

Participating in Medicare's Physician Quality Reporting Initiative
What You Need to Know
Prepared by the American College of Cardiology

Q1: What is PQRI?

A: PQRI is the "Physicians Quality Reporting Initiative," formerly known as the "Physician Voluntary Reporting Program (PVRP). In December, President Bush signed the Tax Relief and Health Care Act of 2006, mandating establishment of a physician quality reporting system and authorizing a payment incentive for voluntary participation.

Q2: When will the PQRI be implemented?

A: PQRI will be implemented by the Centers for Medicare and Medicaid Services (CMS) during the second half of 2007, July 1-December 31.

Q3: Is participation in PQRI mandatory as a condition of payment under Medicare?

A: Participation in PQRI is strictly voluntary.

Q4: What is the incentive for physicians to participate in PQRI?

A: Physicians who report quality measures for care delivered to Medicare beneficiaries July 1-December 31, 2007 may receive an additional 1.5 percent incentive payment.

Q5: How do I register to participate in the program?

A: Registration will not be necessary. However, those who decide to participate in the program ***must begin reporting*** the appropriate quality measure data on claims submitted to their Medicare claims processing contractor ***on July 1, 2007***.

Analysis is expected to be performed at the individual physician level; therefore accurate and consistent use of individual National Provider Identifier (NPI) on claims is required.

Q6: Who is eligible to participate in the program?

A: All Medicare-enrolled eligible professionals may participate, regardless of whether they have signed a Medicare participation agreement to accept assignment on all claims. Eligible professionals include physicians and other practitioners described in Social Security Act (SSA) Section 1861(r) and Section 1842(b)(18)(C) who provide professional services that get paid under the Medicare Physician Fee Schedule (MFS). Services which are paid under the MFS are eligible for the incentive payment. For a complete list of eligible professionals, click on this link to the CMS website:

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

Q7: What measures are available for cardiologists to report in 2007?

A: Four of the 15 measures from the ACC starter set for cardiology are included in the 74 measures for 2007. The ACC is asking cardiologists to report on these Physician Consortium for Performance Improvement (PCPI), National Quality Forum (NQF)-endorsed measures, which include at this time:

- ACE or ARB therapy for heart failure patients with LVSD
- Antiplatelet therapy prescribed for CAD patients
- Beta-blocker therapy prescribed for CAD patients with prior MI
- Beta-blocker therapy prescribed for heart failure patients with LVSD

All 74 measures are posted on CMS' website at:

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

The specifications for the measures were posted on April 3, 2007 and are also available on the website:

http://www.cms.hhs.gov/PQRI/Downloads/Specifications_2007-02-04.pdf

Q8: How will the measures be reported?

A: Reporting is claims-based. CPT Category II codes (or temporary G-codes where CPT Category II codes are not yet available) will be used for reporting quality data. ***These codes, which supply the measure numerator, must be reported on the same claim as the payment codes, which supply the measure denominator.***

An Alphabetic Index of Performance Measures by Clinical Condition or Topic, which is an appendix to the AMA's CPT coding reference and describes the approved Category II codes, is available on the AMA website at <http://www.ama-assn.org/ama/noindex/category/17467.html>.

Q9: How will the physician document that the quality measure has been achieved?

A: During a visit, inpatient or outpatient, a patient is identified as eligible for reporting based on clinical condition. The eligible professional documents the care in the medical record and completes a worksheet or charge slip for the billing staff to facilitate capture of the quality code for the claims submission process. The ACC has developed a worksheet for use by cardiology practices to help with data collection.
http://www.acc.org/advocacy/pdfs/PQRI_worksheet.pdf

Practices may begin submitting quality codes before July 1 in order to work out administrative processes which can facilitate successful reporting thresholds.

Q10: How will exceptions be recognized and documented?

A: Performance measurement exclusion modifiers were developed for use to indicate that a service specified by a performance measure was considered, but, due to either medical, patient, or systems reason(s) documented in the medical record, the therapy or service was not provided. These modifiers serve as denominator exclusions from the measure. There is also a modifier to indicate that the reason for not providing the therapy or service was not documented.

Exceptions must be documented in the medical record, but how and where in the record is at the discretion of the practice.

Q11: How should the billing staff enter the quality code on the claim?

A: Billing staff enter Category II codes (quality codes) on claims in the same location used for other HCPCS code reporting:

- 837 Electronic Claims:
 - SV1 “Professional Service” segment of the 2400 “Service Line” Loop, SV101-1, SV101-2
- CMS 1500: Field 24D

The “submitted charge” cannot be left blank; it should be \$0.00. If the billing software does not accept a \$0.00 charge, a small amount can be substituted (i.e., \$1.00)

Physicians must continue to report appropriate CPT procedure or E&M codes and ICD-9_CM diagnostic codes for both inpatient and outpatient encounters for which quality measures are relevant. In addition, practices

should consider adding the appropriate CPT Category II codes to their superbills.

