

The 2009 Physician Quality Reporting Initiative (PQRI)

**American Academy of Professional Coders
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Overview

- Value-Based Purchasing and PQRI
- PQRI Reporting: Measures & Codes
- Implementing PQRI
- 2009 Electronic Prescribing Incentive Program
 - Utilizes many of the same billing/coding principles as PQRI reporting
- Resources

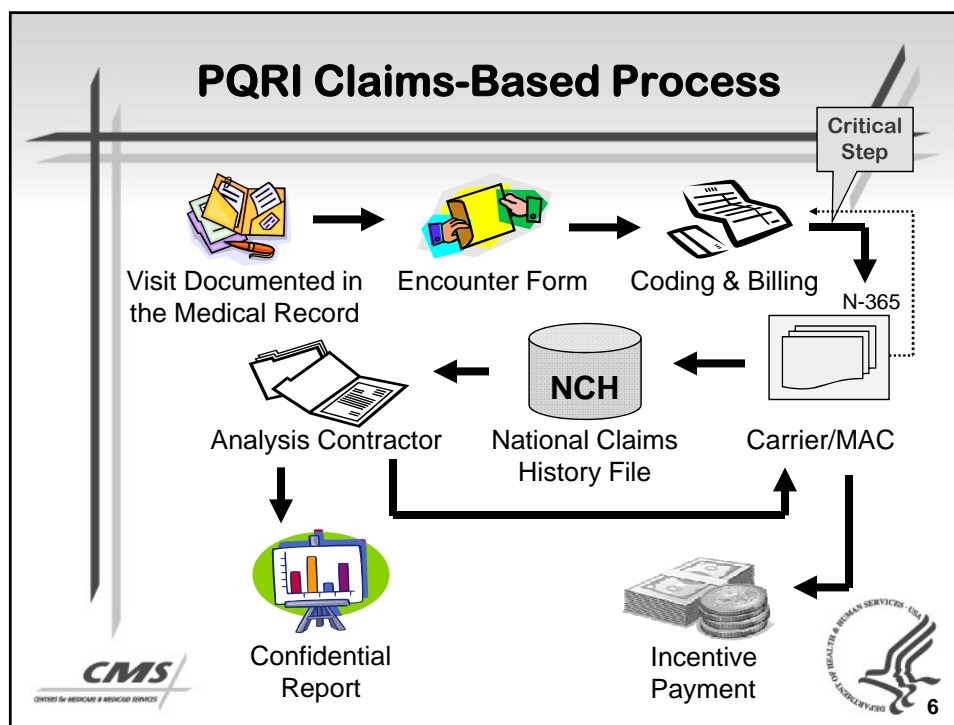
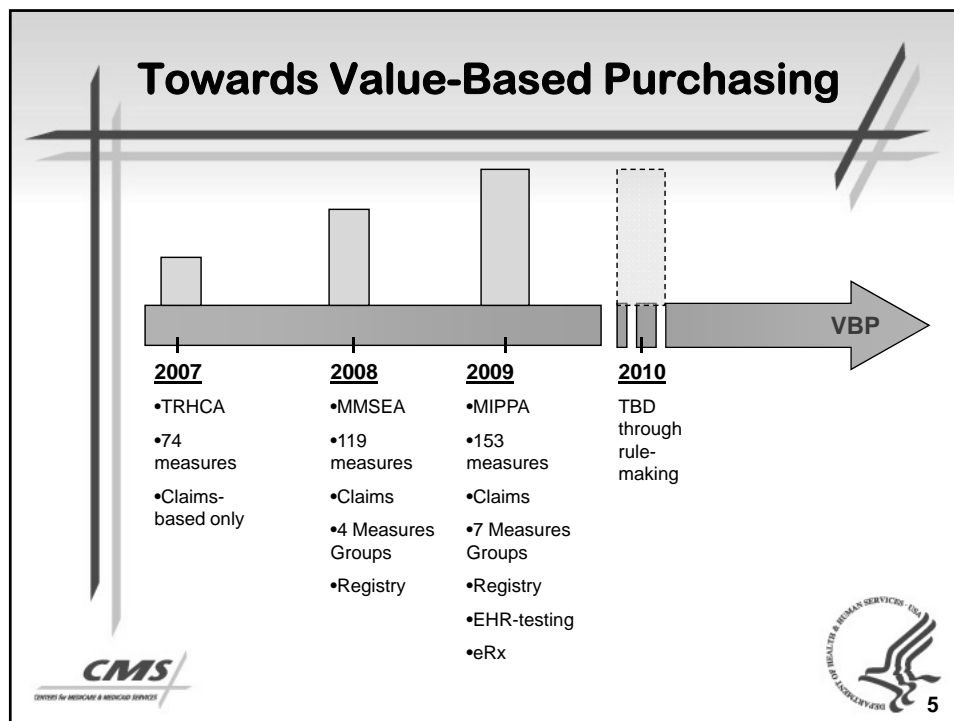


