The 2009 Physician Quality Reporting Initiative (PQRI)

American Academy of Professional Coders
June 9, 2009

Sylvia W. Publ, MBA, RHIA
CMS Sr. Quality Advisor
Consortium for Quality Improvement
and S&C Operations, CQISCO

Disclaimers

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services. The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide. This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings.

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

CMS

3

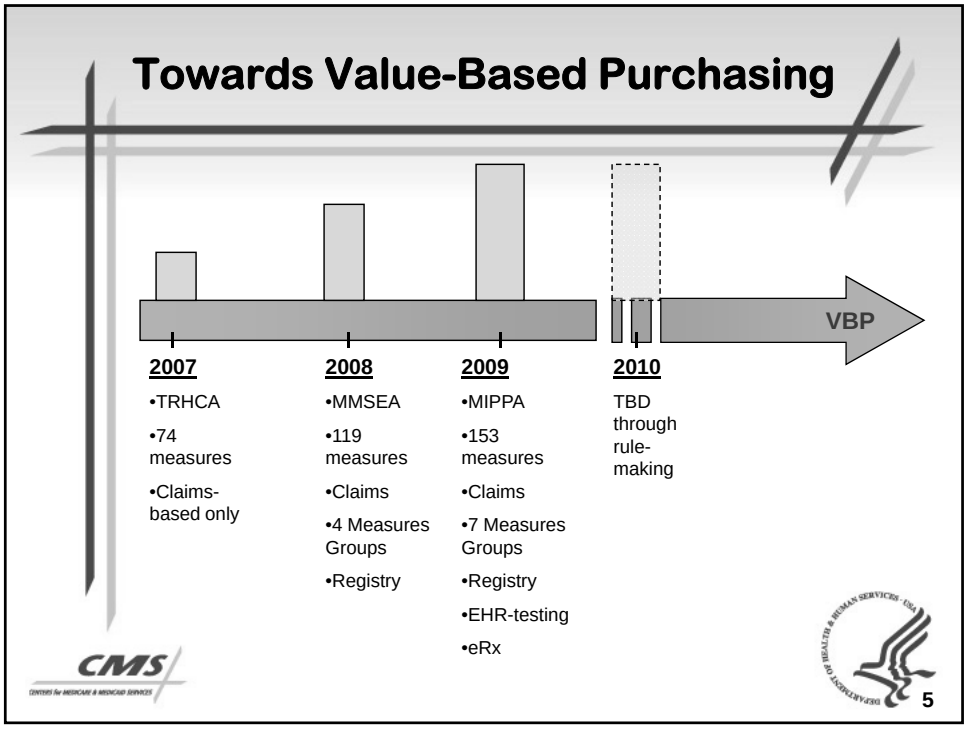
What is PQRI? Who Can Participate?

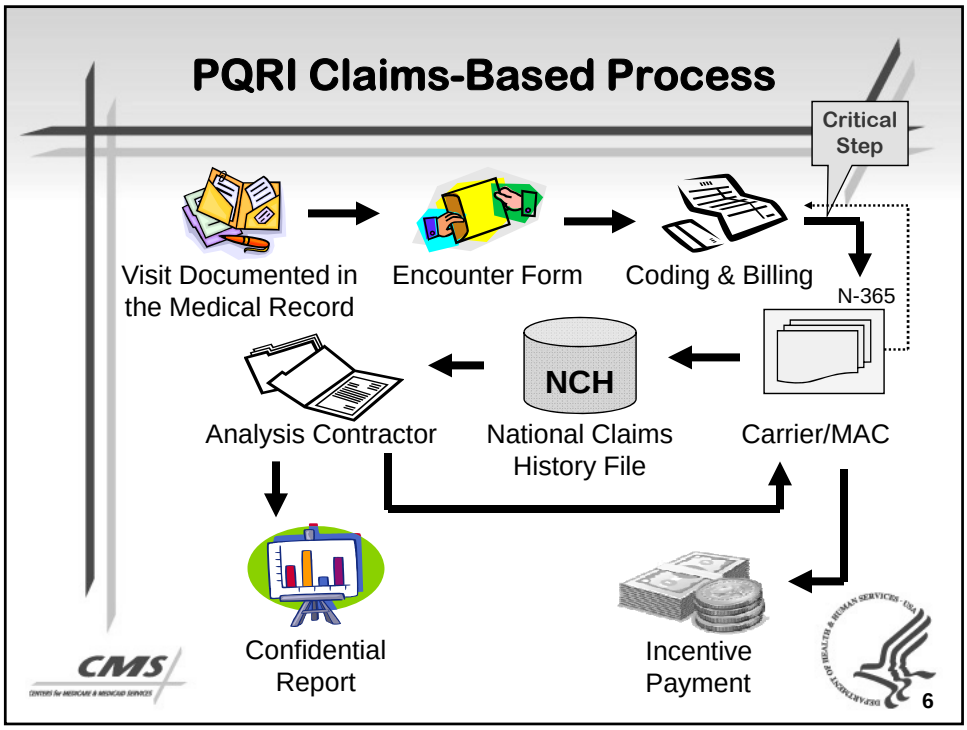
- PQRI is a voluntary individual reporting program that provides an incentive payment to identified eligible professionals (EPs) who satisfactorily report data on quality measures for covered Physician Fee Schedule services furnished to Medicare Part B Fee-for-Service beneficiaries (including Railroad 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

