Medicare Continues Physician Quality Reporting Initiative in 2008

The Physician Quality Reporting Initiative (PQRI), Medicare's pay-for-reporting program, is being continued in 2008. PQRI offers physicians who "participate successfully" a financial incentive of 1.5% of their total allowed Medicare charges for the reporting period January 1 to December 31, 2008. Participation in the program is completely voluntary and requires no enrollment. To assist ACCMA members in determining whether to participate, this article summarizes how PQRI works and what it means for physicians and their practices.

PQRI in Brief

PQRI is a program of the Centers for Medicare and Medicaid Services (CMS). It is a claims-based reporting system, meaning participating physicians report data on quality measures in the form of additional codes on Medicare claims. The "quality codes" required for reporting are CPT Category II codes or G codes where CPT II codes are not available. PQRI collects data for 119 quality measures – up from 74 in 2007 – including 2 new structural measures dealing with electronic medical records and electronic prescribing. To participate successfully, physicians must report data for at least 3 quality measures (or, in some cases, less than 3 measures) applicable to their Medicare patient population. Physician participation in PQRI is completely voluntary, and physicians are not penalized for not participating. Other features of PQRI worth noting include:

- ***Financial Incentive to Participate*** - Physicians may earn a financial incentive of up to 1.5% of their total allowed Medicare charges for services rendered during the reporting period January 1 to December 31, 2008. To "successfully participate," a physician must report data for at least 3 quality measures (or, in some cases, less than 3) on at least 80% of the Medicare claims to which the quality measures apply.

- ***Formula to Cap Payments Eliminated*** – In 2008, CMS will no longer cap payments to physicians who meet the reporting thresholds but who submit a relatively small number of claims relative to other participating physicians. ACCMA is pleased with this development since the cap appeared to disadvantage physicians in specialties with measures that occur infrequently compared to measures common to other specialties.

- ***New Validation Process to Determine Successful Participation*** – CMS has implemented a new process to determine whether physicians submitting data for fewer than three measures could have reported on other measures as well. If so, the incentive payment will be denied. See below for more information.

- ***No Enrollment Required*** - PQRI is open to all enrolled Medicare providers, both participating and non-participating, providing services paid under the Medicare Part B fee-for-service health plan. Physicians wishing to participate in PQRI need only submit properly coded Medicare claims, including the appropriate "quality codes" (CPT II or G codes) for the selected quality measures.

- ***National Provider Identifier (NPI) Number Required*** - CMS tracks quality data at the individual provider level using the new NPI number. As a reminder, all Medicare claims must include a valid NPI number by March 1, 2008, or the claims will reject.

- ***Individual Data Shared with Participants*** - PQRI data is not released to the public, but CMS will issue participating physicians a summary report that compares the outcomes they have reported to other physicians reporting data for the same quality measures.

Participating in PQRI

Physicians who are considering participating in PQRI should work with their staff to determine whether the potential financial incentive of 1.5% of total allowed Medicare charges outweigh the administrative costs of reporting the additional data. The following process may help physicians weigh the costs and benefits of participating in PQRI:

1. *Identify at least 3 quality measures that are likely to occur the most frequently in your Medicare patient population.* Although PQRI collects data on 119 quality measures, to "successfully participate" physicians need only report data for at least 3 quality measures on at least 80% of the claims to which the measures apply. In the event that fewer than three quality measures apply to your Medicare patient population, you must report on all of the applicable quality measures at least 80% of the time in order to receive the payment. To maximize your chances of meeting the required thresholds to recoup the full incentive payment, physicians should select quality measures that are likely to occur the most frequently in their Medicare patient population. See below for more information about CMS' validation processes.

2. *Review the "PQRI Measure Specifications" and learn the exact requirements for your measures.* CMS has written specification for each of the 119 measures, which are available online (www.cms.hhs.gov/pqri under "Measures/Codes") or by contacting the ACCMA (510/654-5383). The measure specifications define the measure, the patient population to be measured, the "quality codes" and modifiers that apply, and provide a clinical explanation for the measure.