What is PQRI? Who Can Participate?

- PQRI is a voluntary individual reporting program that provides an incentive payment to identified eligible professionals (EPs) who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Medicare Part C – Medicare Advantage patients are not included in claims-based reporting of measures or measures groups but may be included in registry-based reporting.
- FQHCs, RHCs, IDTFs, ILs and other providers are not considered eligible. These entities are not defined as EPs in the Tax Relief Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 and do not qualify for an incentive. Additionally, these entities are paid under a different fee schedule.

http://www.cms.hhs.gov/PQRI/10_EligibleProfessionals.asp#TopOfPage





2009 PQRI Measures/Codes Downloadable Resources

http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage

- **2009 PQRI Measures List**: measure developer, reporting method
- **Reporting Individual Measures via Claims**
 - "2009 PQRI Measures Specifications Manual for Claims and Registry and Release Notes"
 - "2009 PQRI Implementation Guide"
- **Reporting Measures Groups**
 - "2009 PQRI Measures Groups Specifications Manual"
 - "2009 PQRI Getting Started in Reporting of Measures Groups"



2009 PQRI Resources

http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage

- **Registry-based Reporting**
 - Individual Measures (at least 3 or more)
 - Measures Groups
- **List of Qualified Registries** (additional registries qualifying for 2009)

http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage

- MLN Matters Articles
- Fact Sheets
- Tip Sheets
- 2009 PQRI Patient-Level Measures List



Claims-Based Reporting Principles

- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
 - on the same claim
 - for the same beneficiary
 - for the same date of service (DOS)
 - for the same EP (NPI within the holder of the tax ID number - TIN/NPI)
- All diagnoses reported on the base claim will be included in PQRI analysis.
- Claims may **NOT** be resubmitted simply to add or correct quality-data codes (QDCs).
- QDCs must be submitted with a line-item charge of zero dollars (\$0.00) at the time the associated covered service is performed. If a system does not allow a \$0.00 line-item charge, a nominal amount can be substituted.
- The submitted charge field cannot be blank.



Claims-Based Reporting Principles (ctd.)

- Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be \$0.00).
- QDC line items will be denied for payment by the carrier, but are then passed through the claims processing system for PQRI analysis. EPs will receive a **Remittance Advice** (RA) associated with the claim which contains the PQRI QDC line-item that will include a standard remark code (**N365**) and a message that confirms that the QDCs passed into the National Claims History (NCH) file. N365 reads: "This procedure code is not payable. It is for reporting/information purposes only." The N365 remark code does **NOT** indicate whether the QDC is accurate for that claim or for the measure the EP is attempting to report.



Appendix D: CMS-1500 Claim Example
 Example of PQRI billing on a CMS-1500 claim. See <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf> for more information.

21. Review applicable PQRI measures related to ANY diagnosis (Dx) listed in Item 21. Up to 8 Dx may be entered electronically OR up to 4 Dx on paper.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier as needed

QDC codes must be submitted with a line-item charge of \$0.00 or \$0.01. Charge field cannot be blank.