CMS

4


Towards Value-Based Purchasing
VBP
2007
•TRHCA
•74 measures
•Claims-based only
2008
•MMSEA
•119 measures
•Claims
•4 Measures Groups
•Registry
2009
•MIPPA
•153 measures
•Claims
•7 Measures Groups
•Registry
•EHR-testing
•eRx
2010
TBD through rule-making
CMS
5


PQRI Claims-Based Process
Critical Step
Visit Documented in the Medical Record
Encounter Form
Coding & Billing
N-365
Analysis Contractor
NCH
National Claims History File
Carrier/MAC
Confidential Report
Incentive Payment
CMS
6

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"*

CMS

7

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

CMS

8

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.

CMS

9

Claims-Based Reporting Principles (ctd.)

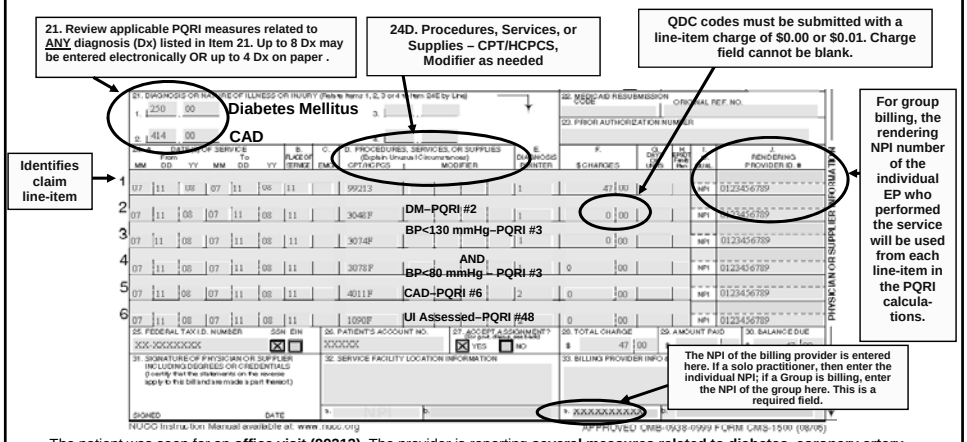
- Entire claims with a zero charge will be rejected. (Total charge for the claim cannot be $0.00).
- QDC line items will be denied for payment by the carrier, but are then passed through the claims processing system for PQRI analysis. EPs will receive a **Remittance Advice** (RA) associated with the 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.

CMS

10

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.



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.

