On December 20, 2006 the President signed P.L. 109-432, the Tax Relief and Health Care Act of 2006 (TRHCA), authorizing the establishment of a voluntary physician quality reporting system by the Centers for Medicare and Medicaid Services (CMS) labeled the Physician Quality Reporting Initiative (PQRI).
PQRI 2007

- The first PQRI program covered services from July 1, 2007 through December 31, 2007.
- There were 74 eligible measures.
- APMA identified six measures that were likely to be reported by podiatric physicians.
2008 PQRI: The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)

MMSEA authorized continuation of PQRI for 2008:

- Eliminated cap on incentive payment
  - Incentive payment remained 1.5% of total allowable charges for PFS covered professional services furnished during reporting period.
  - Required alternative reporting periods and alternative reporting criteria for 2008 and 2009.
2008 PQRI Measures

• Published in 2008 Physician Fee Schedule (PFS) Rule, November 2007
  – 119 measures:
    » 117 clinical measures
    » 2 structural measures
• Clinical measures apply to specialties, accounting for over 95% of Medicare Part B spending.
• Structural measures apply broadly across specialties and disciplines.
On October 30, 2008 CMS issued a final rule that updates payment policies and rates under the Medicare Physician Fee Schedule (MPFS) for calendar year 2009, beginning January 1, 2009.

The final rule included the 2009 PQRI program and the E-prescribing Incentive Program.
MIPPA

Congress extended PQRI under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, which continues the program indefinitely and increased the incentive that eligible professionals can receive for satisfactorily reporting data from 1.5% to 2.0% of their covered professional charges in 2009 and 2010.
In addition, the law requires CMS to post on its Web site the names of eligible professionals who satisfactorily report PQRI measures.
ADDITIONAL MEASURES

CMS added 52 new quality measures bringing the total number of measures to 153 from which eligible professionals can select for 2009.

These new measures address areas such as osteoarthritis, rheumatoid arthritis, back pain, CABG, CKD, melanoma, oncology, CAD, hepatitis, and HIV/AIDS.
There are 131 individual quality measures that can be reported through claims-based submission (out of the total 153 measures).

Individual claims-based submission is the way the majority of podiatric physicians will report in the PQRI program.
SO, HOW DO I PARTICIPATE?
Pick your three measures:

– **Measure 126**: Diabetic Foot and Ankle Care, Peripheral Neuropathy: Neurological Evaluation

– **Measure 127**: Diabetic Foot and Ankle Care, Ulcer Prevention: Evaluation of Footwear

– **Measure 163**: Diabetes Mellitus: Foot Exam
REPORT YOUR MEASURES
Definition: A lower extremity neurological exam consists of a documented evaluation of motor and sensory abilities including reflexes, vibratory, proprioception, sharp/dull and 5.07 filament detection.
## PQRI Data Collection Sheet

**Diabetes Mellitus**

**Diabetic Foot and Ankle Care, Peripheral Neuropathy — Neurological Evaluation**

### Clinical Information

<table>
<thead>
<tr>
<th>Step 1</th>
<th>Is patient eligible for this measure?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Patient is aged 18 years and older.</td>
<td>□</td>
</tr>
<tr>
<td>Patient has diabetes mellitus.</td>
<td>□</td>
</tr>
<tr>
<td>There is a CPT Code for this visit.</td>
<td>□</td>
</tr>
</tbody>
</table>

If **No** is checked for any of the above, STOP. Do not report a G-code.

### Billing Information

<table>
<thead>
<tr>
<th>Step 2</th>
<th>Does patient meet or have an acceptable reason for not meeting the measure?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower Extremity Neurological Exam¹</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>□</td>
</tr>
<tr>
<td></td>
<td>Not performed for the following reason:</td>
</tr>
<tr>
<td></td>
<td>• Documented reasons (e.g., patient was not an eligible candidate for lower extremity neurological exam)</td>
</tr>
<tr>
<td></td>
<td>Document reason here and in medical chart.</td>
</tr>
</tbody>
</table>

If **No** is checked for all of the above, report GB405 (Lower extremity neurological exam not performed.).
Diabetes Mellitus

