
Rationale	<p>A brief statement describing the evidence base and/or intent for the measure that serves to guide interpretation of results.⁴</p>
Remittance Advice (RA)	<p>Means utilized by Medicare contractors to communicate to providers claims processing decisions such as payments, adjustments, and denials.⁷</p>
Reporting Frequency	<p>The number of times QDCs specified for a quality measure must be submitted on claims during the reporting period. The reporting frequency for each measure is described in the 2010 PQRI Measure Specifications Manual for Claims and Registry posted on the CMS Web site, http://www.cms.hhs.gov/PQRI.</p>
Reporting Options	<p>2010 PQRI reporting methods available for incentive payment: claims-based; registry-based; electronic health record (EHR); or measures group. Refer to the 2010 PQRI Participation Decision Tree (Appendix C).</p>
Reporting Period	<p>The period during which PQRI measures are to be reported for covered professional services provided.</p> <p>6-month (July 1, 2010 through December 31, 2010) or 12-month (January 1, 2010 through December 31, 2010) time periods are available depending upon the 2010 PQRI reporting option the eligible professional selects for submitting PQRI quality data.</p>
TRHCA	<p>Tax Relief and Health Care Act of 2006.</p>