1. DIAGNOSIS OR REASON FOR ILLNESS OR INJURY (Include Item 1, 2, 3 or 4 from 24E by Line)										2. MODIFIER (See Instructions)										3. PRIOR AUTHORIZATION NUMBER									
250.00																													
Diabetes Mellitus																													
CAD																													
1 07 11 08 07 11 08 11 3048F										DM-PQRI #2										0.00									
2 07 11 08 07 11 08 11 3078F										BP<130 mmHg-PQRI #3										0.00									
3 07 11 08 07 11 08 11 3078F										AND										0.00									
4 07 11 08 07 11 08 11 4011F										BP<80 mmHg-PQRI #3										0.00									
5 07 11 08 07 11 08 11 4011F										CAD-PQRI #6										2 0.00									
6 07 11 08 07 11 08 11 1090F										UI Assessed-PQRI #48										0 0.00									
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The patient was seen for an office visit (99213). The provider is reporting several measures related to diabetes, coronary artery disease (CAD), and urinary incontinence:

- Measure #2 (LDL-C) with QDC 3048F + diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);
- Measure #3 (BP in Diabetes) with QDCs 3074F + 3078F + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);
- Measure #6 (CAD) with QDC 4011F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and
- Measure #48 (Assessment - Urinary Incontinence) with QDC 1090F. For PQRI, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.

Note: All diagnoses listed in Item 21 will be used for PQRI 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. 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. PQRI analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

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What Are PQRI Measures Groups?

- **4 or more individual measures** related to a clinical topic that have a common patient population specified in the denominator that is defined by diagnosis and/or encounter codes
- **Measures Groups Specifications** are **not** the same as those for individual measures. Use the correct manual:

<http://www.cms.hhs.gov/apps/ama/license.asp?file=/PQRI/downloads/2009PQRIQualityMeasureSpecificationsManualandReleaseNotes.zip>
- **Reporting Periods* Available:**
 - 12-month (full-year incentive) Jan 1-Dec 31, 2009
 - 6-month (half-year incentive) July1-Dec 31, 2009
- **Reporting Methods Available:**
 - Claims or Registry

***See Appendix C Decision Tree, 2009 PQRI Implementation Guide:**
http://www.cms.hhs.gov/PQRI/Downloads/2009_PQRI_ImplementationGuide_040909.pdf

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2009 PQRI Measures Groups

- 7 measures groups:
 - Diabetes Mellitus
 - Chronic Kidney Disease
 - Preventive Care
 - Coronary Artery Bypass Graft (CABG) (new-registry only)
 - Rheumatoid Arthritis (new)
 - Perioperative Care (new)
 - Back Pain* (new) - reportable only as a measures group, not as individual measures

ESRD measures group removed for 2009

- ESRD measures group removed for 2009



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CMS-1500 Claim [Detailed Measures Group] – Sample 1 (continues on next pg)

See http://www.cms.hhs.gov/PQR/15_MeasuresCodes.asp#TopOfPage for more information.

21. Review and determine if ANY diagnosis (Dx) listed in Item 21 meets the patient sample criteria for the RA measures group.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier as needed

Quality-Data Codes (QDCs) must be submitted with a line-item charge of \$0.00. Charge field cannot be blank.

Identifies claim line-item

Report ALL applicable measures' QDCs within the RA measures group

For group billing, the rendering NPI number of the individual Eligible Professional (EP) who performed the service will be used on each line-item in the PQRI calculations.

The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI. If a group billing, enter the NPI of the group here. This is a required field.