04/09/2009 11

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

CMS

12

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

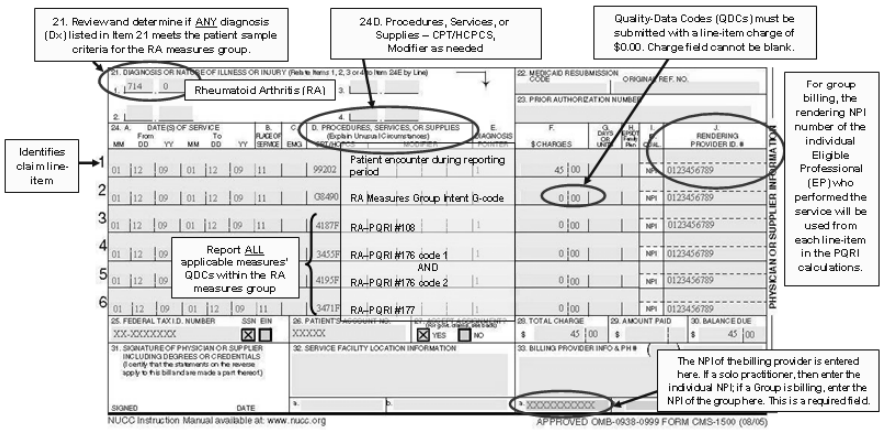
ESRD measures group removed for 2009

13

Measures Group Claim Sample

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

The following is a claim 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 is for reporting of individual measures for the RA measures group; the second sample shows reporting performance of all measures in the group using a composite G-code.
See http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage for more information.



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.
- 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**);

Version 2.1

RA Measures Group Sample 1 continues on the next page.

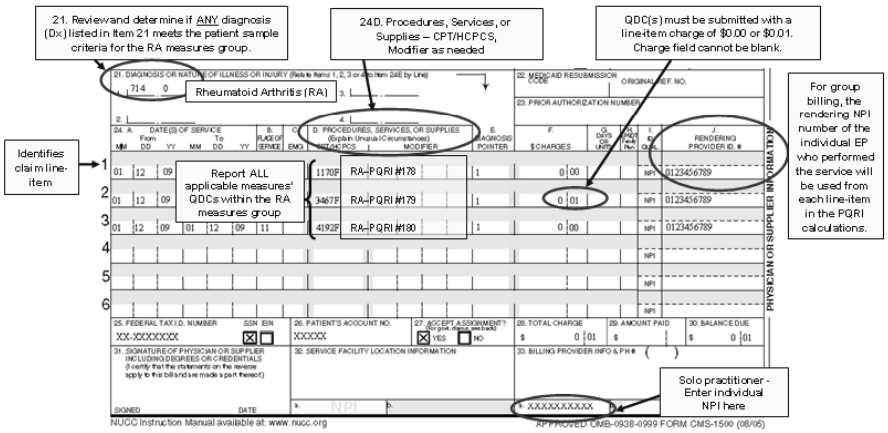
4/9/09
Page 1 of 3

14

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

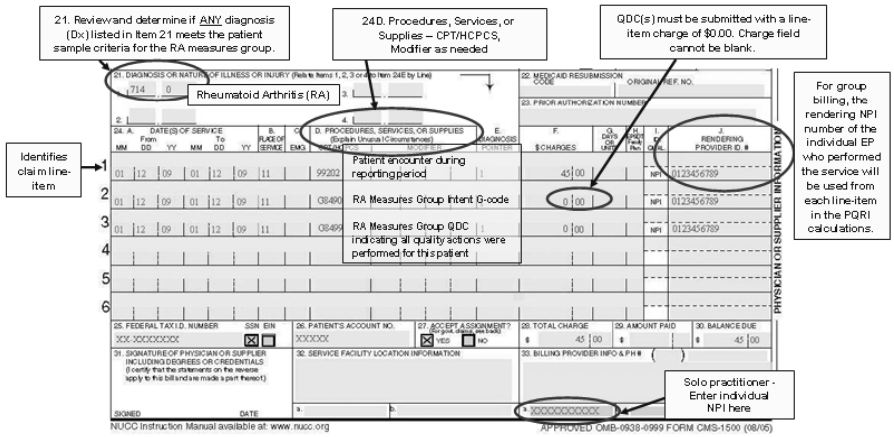


- Measure **#178** (RA-Functional Status Assessment) with **QDC 1170F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**);
- Measure **#179** (RA-Assessment & Classification) with **QDC 3476F** + RA line-item diagnosis (24E points to **Dx 714.0** in **Item 21**); and
- Measure **#180** (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.

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/15_MeasuresCodes.asp#TopOfPage for more information.



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.

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

CMS

17

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***).

CMS

18

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***)

CMS

19

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.

CMS

20

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

21

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

22

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).

CMS

23

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

CMS

24

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

CMS

25

Tips for Success: "Don't Wing It, Ensure it!"