3. *Assess the potential benefit to your practice.* A good proxy to estimate the potential financial incentive may be 1.5% of the total allowed charges for services paid under the Medicare physician fee schedule from January 1 to December 31, 2007. Remember, this assumes that you meet the requirements for participation and are not subject to the cap on payments described below.

4. *Assess the potential costs to your practice*. To participate successfully, it is important that your staff be able to identify reportable cases based on permissible combinations of CPT E/M and ICD-9 codes, code Medicare claims properly, and use the new NPI numbers. Physicians are encouraged to talk with their office manager and billing staff to estimate any additional costs to do this.

5. *Make a decision and get prepared.* Only physicians can determine whether the financial benefits of participating in PQRI outweigh the administrative costs of PQRI's reporting requirements. If you elect to participate, be sure to evaluate your current billing and coding processes and implement needed changes as soon as possible to help increase your chances that you meet the 80% reporting threshold and avoid the cap.

Validation Process to Determine "Successful Participation"

As noted above, physicians must "successfully participate" in PQRI in order to recoup the full incentive payment of 1.5% of allowed Medicare charges. CMS has introduced a new validation process in 2008 – known as the "measure-applicability validation process" – to verify whether a physician reporting on fewer than three measures could have reported on additional measures. This first step in the process involves a clinical relation test, which analyzes claims to determine if there were other measures that applied to the patient population, and therefore, could have been reported. The second step will be applied to physicians whose claims demonstrate that potential additional measures could have been reported. If CMS finds that the physician had 30 or more patients/encounters during the reporting period to which a measure applied but was not reported, CMS will deny payment of the financial incentive.

Procedures for PQRI Reporting

PQRI "quality data" codes are CPT II codes or G codes where CPT II codes are not yet available, and reporting requirements follow current rules for reporting as stated in the CPT codebook. PQRI reporting is accomplished by listing the quality data codes as line items on the electronic or paper claims form in which the procedures are billed, with all the necessary data elements (or fields) on the billing line item, including (but not necessarily limited to) date of service, place of service, PQRI quality code along with modifier (if appropriate), diagnosis pointer, submitted charge ($0.00 should be entered for PQRI codes), and the physician's individual NPI number. If a physician's billing software does not accept a $0.00 charge for the PQRI codes, a small amount can be substituted (such as $0.01). CMS will deny any claim that leaves the "submitted charge" field blank.

Financial Incentive Paid to TIN

PQRI tracks compliance with the reporting requirements at the individual provider level (using the new NPI number), but the PQRI payment will be made to the Taxpayer Identification Number (TIN) used by the reporting physician. Participating physicians within the same practice (using a common TIN) should expect to receive the physicians' incentives in a lump sum. Likewise, physicians who see patients on behalf of more than one practice (and, therefore, use more than one TIN when submitting Medicare claims) should expect their PQRI payment to be made to the respective TIN under which the services were reported. CMS anticipates that incentive payments earned by participating physicians will be paid in mid-2009 as a lump-sum.

Unfortunately, the legislation authorizing PQRI specifically prohibits administrative or judicial review of the determination of satisfactory reporting, the payment limitation or cap and the bonus incentive payment.

Understanding the Measure Specifications

The ACCMA advises participating physicians to become familiar with the "PQRI Measure Specifications" that are available online (www.cms.hhs.gov/pqri under "Measures/Codes"). The "PQRI Measure Specifications" share a common format that outlines most of the information a physician needs to participate in PQRI successfully:

Measure Number, Descriptive Title and Description: In addition to assigning each measure a number, CMS provides a descriptive title and description of the quality measure. Using measure #2 as an example, the descriptive title is "Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus," and the corresponding description is "Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent LDL-C level in control (less than 100 mg/dl)."

