

What's new for AOA CAP-PQRI in 2010

1. The 2010 bonus payment for participation in the Centers for Medicare and Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI) is 2%.

2. CMS has expanded the number of measure groups to thirteen. Greatly expanding your opportunity to participate, the AOA CAP-PQRI will offer all thirteen:

1. back pain,
2. chronic kidney disease,
3. community-acquired pneumonia,
4. coronary artery bypass graft,
5. coronary artery disease,
6. diabetes mellitus,
7. heart failure,
8. hepatitis C,
9. HIV/AIDS,
10. ischemic vascular disease,
11. perioperative care,
12. preventive care, and
13. rheumatoid arthritis.

2. In order to continue to provide this valuable benefit, there is a fee to participate in CAP-PQRI this year. The fee is \$199 for AOA members and \$299 for non-members and MDs. Physicians who participated in the 2008 AOA CAP-PQRI received bonuses in the range of \$1,200-\$3,000. The bonus payments for the 2009 PQRI will be made by CMS in the fall.

3. The AOA CAP-PQRI has a money back guarantee for AOA members. Due to our rigorous data-checking programs, CAP-PQRI has been highly successful in submitting data to CMS for the bonus payment. Given our confidence in the program, we will refund your \$199 if you submit complete data but do not receive a reimbursement. (Proof of non-payment, i.e., supporting documentation from CMS, will be required for the refund.) Nationwide, over 96% of physicians using a registry to submit data to CMS in 2008 received a bonus payment.

4. This year physicians may select data from 30 unique patient charts to submit for PQRI. Two of the 30 charts must still be for Medicare Fee for Service patients. Prior to 2010, physicians had to submit data based on a sequential sample of patient charts.

5. CMS requires all registries to conduct audits of participant data. Please make sure that you keep track of your 30 patient charts and match them with their computer generated Patient Identifier numbers. This number is the approximately 8 digit number that is automatically populated in the system when you add a new patient to the program. We suggest you keep a list in an Excel file for easy access and also record this number in the patient chart.

To get started, all you need to do is follow these instructions.

In order to participate in CAP-PQRI, you must have your AOA Member (ID) number and password. Non-members, please follow the instructions under number 11 below.

To **ESTABLISH** an AOA ID number and password:

1. Go to www.DO-Online.org
2. On the right side of the screen you will see a “Member Login” box
3. Under the “Log In” button, you will see “Create an Account”.
4. Click on “Create an Account,” then
5. Click “I Agree” to the Terms of Agreement screen.
6. On the next screen, you will begin to establish your personal account by entering your AOA membership number, your last name, etc.

You can access CAP-PQRI once you have established your account (AOA ID number and password).

1. Log on to DO-Online.org using your AOA ID and password.
2. Select CAP-PQRI under the Clinical Resources tab. On the right hand side of the page, click on the DOCMEonline.com link. This will take you to the My CME Profile screen. On the drop down screen, select Physician as your profession and enter. This takes you to the Activity screen for PQRI. Enter the activity by clicking Start Now.
3. Register for the program by providing your office information, Tax Identification Number (TIN), and National Provider Identifier (NPI).

You must include your correct NPI (National Provider Identifier) and TIN (Taxpayer Identification Number). This is the TIN that your office uses to bill Medicare. Please check with your billing staff if you are not sure of the correct TIN. THIS IS VERY IMPORTANT. Entering an incorrect TIN will prevent you from receiving your reimbursement payment from CMS and will invalidate your PQRI data.

4. Pay the \$199 registration fee online using a credit card.
5. Print out the attestation form from the Website. Complete the form (including your NPI and TIN) and fax it to 888-828-0528, a secure facsimile repository.
6. Choose a Measure Group.
7. Enter required patient information into the Web site. For 2010, CMS is allowing you to enter data from any 30 unique patient charts. However, you must enter data from the charts of at least two Medicare Fee for Service patients.
8. Submit your data through the Web site. All data during the reporting period for 2010 must be

submitted by February 1, 2011 to be eligible for the PQRI reimbursement payment. CMS payments for PQRI 2010 will be made in the fall of 2011.