21. EXPOSURE OR NATURE OF ILLNESS OR INJURY (Yields Items 1, 2, 3, 4 and Item 5A by Line)										22. MEDICARE REIMBURSEMENT CODE										ORIGINAL REF. NO.																			
L714 0 Rheumatoid Arthritis (RA) 3																																							
23. PRIOR AUTHORIZATION NUMBER										24. PROCEDURE, SERVICE, OR SUPPLY (Specify Unusual Occurrences)										25. CHARGES										26. RENDERING PROVIDER I.D.#									
1										Patient encounter during reporting period										45 00										NPI 0123456789									
2										RA Measures Group Intent D-code										0 00										NPI 0123456789									
3										RA-PQRI M08										0 00										NPI 0123456789									
4										RA-PQRI M76 code 1										0 00										NPI 0123456789									
5										AND																													
6										RA-PQRI M76 code 2										0 00										NPI 0123456789									
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- Intent **G-code (G8490)** was submitted to initiate the EP'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.

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Measures Group Claim Sample (ctd.)

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

21. Review and determine if ANY diagnosis (Dx) listed in item 21 meets the patient sample criteria for the RA measures group.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier as needed

QDC(s) must be submitted with a line-item charge of \$0.00 or \$0.01. Charge field cannot be blank.

For group billing, the rendering NPI number of the individual EP who performed the service will be used from each line-item in the PQRI calculations.

Identifies claim line-item

Report ALL applicable measures' QDCs within the RA measures group

Solo practitioner - Enter individual NPI here

NUCC Instruction Manual available at: www.nucc.org

APPROVED CMB-0938-0999 FORM CMS-1500 (06/06)

- 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 3467F + 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 PQRI 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.

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Measures Group Claim Sample – Composite G-Code

CMS-1500 Claim [Sample Measures Group] – Sample 2

A detailed sample of an individual NPI reporting the RA Measures Group on a related CMS-1500 claim is shown below. This sample shows reporting performance of all measures in the group using a composite G-code.

See http://www.cms.hhs.gov/PQRI/5_MeasuresCodes.asp#TopOfPage for more information.

21. Review and determine if ANY diagnosis (Dx) listed in item 21 meets the patient sample criteria for the RA measures group.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier as needed

QDC(s) must be submitted with a line-item charge of \$0.00. Charge field cannot be blank.

For group billing, the rendering NPI number of the individual EP who performed the service will be used from each line-item in the PQRI calculations.

Identifies claim line-item

Patient encounter during reporting period

RA Measures Group Intent G-code

RA Measures Group QDC indicating all quality actions were performed for this patient

Solo practitioner - Enter individual NPI here

NUCC Instruction Manual available at: www.nucc.org

APPROVED CMB-0938-0999 FORM CMS-1500 (06/06)

- 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 EP's submission of the RA Measures Group.
 - Measures Group QDC 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 PQRI 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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How to Get Started

- Gather information from the PQRI web page: www.cms.hhs.gov/pqri (e.g., Measures/Codes, Educational Resources, Tool Kit web pages)
- Gather information from other sources, such as your professional association, specialty society, or the American Medical Association
- Determine which PQRI reporting option(s) best fits practice
- Select a PQRI reporting period: 12 or 6 month

Review this helpful resource from the Tool Kit page:

http://www.cms.hhs.gov/PQRI/Downloads/PQRI_Implementation_4_MR.pdf



Selection of Measures

- **Consider Practice Characteristics:**
 - Clinical conditions usually treated
 - Types of care typically provided – e.g., preventive, chronic, acute
 - Settings where care is usually delivered – e.g., office, ED, surgical suite
 - Quality improvement goals for 2009
- **Review the List of Measures:** determine which measures apply most frequently to the practice's Medicare FFS patients. Many PQRI measures require one-time reporting per patient per reporting period per EPs (See **Patient Level Measures List**).



Measure Selection and Reporting Method

- **Review and study the measures specifications:**
Measures Specifications Manual for Claims and Registry & Release Notes for selected measures carefully to understand reporting instructions, coding and frequency of reporting.
- **Select a reporting method: via claims or via a qualified registry**
The “*2009 PQRI Participation Decision Tree*”
(see **Appendix C of 2009 PQRI Implementation Guide**)



Prepare to Participate in PQRI

- **Assemble an Implementation Team**
 - **Ensure** that the practice's billing software and clearinghouse can capture all the codes and associated modifiers used in PQRI for the measures you have selected. Discuss implementing an edit to identify eligible claims with EDI vendors.
 - **Read and discuss with staff:** reporting principles and specifications for each measure selected for PQRI reporting.