Instructions: In the instructions section, CMS outlines the reporting frequency, the performance period, and the types of codes used to both identify eligible cases and to report quality data. The "reporting frequency" refers to the minimum number of times a physician must report the data for each patient. In the case of measure #2, physicians must report the data at least once for patients seen during the reporting period. Physicians will not be penalized for exceeding the minimum reporting frequency. The "performance period" refers to the period of time during which the quality measurement can take place. In the case of measure #2, physicians who see a patient diagnosed with Type 1 or 2 Diabetes Mellitus who had an LDL-C test performed in the previous 12 months may report the appropriate quality measures and receive credit, even if the LDL-C test was performed prior to the reporting period. The "types of codes" refers to the category of procedure codes that can be used when reporting the measure (i.e. CPT E/M Codes) and not the specific codes, which are specified in subsequent sections.

Numerator: CMS refers to the quality codes as the "numerator", and it is helpful to understand why. Quality measures are based on a simple formula that shows the frequency that a given characteristic occurs within a defined population. Expressed as a simple equation, a quality measure is:

$$\frac{\text{Patient Population with Characteristic X}}{\text{Patient Population}} = \text{\% of Patient Population with Characteristic X}$$

Practically speaking, the "numerator" specifies the characteristic to be measured in terms of specific "quality codes" (CPT Category II codes or G codes where CPT II codes are not yet available). For example, for measure #2, physicians report one of three mutually exclusive characteristics: most recent LDL-C is less than 100 (CPT II 3048F); or, most recent LDL-C is between 100 and 129 (CPT II 3049F); or, most recent LDL-C is greater than or equal to 130 (CPT II 3050F).

The “numerator” section also outlines which modifiers may be appended to the permissible “quality codes” in the event that none of the permissible “quality codes” applies. In the case of measure #2, a physician can append any of the permissible CPT II codes with either the modifier 1P (LDL-C not performed for medical reasons) or the modifier 8P (LDL-C not performed, reason not specified).

Denominator: As noted above, PQRI measures the frequency that a characteristic occurs within a defined population. CMS refers to the characteristic as the “numerator” and refers to the defined patient population as the “denominator.” The “denominator” for a given measure is composed of all patients that share a specific diagnosis and that have been given a specific treatment. CMS has operationalized the “denominator” for each measure by establishing acceptable combinations of ICD-9 diagnosis codes and CPT E/M service codes that correspond to the definition of the patient population. For example, measure #2 defines the patient population as “patients aged 18-75 years with diabetes (type 1 or type 2)”, which is operationalized as those patients with an ICD-9 diagnosis code for diabetes[1] and an appropriate CPT E/M service code[2].

Rationale and Clinical Recommendation Statements: CMS provides physicians with a clinical rationale for collecting data on each measure, as well as the underlying clinical recommendations that form the basis for the measure.

Additional Resources on PQRI

The ACCMA is offering several programs specifically designed to help members who choose to participate in PQRI:

- *ACCMA Assistance*: ACCMA staff are very familiar with PQRI and are here to assist physician members and their staff with any questions or concerns they have. Please contact us at 510/654-5383.

- *PQRI Website:* Participating physicians should consult the PQRI website (www.cms.hhs.gov/pqri), where you can find information about the specific quality measures, reporting requirements, and a list of frequently asked questions. CMS has also posted some educational resources and tools.

- *AMA Resources:* The AMA has created tools and resources to help physician offices successfully implement PQRI. Among the tools are worksheets for successfully capturing and coding the quality data. The resources can be found online at http://www.ama-assn.org/ama/pub/category/17432.html.

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[1] 250.00-250.93 (DM); 648.00-648.04 (DM in pregnancy, not gestational)

[2] 99201-99205, 99211-99215 (E/M); 99341-99345, 99347-99350 (home visit); 99304-99310 (nursing facility); 99324-99328, 99334-99337 (domiciliary); G0344.