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Information for Medicare Fee-for-Service Health Care Professionals

News Flash - Revised errata sheets and downloadable versions (April 2007) of the Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals and the Facilitator's Guide – Companion to Medicare Physician Guide: A Resource for Residents, Practicing Physicians, and Other Health Care Professionals have been posted on the CMS Medicare Learning Network. To access these publications, visit *http://www.cms.hhs.gov/MLNProducts/MPUB/list.asp*

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Physician Quality Reporting Initiative (PQRI) Coding & Reporting Principles

Provider Types Affected

Physicians and other practitioners who qualify as eligible professionals to participate in the Centers for Medicare & Medicaid Services (CMS) Physician Quality Reporting Initiative (PQRI)

What Providers Need to Know

CR 5640, from which this article is taken, provides information about, and instructions for, the coding and reporting of, quality measures in the CMS PQRI. The current PQRI reporting period is for claims with dates of service from July 1, 2007 through December 31, 2007. Prompt submission of claims with quality measures is imperative as the claims will only be included in the PQRI analysis (and the associated bonus payment calculation) if received by Medicare's National Claims History (NCH) file on or before February 29, 2008.

Background

CMS (authorized under Title 1, Section 101 of the 2006 Tax Relief and Health Care Act of 2006 (TRHCA)), created the 2007 Physician Quality Reporting Initiative (PQRI), which establishes a financial incentive for eligible professionals to participate in a voluntary quality-reporting program.

These eligible professionals, who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007, may earn a bonus payment (subject to a cap) of 1.5% of total allowed charges for covered Medicare physician fee schedule services during that same period.

2007 Physician Quality Reporting Initiative Specifications

In 2007, PQRI reporting is based on 74 unique measures. The *CMS 2007 Physician Quality Reporting Initiative Specifications* document (referred to in this article and in related CR5640 as *Specifications*) contains the 74 measures associated with clinical conditions that are routinely represented on Medicare fee-for-service claims through the use of diagnosis codes from the *International Classification of Diseases, 9th Revision-Clinical Modification* (ICD-9-CM) and procedure codes from the *HealthCare Common Procedure Coding System* (HCPCS). You can find this *Specifications* document on the CMS PQRI website (http://www.cms.hhs.gov/pqri).

The *Specifications* describe specific measures and associated codes that address various aspects of care such as: prevention, management of chronic conditions, management of acute episodes of care, procedure-related care, resource utilization, and care coordination. They also contain descriptions for each PQRI quality measure and include instructions on how to code each measure's numerator and denominator.

Each measure has a reporting frequency requirement for each eligible patient seen during the reporting period, (for example, report one-time only, once for each procedure performed, once for each acute episode, per each eligible patient). Some measures also include specific performance timeframes related to the clinical action in the numerator that may be distinct from the measure's reporting frequency requirement. (For example, performance timeframes may be stated as "within 12 months" or "most recent.")

PQRI Quality-Data Codes

There are specific PQRI quality-data codes associated with each of the 2007 PQRI measures. These quality-data codes, translate clinical actions so they can be captured in the administrative claims process, are primarily CPT II codes, although temporary G codes will be used on an exception basis where CPT Category II codes have not yet been developed.

PQRI quality-data codes can relay information such as:

- The measure requirement was met;
- The measure requirement was not met due to documented allowable performance exclusions (i.e., using performance exclusion modifiers); and

- The measure requirement was not met and the reason is not documented in the medical record (i.e. using the 8P reporting modifier).

You should be aware that individual PQRI quality-data codes can be associated with more than one measure. In order to determine which quality-data codes and modifiers to report as a line item on a claim, you will need to understand the measures that you have selected to report.

Further, PQRI measures may require that you append a modifier to a CPT Category II code. CPT Category II modifiers serve to exclude patients from a given measure's denominator when the measure's specification permits their use, and may only be reported with CPT II codes. They cannot be used with G-codes. Coding instructions included in the *Specifications* document indicate when a modifier is required.