Prepare to Participate in PQRI

- **Develop a process** for concurrent data collection so that all eligible claims and PQRI QDCs are correctly identified and submitted
- **Regularly review the Remittance Advice** notices from the Carrier/MAC to ensure receipt of **N365** remark code for each QDC submitted



2007 PQRI Experience Report

Invalid QDC Submission Attempts

- 12.15% Missing individual NPI
- 18.89% Incorrect HCPCS (CPT1) code*
- 13.93% Incorrect DX code*
- 7.24% Both incorrect HCPCS code and incorrect DX code*
- 4.97% All line items were QDCs only

*Denominator mismatch

<http://www.cms.hhs.gov/PQRI/Downloads/2008QDCError3rdQuarter.pdf>



2007 PQRI Contributing Factors

- Split claims
- Diagnosis Pointer
- Missing NPI
- QDC reported on denied claim
- Missing QDC on eligible claim (e. g., incident to billing)
- Shared codes (e.g., measures #7 and #8 – replaced CPT II codes with G-codes beginning PQRI 2008).



Some Common Errors in Claims-based Reporting

Review the measure's denominator:

Eligible claim submitted without QDC(s)*

- Not identifying all eligible claims per the measure denominator: some measures include sites of care other than office visit-(HH/NH); incident to claims; Railroad Retirement claims;
- Eligible claim submitted as a QDC-only claim (no denominator information on the claim)
 - Billing software/clearinghouse may be splitting the claim
- Ineligible claim with QDC for measure
 - Dx is incorrect or insufficient on claim for measure reported
 - Surgical procedure is incorrect on claim for measure reported
 - Age/gender on claim is incorrect for measure reported
- Eligible claim with insufficient QDCs
- Eligible claim denied by carrier, subsequently submitted but without adding QDC(s)
- Eligible claim paid partially by primary payer submitted without QDC as Medicare Secondary Payer



Common Errors cont'd

- Missed reporting QDC on eligible claim (e.g., incident to claims NH HH)
- Reporting a QDC on a claim with an office visit code when the measure required a surgical procedure code or a consultation code
- Reporting a QDC on a claim when the diagnosis and the CPT I service were not listed in the denominator for the measure
- Reporting one QDC when the claim requires two QDCs
- Reporting one Dx on a claim when two Dxs should be reported
- Reporting a QDC with incorrect CPT II modifier or incorrectly used a CPT I modifier
- Reporting a QDC on a claim for a service that was not covered by Medicare (or claim was denied by carrier).
- Individual rendering NPI was not listed on the claim, therefore, that claim was not included in PQRI analysis



Tips for Success: “Don’t Wing It, Ensure it!”

- Understand the measures you have selected to report: both numerator and denominator coding.
- Establish a workflow that allows accurate identification of each denominator-eligible Part B Medicare claim (i.e., claims for services listed in the denominator coding section of each measure’s specifications)
- Consider implementing an edit on billing software to ensure all eligible claims are flagged for PQRI
- A useful resource available on the PQRI Educational Resources section:

http://www.cms.hhs.gov/PQRI/Downloads/pqri_satisfactorily508.pdf



Resources: PQRI Website

www.cms.hhs.gov/pqri

Address http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPage Go Links

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Physician Quality Reporting Initiative

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Overview

Physician Quality Reporting Initiative

NEW - Click on the **"Spotlight"** link to the left to view

"What's New" for PQRI

NEW! 2007 PQRI Reporting Experience. A report describing the 2007 PQRI reporting experience is available in the **"Downloads"** section below. This report provides a detailed analysis of the 2007 program. It outlines the issues identified for 2007 and CMS plans for modifications to the analytics for the 2008 PQRI. In addition, CMS will apply these modifications to the 2007 PQRI data and re-run the data. CMS expects that additional eligible professionals will qualify for an incentive payment for both 2007 and 2008 based on these efforts. It is anticipated that these activities will be completed by the fall 2009.