Diabetic Foot and Ankle Care, Peripheral Neuropathy — Neurological Evaluation

Coding Specifications
CPT codes
- 10060, 10061 (incision and drainage of abscess),
- 10180 (incision and drainage, complex, postoperative wound infection),
- 11000 (debridement of extensive escharous or infected skin),
- 11040, 11041, 11042, 11043, 11044 (debridement),
- 11055, 11056, 11057 (paring or cutting of benign hyperkeratotic lesion),
- 11719 (trimming of dystrophic nails),
- 11720, 11721 (debridement of nail(s) by any method(s)),
- 11730 (avulsion of nail plate, partial or complete, simple; single),
- 11740 (evacuation of subungual hematoma),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99211, 99212, 99213, 99214, 99215 (office — established patient),
- 99304, 99305, 99306, 99307, 99308, 99309, 99310 (nursing facility care),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary),
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 (home visit)

Quality codes for this measure (one of the following for every eligible patient):

G-Code descriptors
(Data Collection sheet should be used to determine appropriate combination of codes.)
- G8401: Lower extremity neurological exam performed and documented
- G8406: Clinician documented that patient was not an eligible candidate for lower extremity neurological exam measure
- G8405: Lower extremity neurological exam not performed
Definition: Evaluation for proper footwear includes a foot examination documenting the vascular, neurological, dermatological, and structural/biomechanical findings. The foot should be measured using a standard measuring device and counseling on appropriate footwear should be based on risk categorization.
Diabetes Mellitus

Diabetic Foot and Ankle Care, Ulcer Prevention — Evaluation of Footwear

PQRI Data Collection Sheet

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Provider Identifier (NPI)</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinical Information**

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Patient is aged 18 years and older.
- Patient has a diagnosis of diabetes mellitus.
- There is a CPT E/M Service Code for this visit.

If No is checked for any of the above, STOP. Do not report a G-code.

**Billing Information**

<table>
<thead>
<tr>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td>Refer to coding specifications document for list of applicable codes.</td>
</tr>
</tbody>
</table>

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

<table>
<thead>
<tr>
<th>Footwear Evaluation</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Performed

Not performed for the following reason:
- Documented reasons (eg, patient was not an eligible candidate for footwear evaluation)

<table>
<thead>
<tr>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>G8410</td>
</tr>
<tr>
<td>G8416</td>
</tr>
</tbody>
</table>

- If No is checked for all of the above, report G8415. (Footwear evaluation not performed.)
Diabetes Mellitus

Diabetic Foot and Ankle Care, Ulcer Prevention — Evaluation of Footwear

Coding Specifications

Codes required to document patient has diabetes mellitus and a visit occurred:

An ICD-9 diagnosis code for diabetes mellitus and a CPT code are required to identify patients to be included in this measure.

Diabetes mellitus ICD-9 diagnosis codes

- 250.00, 250.01, 250.02, 250.03 (diabetes mellitus without mention of complication),
- 250.10, 250.11, 250.12, 250.13 (diabetes with ketoacidosis),
- 250.20, 250.21, 250.22, 250.23 (diabetes with hyperosmolarity),
- 250.30, 250.31, 250.32, 250.33 (diabetes with other coma),
- 250.40, 250.41, 250.42, 250.43 (diabetes with renal manifestations),
- 250.50, 250.51, 250.52, 250.53 (diabetes with ophthalmic manifestations),
- 250.60, 250.61, 250.62, 250.63 (diabetes with neurological manifestations),
- 250.70, 250.71, 250.72, 250.73 (diabetes with peripheral circulatory disorders),
- 250.80, 250.81, 250.82, 250.83 (diabetes with other specified manifestations),
- 250.90, 250.91, 250.92, 250.93 (diabetes with unspecified complication)

AND

CPT codes

- 10060, 10061 (incision and drainage of abscess),
- 10180 (incision and drainage, complex, postoperative wound infection),
- 11000 (debridement of extensive eczematous or infected skin),
- 11040, 11041, 11042, 11043, 11044 (debridement),
- 11055, 11056, 11057 (paring or cutting of benign hyperkeratotic lesion),
- 11719 (trimming of nondystrophic nails),
- 11720, 11721 (debridement of nail(s) by any method(s)),
- 11730 (avulsion of nail plate, partial or complete, simple; single),
- 11740 (evacuation of subungual hematoma),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99211, 99212, 99213, 99214, 99215 (office — established patient),
- 99304, 99305, 99306, 99307, 99308, 99309, 99310 (nursing facility care),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary),
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 (home visit)

Quality codes for this measure (one of the following for every eligible patient):

G-code descriptors

(Data Collection sheet should be used to determine appropriate combination of codes.)

