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
Towards Value-Based Purchasing

- 2007: TRHCA
  - 74 measures
  - Claims-based only
- 2008: MMSEA
  - 119 measures
  - Claims
  - 4 Measures Group
  - Registry
- 2009: MIPPA
  - 153 measures
  - Claims
  - 7 Measures Groups
  - Registry
  - EHR-testing
  - eRx
- 2010: TBD
  through rule-making

PQRI Claims-Based Process

- Visit Documented in the Medical Record
- Encounter Form
- Coding & Billing
- Analysis Contractor
- National Claims History File
- Confidential Report
- Incentive Payment
- Carrier/MAC
- N-365
- Critical Step

Incentive Payment
Confidential Report
NCH
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 Implementation Guide”

• **Reporting Measures Groups**
  - “2009 PQRI Measures Groups Specifications Manual”
  - “2009 PQRI Getting Started in Reporting of Measures Groups”

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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

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:
  

- **Reporting Periods**: Available:
  - 12-month (full-year incentive) Jan 1-Dec 31, 2009
  - 6-month (half-year incentive) July 1-Dec 31, 2009

- **Reporting Methods Available**:
  - Claims or Registry

*See Appendix C Decision Tree, 2009 PQRI Implementation Guide:
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

Measures Group Claim Sample

CMS-1500 Claim (Detailed Measures Group) - Sample 1 continues on next page

The following is a sample for reporting the Rheumatoid Arthritis (RA) Measures Group on a CMS-1500 claim and it continues on the next page. Two samples are included, one for reporting of individual measures for the RA Measures Group, the other for reporting of combined RA Measures Group.


The patient was seen for an office visit (0432). The provider reports all measures (0745, 0746, 0747, 0748, 0749, and 0750) in the RA Measures Group:
- RA-Score (202-5ED Therapy) with QOC 0H2F = RA rheumatoid arthritis diagnosis (QOC points to be 714b in Item 2c)
- Measure 0745 (RA-Treatment Goals) only with 0745 = RA rheumatoid arthritis diagnosis (QOC points to be 714c in Item 2c)
- Measure 0746 (RA-Treatment Goals) only with 0746 = RA rheumatoid arthritis diagnosis (QOC points to be 714d in Item 2c)
- Measure 0747 (RA-Follow-up Assessment of Disease Activity) with QOC 0H2F = RA rheumatoid arthritis diagnosis (QOC points to be 714b in Item 2c)
Measures Group Claim Sample (ctd.)

CMS-1500 Claim (Detailed Measures Group) - Sample 1/3

1. Measurment determination (Q21) diagnosis [instructeed in Item 21] meets the patient sample criteria for the RA measure group.

2. Procedure, service, or supply - OPTIMEPCS, Modifier 0 needed.

3. OIGD must be submitted with the charge of $100 or $250, with no additional reimbursement.

- Measure M283: (A) Race (Status Assessment) with OIGD 15765F - RA line-item diagnosis (20 points to be counted in Item 21).
- Measure M283: (B) Age [Diagnosis] (Classification) with OIGD 10905F - RA line-item diagnosis (3 points to be counted in Item 21).
- Measure M283: (C) Diagnoses (I) by type [with ICD-10 codes] (20 points to be counted in Item 21).
- Measure M283: (D) Diagnoses (II) by type [with ICD-10 codes] (20 points to be counted in Item 21).

Net all diagnoses in Item 21 will be reported as a single diagnosis on a claim that will be analyzed as specified in Item 21.

HIPAA requirements: Items 24(d) and (e) contain the HIP of the individual provider that rendered the service when a group is billing.

Version 1.1

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Measures Group Claim Sample - Composite G-Code

CMS-1500 Claim (Sample Measure Group) - Sample 2

A detailed sample of an individual HIP reporting the RA Measures Group or an individual CMS-1500 claim is shown below. This sample shows the reporting of each measure in the group using a composite G-code.


- Item Q21: Diagnosis (Status Assessment) that meets the patient sample criteria for the RA measure group.

- Item Q21: Procedure, service, or supply - OPTIMEPCS, Modifier 0 needed.

- Item Q21: OIGD must be submitted with the charge of $100 or $250, with no additional reimbursement.

The patient was seen for an office visit (0922). The provider reports all measures M283A, M283B, M283C, M283D, M283E, and M283F in the RA Measure Group:

- Item G283: (A) Race (Status Assessment) for the composite G-code OIGD 15765F - RA line-item diagnosis (20 points to be counted in Item 21). The composite G-code OIGD may not be used for performance measures 21, 22, 23, or 24, and O-code reporting must apply.

- Item M283: (A) Diagnoses (I) by type [with ICD-10 codes] (20 points to be counted in Item 21). All diagnoses listed in Item 21 will be used for the FHI analysis. (Measures that require the reporting of more diagnoses on a claim will be analyzed as specified in Item 21.)

HIPAA requirements: Items 24(d) and (e) contain the HIP of the individual provider that rendered the service when a group is billing.

Version 1.2
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:

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

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:
Resources: PQRI Website
www.cms.hhs.gov/pqri

Physician Quality Reporting Initiative

Overview

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 analytic core 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.

Centers for Medicare & Medicaid Services

2009 Electronic Prescribing Incentive Program
Resources:
http://www.cms.hhs.gov/ERXIncentive
- Measure Specifications
- Claims-Based eRx Reporting Principles
- Sample eRx Claim

How the eRx Incentive Program Works

Denominator-eligible Encounter Documented in Medical Record & e-Rx Generated

Analysis Contractor

Confidential Report for e-prescriber

Critical Step

PBM

E-Rx Transmitted to Pharmacy

NCH National Claims History File

Successful e-prescriber = Incentive Payment

Carrier/MAC

Coding & Billing

N-365
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

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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**