Background. The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI).

For additional information about PQRI legislative requirements, click on the **"Statute/Regulations/Program Instructions"** link at left.

2009 PQRI. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110-275) made the PQRI program permanent, but only authorized incentive payments through 2010. EPs who meet

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FAQs, Listserv

Address http://www.cms.hhs.gov/PQRI/00_EducationalResources.asp#TopOfPage Live Search

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2009 Patient-Level Measures [PDF 83KB]

2009 PQRI Tip Sheet: PQRI Made Simple-Reporting Preventive Care Measures Group [PDF416 KB]

2008 PQRI MLN Matters Articles [ZIP 145KB]

2008 PQRI Tip Sheets [ZIP 1 MB]

2008 PQRI Fact Sheets [ZIP 1MB]

2008 PQRI Patient-Level Measures List [PDF 348KB]

Related Links Inside CMS

PQRI FAQs

All Educational Resources FAQs

MLN Matters Articles 6394

Physician ODF Listserv

Physician Listserv

Related Links Outside CMS

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Centers for Medicare & Medicaid Services, 7500 Security Boulevard Baltimore, MD 21244

2009 Electronic Prescribing Incentive Program Resources:

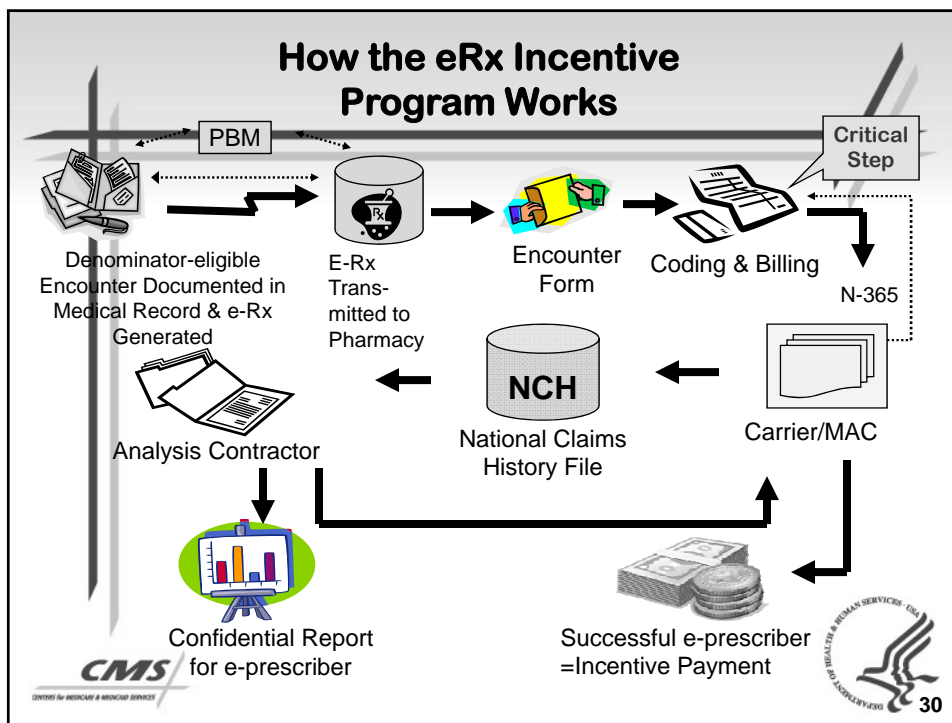
<http://www.cms.hhs.gov/ERXIncentive>

- Measure Specifications
- Claims-Based eRx Reporting Principles
- Sample eRx Claim



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How the eRx Incentive Program Works



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eRx Measure – Numerator (QDCs)