9. Data can be collected on the abstraction form and later entered into the AOA-CAP PQRI Web site. **IMPORTANT:** Keep records of the abstracted cases using the abstraction number supplied on the Web site. CMS requires that the AOA conduct an audit of the data. We will request one chart from a sample of participating practices for validation purposes.

10. The claims (billing) for your 30 patients must be submitted in a timely manner to be processed by CMS in early 2011. Please consult your carrier on when claims need to be submitted in order to be processed by the required date. The date can fluctuate from carrier to carrier and the method of claim submission (paper, electronic).

11. For non-members, access the CAP PQRI at www.do-online.org/pqri. On the right hand side of this page, click on the link for non AOA members. On the Entry screen, click on Start Now to enter the program. Continue from Step 3 as listed above. The cost for non members is \$299.

For more information on how to use the CAP to report PQRI data, visit www.do-online.org/pqri or contact Angi Beranek, MPA, Manager, Division of Clinical Quality, at aberanek@osteopathic.org or (800) 621-1773, ext. 8198.

Diabetes Mellitus Measure Group Patient Visit Form 2010

Please complete the chart review for the 2010 Diabetes Mellitus Measure group.

The visit date you are reporting on must occur in the 2010 Reporting Period (1/1/2010 - 12/31/2010).

Patient visit date: *

Patient ID: *

Is Medicare the patient's primary or secondary insurance provider? *

Yes No

Select the Medicare program that the patient participates in: *

- Medicare Part B Fee-For-Service (FFS)
 Medicare Part C Non-Fee-For-Service (Non-FFS)

The Patient must be between the ages of 18 through 75 to qualify for the 2010 Diabetes Mellitus Measure Group.

Patient age *

 (yrs)

If the diagnosis code is not listed, this patient is not eligible for the 2010 Diabetes Mellitus Measure Group.

Please select the applicable diagnosis code for Diabetes Mellitus. The date of service for this diagnosis must occur within the 2010 Reporting Period (1/1/2010 - 12/31/2010). *

The Date of Service for the Diabetes Mellitus diagnosis must occur within the 2010 Reporting Period (January 1, 2010 - December 31, 2010).

Please enter the Date of Service for the diagnosis on which you are reporting. A valid diagnosis must occur within the 2010 reporting period. *

Was a Hemoglobin A1c performed within the 12 months prior to this visit? *

Yes No

Most recent Hemoglobin A1c level within the 12 months prior to this visit: *

 (%)

Was a LDL-C level performed within the 12 months prior to this visit? *

Yes No

Most recent LDL-C level within the 12 months prior to this visit: *

 (mg/dL)

Was a blood pressure measurement performed within the 12 months prior to this visit? *

Yes No

Most recent systolic blood pressure within the 12 months prior to this visit: *

 (mmHg)

Most recent diastolic blood pressure within the 12 months prior to this visit: *

 (mmHg)

Was a dilated eye exam for diabetic retinal disease performed at least once within the 12 months prior to this visit? *

Yes No

Did the patient have a negative retinal exam (no evidence of retinopathy) in the year prior to the reporting period? (If retinal exam not done in previous year, answer no.) *

Yes No

Was a urine protein screening or medical attention for nephropathy performed within the 12 months prior to this visit? *

Yes No

Was a foot exam (visual inspection, sensory exam with monofilament, or pulse exam) performed within the 12 months prior to this visit? *

Yes
 No, medical reason documented
 No, reason not specified

Valid Diabetes Mellitus Diagnosis Codes

250.00	250.21	250.42	250.63	250.90	362.05
250.01	250.22	250.43	250.70	250.91	362.06
250.02	250.23	250.50	250.71	250.92	362.07
250.03	250.30	250.51	250.72	250.93	366.41
250.10	250.31	250.52	250.73	357.20	648.00
250.11	250.32	250.53	250.80	362.01	648.01
250.12	250.33	250.60	250.81	362.02	648.02
250.13	250.40	250.61	250.82	362.03	648.03
250.20	250.41	250.62	250.83	362.04	648.04