PQRI Fact Sheet

www.cms.hhs.gov/PQRI

Statute and Overview

On December 20, 2006, the President signed the Tax Relief and Health Care Act of 2006 (TRHCA). Section 101 under Title I authorizes the establishment of a physician quality reporting system by the Centers for Medicare & Medicaid Services (CMS). CMS has titled the program the Physician Quality Reporting Initiative (PQRI).

PQRI establishes a financial incentive for eligible professionals to participate in a **voluntary quality reporting program**. 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**.

CMS is developing and implementing pay for performance to encourage the provision of high-quality, cost-effective care for Medicare beneficiaries. To view the legislative language and see a detailed list of eligible professionals, visit the CMS PQRI website.

Specifications

In 2007, PQRI reporting is based on 74 unique measures. The CMS *2007 Physician Quality Reporting Initiative Specifications* document is posted on the CMS PQRI website. These specifications contain 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, Ninth Revision, Clinical Modification (ICD-9-CM)* and procedure codes from the Healthcare Common Procedure Coding System (HCPCS).

The *Specifications* document describes specific measures and associated codes that address various aspects of care such as: prevention, management of chronic conditions, acute episode of care management, procedure-related care, resource utilization, and care coordination. The *Specifications* document contains descriptions for each PQRI quality measure and includes 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 (e.g., report one-time only, once for each procedure performed, once for each acute episode, per each eligible patient).

Some measures 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. PQRI quality-data codes are CPT® II codes, though temporary G codes will be used on an exception basis where CPT Category II codes have not yet been developed. PQRI quality-data codes translate clinical actions so they can be captured in the administrative claims process. For example, PQRI quality-data codes can relay that:

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

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

CPT II Modifiers

Individual PQRI quality-data codes can be associated with more than one measure or can require a specific modifier. PQRI measures may require an eligible professional to append a modifier to a CPT Category II code. CPT II modifiers may only be reported with CPT II codes and cannot be used with G codes. Coding instructions included in the *Specifications* document indicate when a modifier may be applicable for a given measure. CPT II Modifiers fall into two categories:

1. Performance Measure Exclusion Modifiers

There are three exclusion modifiers that indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record. One or more exclusions may be applicable for a given measure. Certain measures have no applicable exclusion modifiers. Refer to the measure specifications to determine the appropriate exclusion modifiers.

2. Performance Measure Reporting Modifier

*"**8P** - Action not performed, reason not otherwise specified"* 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.

Integration of PQRI Quality-Data Code Reporting Into Your Care Delivery Process

1. **Select Measures**
   Eligible professionals should select measures that address the services they provide to patients. When selecting measures, consider:
   - Conditions treated
   - Types of care provided (e.g., preventive, chronic, acute)
   - Settings of care (e.g., office, ED, surgical suite)
   - Individual quality improvement goals for 2007
2. **Define Team Roles**
   Discuss measures and plan your approach to capture quality data for reporting with team.
3. **Modify Workflows and Billing Systems**
   Walk through your care process and determine what systems changes will be required to capture quality-data codes.
   - Consider using worksheets or other tools for data capture
   - Discuss systems capabilities with practice management software vendors and third-party billing vendors and clearinghouses
   - Test systems

PQRI Participation Strategies: Reporting Quality Data

- The CPT Category II code, which supplies the numerator, must be reported on the same claim as the payment ICD-9-CM and CPT Category I codes, which supply the denominator of the measures.
- Multiple CPT Category II codes can be reported on the same claim, as long as the corresponding denominator codes are also on that claim.
- The individual National Provider Identifier (NPI) of the participating professional must be properly used on the claim.
- Multiple eligible professionals with their NPIs may be reported on the same claim with each quality-data code line item corresponding to the services rendered by the professional for that encounter.
- Submitted charge field cannot be blank.
- Line item charge should be $0.00; if a system does not allow $0.00 line item charge, use a small amount like $0.01.
- Entire claims with a zero charge will be rejected.
- Claims must reach the National Claims History (NCH) file by February 29, 2008 to be included in the analysis.
- Quality-data code line items will be denied for payment but then passed through to the NCH file for PQRI analysis.
- Claims that are resubmitted only to add CPT Category II codes will not be included in the analysis.

Ensuring Success

- Take advantage of the educational resources available to you on the PQRI website. These include a 2007 PQRI tool kit designed to help eligible professionals be successful.
- Start reporting July 1, 2007 to increase the probability of achieving the 80 percent rate of reporting during the reporting period.
- Report on as many measures as possible to increase the likelihood of achieving successful reporting.
- Report on as many eligible patients as you can to decrease the probability of being subject to the bonus cap.
- Ensure that quality codes are reported on the same claim as the diagnosis and CPT I codes.

For additional educational resources or information on the Physician Quality Reporting Initiative, the CMS PQRI website contains all publicly available information at: http://www.cms.hhs.gov/PQRI.

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