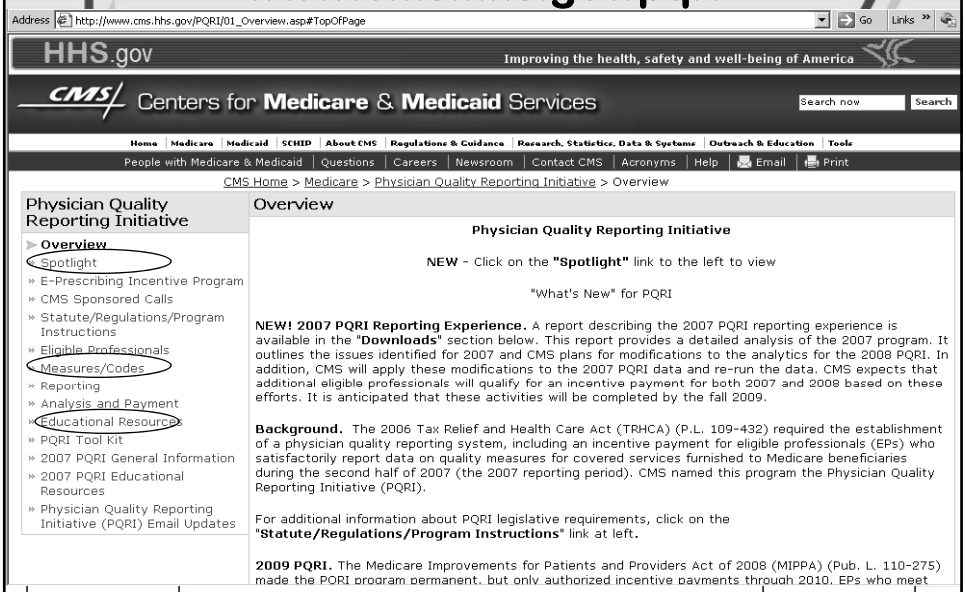
- Understand the measures you have selected to report: both numerator and denominator coding.
- Establish a workflow that allows accurate identification of each denominator-eligible Part B Medicare claim (i.e., claims for services listed in the denominator coding section of each measure's specifications)
- 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

CMS

26

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



27

FAQs, Listserv

Centers for Medicare & Medicaid Services

2009 Electronic Prescribing Incentive Program Resources:

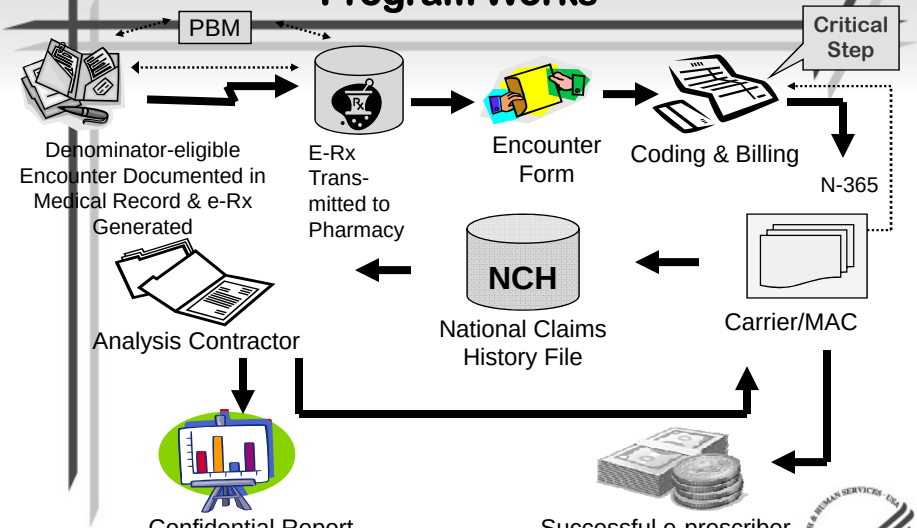
http://www.cms.hhs.gov/ERXIncentive

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

CMS

29

How the eRx Incentive Program Works



CMS

30

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 <u>not Used</u> 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 <u>no</u> 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

CMS

31

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.

CMS

32

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

33

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

34

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)

CMS

35

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

CMS

36

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

CMS

37

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

CMS

38

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***

39