- **Prescriptions Generated via *Qualified* E-Prescribing System**
 - **G8443:** All prescriptions created during the encounter were generated using a qualified e-prescribing system **OR**
- **E-Prescribing System Available, but not Used for One or More Prescriptions Due to Patient/System Reasons**
 - **G8446:** Provider does have access to a qualified e-prescribing system. Some or all prescriptions generated during the encounter were printed or phoned in as required by state or federal law or regulations, patient request, or pharmacy system being unable to receive electronic transmission; **OR** because they were for narcotics or other controlled substances **OR**
- **Qualified E-Prescribing System Available, but no Prescription(s) were Generated During the Encounter**
 - **G8445:** No prescriptions were generated during the encounter. Provider does have access to a qualified e-prescribing system



eRx Measure –

eRx System Available:

If your eRx system is available but not used for one or more prescriptions because the pharmacy is unable to accept the transmittal, the EP should report QDC G8446. If your eRx system is not available due to malfunction or some other reason, you have not transmitted an eRx and therefore cannot report a G-code under this circumstance.



eRx Measure – Denominator (Eligible Cases) Codes

Patient encounter for covered services during the reporting period (CPT or HCPCS):

- 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809
- 92002, 92004, 92012, 92014
- 96150, 96151, 96152
- 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
- G0101, G0108, G0109



Reporting Scenarios for eRx



A 70-year old male patient presents to the clinician's office for medical care.

Scenario 1:

The clinician discusses current medications and prescribes new medication, updates active medication list in eRx system, transmits prescription electronically to pharmacy.

Reports G8443

Scenario 2:

Patient uses a pharmacy that cannot accept eRx and asks for a hard copy.
OR
Prescription is for a controlled substance. Physician updates meds in eRx system, eRx system provides hard copy of prescription to patient.

Reports G8446

Scenario 3:

The clinician documents there were no prescriptions generated; provider does have access to a qualified eRx system.

Reports G8445



All of these scenarios represent successful 2009 reporting



What is Not eRx

- Calling in a prescription
- Patient seen in ED is sent home with a written prescription
- Physician-generated faxed prescription to receiving pharmacy fax
- Sending a prescription via PDA (*exception*: depends on software used – must meet eRx system qualifications)
- Knowingly sending a computer-generated fax initiated at the doctor's office to a pharmacy (*exception*: if sent via qualified eRx system and pharmacy system generates message as a fax, it is eRx)
- Office visits during a global surgical period that result in a prescription
- Medicare Advantage patients (although you can eRx for these patients, MA claims do *not* count toward incentive payment calculation)



Allowable Reasons for Not Electronic Prescribing

G8446 E-Prescribing System Available, but not used for One or More Prescriptions Due to Patient/System Reasons

- Provider does have access to a qualified system, but due to one of the following reasons in the code descriptor, cannot eRx.
- Only the allowable reasons delineated in the code descriptor can be applied to G8446:
 - Controlled substance
 - State, federal law
 - Patient asks for hard copy
 - Pharmacy cannot receive eRx transmittal



Benefits of PQRI eRx Participation

- Receive confidential feedback reports to support quality improvement
- Earn an incentive payment
- Make an investment in the future of the practice
 - Prepare for higher bonus incentives over time
 - Prepare for pay-for-performance
 - Prepare for public reporting of performance results



It's Not Too Late to Begin*

If you haven't started reporting, you can still start reporting through claims:

- a 30-consecutive patient measures group sample for a full year incentive OR
- an 80% sample measures group for a half-year incentive (15 patient minimum)

OR

You can report at least 3 individual measures or at least 1 measures group via registry for either a full or half-year incentive



Thank You

1 CEU Index #: **AAPC0601091253A**

For questions about PQRI/eRx contact:

- QualityNet Help Desk: **866-288-8912**
7:00 a.m. – 7:00 p.m. CST
- Carrier/MAC: claims, payment questions
- Submit PQRI program questions to:
pqri_inquiry@cms.hhs.gov

For questions regarding measure construct
contact measure developer identified on
2009 PQRI Measures List



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