- **G8410:** Footwear evaluation performed and documented
- **G8416:** Clinician documented that patient was not an eligible candidate for footwear evaluation measure
- **G8415:** Footwear evaluation was not performed
Diabetes Mellitus

Foot Exam

This measure is to be reported for all patients aged 18 through 75 years with diabetes mellitus — a minimum of once per reporting period.

Measure description
Percentage of patients aged 18 through 75 years with diabetes mellitus who had a foot examination

What will you need to report for each patient with diabetes mellitus for this measure?
If you select this measure for reporting, you will report:
- Whether or not you performed a foot examination (includes visual inspection, sensory exam with monofilament, or pulse exam)

What if this process or outcome of care is not appropriate for your patient?
There may be times when it is not appropriate to perform a foot examination, due to:
- Medical reasons (i.e., patient with bilateral foot/leg amputation)

In these cases, you will need to indicate that the medical reason applies, and specify the reason on the worksheet and in the medical chart. The office/billing staff will then report a code with a modifier that represents these valid reasons (also called exclusions).
# Diabetes Mellitus

## Foot Exam

**PQRI Data Collection Sheet**

<table>
<thead>
<tr>
<th>Patient's Name</th>
<th>Practice Medical Record Number (MRN)</th>
<th>Birth Date (mm/dd/yyyy)</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Provider Identifier (NPI)</th>
<th>Date of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Information

**Step 1  Is patient eligible for this measure?**

<table>
<thead>
<tr>
<th>Patient is aged 18 through 75 years on date of encounter.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient has a line item diagnosis of diabetes mellitus.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>There is a CPT E/M Service Code or G-code for this visit.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If No is checked for any of the above, STOP. Do not report a CPT category II code.</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Billing Information

**Code Required on Claim Form**

- Verify date of birth on claim form.
- Refer to coding specifications document for list of applicable codes. Codes determining a patient's eligibility must be reported on the same claim as the quality code(s) identified below.

**Step 2  Does patient meet or have an acceptable reason for not meeting the measure?**

**Foot Exam (includes visual inspection, sensory exam with monofilament or pulse exam)**

<table>
<thead>
<tr>
<th>Performed</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Not performed for the following reason:  |
|                                         |
| • Medical (ie, patient with bilateral foot/leg amputation) | Yes | No |
|                                                           |     |    |

| Document reason here and in medical chart. | Yes | No |
|                                           |     |    |

**Code to be Reported on Line 24B of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)**

- 2028F

**If No is checked for all of the above, report 2028F-8P**
- (Foot exam was not performed, reason not otherwise specified.)
Diabetes Mellitus

Foot Exam

Coding Specifications
Codes required to document patient has diabetes mellitus and a visit occurred:

A line item ICD-9-CM diagnosis code for diabetes mellitus and a CPT E/M service code or G-code are required to identify patients to be included in this measure.

All measure-specific coding should be reported ON THE SAME CLAIM.

Diabetes mellitus line item ICD-9-CM diagnosis codes
- 250.00, 250.01, 250.02, 250.03 (diabetes mellitus without mention of complication),
- 250.10, 250.11, 250.12, 250.13 (diabetes with ketoacidosis),
- 250.20, 250.21, 250.22, 250.23 (diabetes with hyperosmolarity),
- 250.30, 250.31, 250.32, 250.33 (diabetes with other coma),
- 250.40, 250.41, 250.42, 250.43 (diabetes with renal manifestations),
- 250.50, 250.51, 250.52, 250.53 (diabetes with ophthalmic manifestations),
- 250.60, 250.61, 250.62, 250.63 (diabetes with neurological manifestations),
- 250.70, 250.71, 250.72, 250.73 (diabetes with peripheral circulatory disorders),
- 250.80, 250.81, 250.82, 250.83 (diabetes with other specified manifestations),
- 250.90, 250.91, 250.92, 250.93 (diabetes with unspecified complication),
- 357.2 (polyneuropathy in diabetes),
- 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07 (diabetic retinopathy),
- 366.41 (diabetic cataract),
- 648.00, 648.01, 648.02, 648.03, 648.04 (diabetes mellitus in pregnancy, not gestational)