There are two kinds of CPT II Modifiers:

- 1. Performance Measure Exclusion Modifiers indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. Performance measure exclusion modifiers fall into one of three categories:
  - 1P -- Performance Measure Exclusion Modifier due to Medical Reasons: Includes: Not Indicated (absence of organ/limb, already received/performed, other); Contraindicated (patient allergic history, potential adverse drug interaction, other)
  - 2P - Performance Measure Exclusion Modifier due to Patient Reasons: Includes: Patient declined; economic, social, or religious reasons; other patient reasons
  - 3P - Performance Measure Exclusion Modifier due to System Reasons: Includes: Resources to perform the services not available; insurance coverage/payor-related limitations; other reasons attributable to health care delivery system
- 2. Performance Measure Reporting Modifier facilitates reporting a case when the patient is eligible but an action described in a measure is not performed and the reason is not specified or documented.
  - 8P - Performance Measure Reporting Modifier - action not performed, reason not otherwise specified

Submission of Quality-Data Codes

2007 PQRI requires that the PQRI quality-data codes be added as a line item on the claim submitted to carriers/MACs for the associated covered service. Claims with quality-data code line items can be submitted on the electronic 837-P, or as a paper claim if you are authorized to submit paper claims.

Key claim submission information is listed below:

- The "submitted charge" field for the quality-data code line item cannot be left blank or the claim will be rejected;
- Carriers/MACs *will not* pass Quality-data codes on rejected claims to the National Claims History (NCH) File. You will need to re-submit rejected claims with all of the corrections that the carrier/MAC require, including all quality-data code line items;
- Quality-data code line items must be submitted with a charge of zero dollars ($0.00). If your system does not allow a $0.00 line item charge, use a small amount such as $0.01. (Carriers/MACs will deny quality-data code line items for payment when submitted with a charge of zero dollars or a small amount (e.g., $0.01), but will pass these codes through to the NCH file to be processed for PQRI analysis.)
- The CPT Category II code, which supplies the numerator, must be reported on the same claim form as the payment ICD-9 and CPT Category I codes, which supply the measure's denominator.
    - *Multiple CPT Category II codes can be reported on the same claim, as long as the corresponding denominator codes are also included as line items for that claim.*
    - *Multiple Eligible Professionals (using their National Provider Identifiers (NPIs)) may be reported on the same claim with each quality data code line item corresponding to the services rendered by that professional for that encounter.*
    - *Medicare's claims processing systems will treat previously submitted claims, that are resubmitted only to add PQRI quality-data codes, as duplicate claims. These claims will not be included in the PQRI analysis.*

National Provider Identifier (NPI) Requirement for Participation in 2007 PQRI

To participate in PQRI, you must have an NPI, which you will need to provide in the "Rendering Provider" field on the claim. For claims submitted by group practices, multiple individual eligible professionals can report quality-data codes on the same claim, with each individual's NPI listed in the "Rendering Provider" field for the quality-data code line item. To learn more about the NPI and how to obtain one, visit the NPI website at *http://www.cms.hhs.gov/NationalProvIdentStand/01_Overview.asp* on the Internet.

Timeliness of Claim Submission

Quality-data codes must be reported on claims for payment of services provided during the reporting period which is for dates of service on and after July 1, 2007 through December 31, 2007. It is important to note that *all* claims must reach the NCH file by February 29, 2008 to be included in the bonus calculation. Therefore, you should promptly file claims for services furnished toward the end of the reporting period.

PQRI Analysis

Analysis of PQRI claims will not be conducted by the carrier or the MAC. Rather, CMS will use an independent PQRI analysis contractor to analyze data from NCH and to evaluate PQRI data submitted on claims to determine eligibility for a bonus and to calculate the bonus amount.

2007 PQRI Participation Handbook

CMS will issue a detailed handbook about how to implement PQRI measures in clinical practice, and facilitate successful reporting. The handbook will include information, arranged in alphabetical order by clinical condition, to help you:

- Identify eligible cases based on ICD-9-CM and CPT Category I codes;
- Choose the correct quality-data codes to report;
- Know when to use "exclusion" modifiers (i.e., 1P, 2P, and 3P); and
- Know when to use a reporting modifier (i.e., 8P).

The handbook will also include sample clinical vignettes that will describe how to code and report a particular measure under unique circumstances that may arise.

Additional Information

You can find the official instruction, CR5640, issued to your carrier or A/B MAC by visiting *http://www.cms.hhs.gov/Transmittals/downloads/R277OTN.pdf* on the CMS website. Also, you may wish to review MLN Matters article, MM5558, for additional information. That article provides an overview of the 2007 PGRI and identifies who is eligible to participate. The article is available at *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5558.pdf* on the CMS website.

If you have any questions, please contact your carrier or A/B MAC at their toll-free number, which may be found at *http://www.cms.hhs.gov/MLNProducts/downloads/CallCenterTollNumDirectory.zip* on the CMS website.