Q12: What are the reporting requirements?

A: To be eligible for the incentive payment, an eligible professional must report on at least three quality measures. Of those three measures, reporting must occur on at least 80 percent of the cases for which that measure is reportable. If it is determined that reporting occurred less than 80 percent of the time for any one of the measures, the professional would be ineligible for the incentive payment.

Q13: What happens if there are not three measures that reflect the types of services that I provide in my practice?

A: Those professionals who identify only one or two applicable measures will be asked to report on those measures at least 80 percent of the time. However, those professionals will be audited to determine whether additional measures COULD HAVE been reported based on a sample of the provider's patient population. CMS will then determine whether the one or two measures reported by the professional were in fact the only measures appropriate to be reported. If it is determined that there were additional appropriate measures, the professional would be deemed ineligible for the incentive payment.

Q14: How will the incentive payments be calculated and paid?

A: Participating eligible professionals who successfully report may earn a 1.5 percent bonus, subject to a cap. The 1.5 percent bonus calculation is based on total allowed charges during the reporting period for professional services billed under the Physician Fee Schedule. Claims must reach the National Claims History (NCH) file by February 29, 2008.

The cap may apply when relatively few instances of quality measures are reported. The cap is based on the following calculation:

Individual's instances of reporting quality
X (*multiplied by*)
300%
X
National average per measure payment amount

Q15: What is the “average per measure payment” as outlined in the formula to determine the cap?

A: The “average per measure payment” has not yet been estimated by CMS and is not likely to be estimated prior to implementation of the program. The “average per measure payment” will be calculated using the following formula:

National charges associated with quality measures
/ (divided by)
National instances of reporting

Q16: Can I calculate whether my incentive payment would be subject to the cap?

A: Because the “average per measure payment” is not likely to be estimated prior to the implementation of the program, it will be difficult for physicians to determine in advance whether their incentive payment will be subject to the cap. The best estimate for the incentive payment is to determine 1.5 percent of one’s total allowed charges for the time period of July through December 2006.

Q17: When will I receive the incentive payment?

A: Incentive payments will be paid in a lump sum likely sometime in mid-2008 for data reported in 2007.

Q18: How will the incentive payment be received?

A: For 2007, CMS must use the taxpayer identification number (TIN) as the billing unit, so any bonus incentive payments earned will be paid to the holder of the TIN. Both the NPI and the TIN must be furnished on the claim.

Q19: Once the measures are reported, how will the data collected be used by CMS?

A: Confidential feedback reports will be available at or near the time of the bonus payments in 2008. Reports are expected to summarize reporting and performance rates. 2007 PQRI quality data will **NOT** be publicly reported.

Q20: What are some of the factors that I should consider before determining whether to participate in 2007?

A: Some of the issues you may want to consider include the proportion of your patients for whom the ACC-supported measures are applicable, necessary changes in coding and billing processes, potential changes in billing software, and physician and staff training. On the benefit side of the equation, you will want to think about not only the bonus payment, but also the opportunity for your practice to gain experience with performance measure reporting and the chance to help shape the direction of future quality reporting. ACC is developing a tool to help practices with this process.

Q21: Will the PQRI program continue in 2008?

A: Under current law, voluntary reporting of data on quality measures will continue in 2008. The law gives CMS the discretion to expand measures to include structural measures, such as the use of electronic health records and electronic prescribing technology. Proposed measures for 2008 will be published by August 15, 2007 and finalized by November 15, 2007. The law directs CMS to consider the use of medical registry-based reporting. The law does not, however, specify the availability of incentive payments for reporting in 2008.

Q22: Does the ACC support the PQRI program?

A: While not perfect, the ACC supports the PQRI as a starting point for testing the feasibility of a claims-based, quality self-reporting alternative. The ACC will work closely with CMS and Congress this year to improve the program and to explore the use of the National Cardiovascular Data Registry (NCDR) in the PQRI during 2008. While the ACC has made stopping the estimated 10 percent cut in physician payments scheduled for Jan. 1, 2008 its top priority, the ACC will also lobby for funding to encourage continued voluntary physician participation in quality reporting under Medicare.

The ACC is encouraging cardiovascular specialists to participate in the program in 2007. Greater participation by the cardiovascular community will increase opportunities for the ACC to work with CMS to improve measures and the program generally. Quality measurement is fundamental to quality improvement.

Q23: What should I do right now?

- A. Get your NPI
Bookmark the link: <http://www.cms.hhs.gov/pqri/> . Check it often.
Understand the measures.
Educate staff.

Q24: Who can I contact for help at the ACC?

- A. Eileen Hagan, Associate Director, Payer Advocacy
800-253-4636, ext 6475 or ehagan@acc.org