AND

CPT E/M service codes or G-codes
- 97802, 97803, 97804 (medical nutrition therapy),
- 99201, 99202, 99203, 99204, 99205 (office — new patient),
- 99212, 99213, 99214, 99215 (office — established patient),
- 99304, 99305, 99306, 99307, 99308, 99309, 99310 (nursing facility),
- 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337 (domiciliary),
- 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350 (home services),
- G0270, G0271 (medical nutrition therapy)

Quality codes for this measure:

CPT II Code descriptors
(Data collection sheet should be used to determine appropriate code.)
- CPT II 2028F: Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam — report when any of the three components are completed)
- 2028F-IP: Documentation of medical reason for not performing foot exam (i.e., patient with bilateral foot/leg amputation)
- 2028F-RP: Foot exam was not performed, reason not otherwise specified
Claims-Based Reporting Principles

The CPT Category II code(s) and/or G-code(s), which supplies the numerator, must be reported on the same claim form as the payment codes, usually ICD-9-CM and CPT Category I codes, which supply the denominator.
Quality Data Codes (QDCs) must be submitted with a line item charge of zero dollars ($0.00) at the time the associated covered service is performed.

The submitted charge field cannot be blank.

The line item charge should be $0.00.

If a system does not allow a $0.00 line item charge, use a small amount such as $0.01.

Entire claims with a zero charge will be rejected.

(Total charge for the claim cannot be $0.00.)
Quality-data code line items will be denied for payment, but are then passed through the claims processing system for PQRI analysis.

Eligible professionals will receive a Remittance Advice (N365) as confirmation that the QDC(s) passed into the National Claims History file.
Multiple eligible professionals’ QDCs can be reported on the same claim using their individual NPI.
• Some measures require the submission of more than one QDC in order to properly report the measure.

• Eligible professionals may submit multiple codes for more than one measure on a single claim.

• Multiple CPT Category II and/or G-codes for multiple measures that are applicable to a patient visit can be reported on the same claim, as long as the corresponding denominator codes are also line items on that claim.

• The individual NPI of the participating eligible professional(s) must be properly used on the claim.

• Claims may not be resubmitted simply to add QDC(s).
Paper-based submission, accomplished by using the CMS 1500 claim form (version 08-05):

- Relevant ICD-9-CM diagnosis codes are entered in Field 21.
- Service codes (including CPT, HCPCS, CPT Category II and/or G-codes) with any associated modifiers are entered in Field 24D with the diagnosis pointer in Field 24E.
- For group billing, the National Provider Identifier (NPI) of the rendering provider is entered in Field 24J.
- The Tax Identification Number (TIN) of the employer is entered in Field 25.
Individual/Group NPI Submission

- Your individual National Provider Identifier (NPI) must be included on the claim line items for the quality-data codes you submit as well as the line items for the services to which the quality-data code is applicable.
- The PQRI quality-data code must be included on the same claim that is submitted for payment at the time the claim is initially submitted in order to be included in PQRI analysis.
- If a group NPI is used at the claim level, the individual rendering physician’s NPI must be placed on each line item, including all allowed-charge and quality-data line items.
Timeliness of Quality Data Submission

- Claims processed by the Carrier/MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 28, 2010 to be included in the analysis. Claims for services furnished toward the end of the reporting period should be filed promptly.

- Claims that are resubmitted only to add quality-data codes will not be included in the analysis.
SCENARIO

• You see a 68 year old male with NIDDM as a new patient with the chief complaint of “heel pain.”

• You do an H & P including in your physical exam a vascular, neurological, biomechanical, and dermatological exam. You evaluate the patient’s current footwear.
FINDINGS

• Your diagnosis is plantar fasciitis, NIDDM with peripheral neuropathy and loss of protective sensation.

• You counsel the patient regarding diabetic foot care and risks of LOPS.

• You advise the patient about proper shoe gear—patient is eligible for therapeutic shoes.

• You treat the patient for the plantar fasciitis.
CODING

- Diagnosis (ICD-9): 250.60, 727.1
- Procedure (CPT): 99203
- Quality Codes:
  - G8404 (Neurological Exam Performed)
  - G8410 (Footwear Evaluation Performed)
  - 2028F: (Foot Examination Performed)
PQRI Data Collection sheets must be completed for each quality measure and placed in the patient’s chart or documentation in the note of the patient visit of each quality measure being performed (neurological exam, evaluation for footwear and diabetic foot exam).
OTHER POSSIBLE MEASURES TO REPORT

- Measure 20: Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician
- Measure 21: Perioperative Care: Selection of Prophylactic Antibiotic—First or Second Generation Cephalosporin
- Measure 22: Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
- Measure 114: Inquiry Regarding Tobacco Use
- Measure 115: Advising Smokers to Quit
- Measure 124: HIT—Adoption/Use of Health Information Technology (Electronic Health Records)
- Measure 128: Universal Weight Screening and Follow-Up
- Measure 130: Universal Documentation and Verification of Current Medications in the Medical Record
- Measure 131: Pain Assessment Prior to Initiation of Patient Treatment
- Measure 138: Melanoma: Coordination of Care
- Measure 142: Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications
- Measure 154: Falls: Risk Assessment
- Measure 155: Falls: Plan of Care
- Measure 186: Wound Care: Use of Compression System in Patients with Venous Ulcers
I am in a group practice. Do all the doctors in the group have to participate?

No, the PQRI program is done at the individual physician level. That is why they require an individual NPI number linked to each quality measure reported.
QUESTIONS?

I have already missed the entire month of January for reporting. Is it too late to participate this year?

No, many of the measures require reporting only once per reporting period. In the examples used with regards to the diabetic foot measures, the only patients you would have missed the opportunity to report on are those patients with diabetes that you have seen since January 1, 2009 who will not be seen again for the remainder of the year. Since the reporting threshold is 80% of eligible patients, you should still be able to successfully report in 2009.
QUESTIONS?

Can I go back and add quality measures to claims on patients that I have already seen and submitted that I performed the measures on during that visit?

No, you cannot resubmit claims simply to add quality measures.
QUESTIONS?

Do I have to submit the diabetic foot care measures?

No, the only requirement is to successfully report at least three measures. As long as you are able to perform a quality measure you can submit it. Remember, you must submit on at least 80% of eligible patients.
QUESTIONS?

Do I get a bigger bonus if I submit more than three measures?

No, the bonus is always the same 2% if you are a successful reporter in PQRI. The only consideration in submitting more than three measures would be if you were unsuccessful in reporting a measure (did not meet the 80% requirement). If you submitted more than three measures, as long as you successfully submitted at least three you would qualify for the bonus.
QUESTIONS?

This seems like extra work. Why should I participate?

First of all, the 2% bonus. Also, while this is currently a voluntary reporting program, it could in the future become mandatory. Setting up and getting yourself and your staff up to speed now may avoid some anxiety in the future.
I noticed that there are also codes with each measure to report that the measure was not done. After I report a measure that only needs to be reported once per year on a patient, do I need to report that it was not done on subsequent visits?

No, once you have successfully reported a measure on a patient that is required to be reported once per year, you do not and should not report that you did not do the measure on subsequent visits.
QUESTIONS

Does the aggregate reporting total for the three measures need to be 80% or is it 80% for each measure?

The requirement is that each individual measure must be reported for at least 80% of eligible patients. So if you report one measure at 90%, one at 80% and one at 70% you would not qualify for the bonus even though the aggregate average of all three measures is 80%.
I recall reading something about an initial code that you had to submit that indicated you were going to report measures. Is that true?

There is an initial reporting code when you are reporting utilizing measure groups. However, there are no measure groups that podiatrists are qualified to report so there is no initial code to utilize. The method of reporting outlined in this presentation is based upon individual claims reporting. To participate you just start reporting the measures that you have performed.
Is there a minimum number of patients that I have to report on each of the three measures?

No, there are no minimums, just the requirement that you report on at least 80% of the eligible patients for each measure you select to report. If you choose the diabetic foot care measures and you only see 100 patients with diabetes and the appropriate CPT codes are listed in the measure specifications, then you would only have to report the measure on at least 80 patients. If you choose another measure and only had 10 patients that were eligible to report the measure on, you would only have to report that measure on at least 8 patients.
I participated in 2008 and reported the two diabetic foot care measures. Can I report them again in 2009?

Yes, this is a new reporting period and you can report any measures you choose, whether you reported them previously in another reporting period or not.
CMS WEB SITE:
http://www.cms.hhs.gov/PQRI/

AMA WEB SITE:
www.ama-assn.org/go/toolsMedicarePQRI
MY CONTACT INFORMATION

Jim Christina, DPM

jrchristina@apma.org

301-581-9265