Centers for Medicare & Medicaid Services

2008 Physician Quality Reporting Initiative (PQRI)

April 30, 2008

National Provider Call

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Physician Quality Reporting Initiative (PQRI)

The 2006 Tax Relief and Health Care Act (TRHCA):

- Authorized establishment of a physician quality reporting system, 2007 PQRI
- Included 1.5% incentive payment for satisfactory reporting quality data on covered professional services furnished to Medicare beneficiaries July 1, 2007 - December 31, 2007

2007 PQRI Measures

- 74 measures
- Consensus developed and endorsed
- Apply to specialty categories for over 95% physician Part B services
- Applicability depends on services rendered, not designated specialty
- Measures posted on website www.cms.hhs.gov/PQRI

The 2006 Tax Relief and Health Care Act (TRHCA)

2007 PQRI Reporting Criteria:

- Report each applicable measure:
  - if <3, report each for ≥80% of patients
  - if ≥3, report at least 3 for ≥80% of patients
- Incentive payment of 1.5% of total allowable charges for Medicare Physician Fee Schedule (PFS) covered professional services furnished during reporting period, subject to per measure cap

2007 PQRI Participation

2007 Preliminary Data:

- ~16% participation - submitted at least 1 quality-data code
- Slightly over half of participants likely to qualify for bonus

2008 PQRI Measures

- Published in 2008 Physician Fee Schedule (PFS) Rule November 2007
- 119 measures
  - 117 clinical measures
  - 2 structural measures
- Clinical measures apply to specialties, accounting for over 95% of Medicare Part B spending
- Structural measures apply broadly across specialties and disciplines

2008 PQRI: The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)

MMSEA authorized continuation of PQRI for 2008

- Eliminated cap on incentive payment
- Incentive payment remained 1.5% of total allowable charges for PFS covered professional services furnished during reporting period
- Required alternative reporting periods and alternative reporting criteria for 2008 and 2009.

There Are More Ways to Participate in 2008 PQRI!

- **TRHCA** - authorized 1 option, implemented through the 2008 Medicare Physician Fee Schedule Rule
- **MMSEA** – required establishment of alternative reporting periods/reporting criteria for measures groups and registry based reporting
- 8 new options established effective Apr 15, 2008: See *2008 PQRI: Establishment of Alternative Reporting Periods and Reporting Criteria* document posted at: www.cms.hhs.gov/PQRI

2008 Reporting Options - Overview

- Two Reporting Periods
  - 12 months (January 1 - December 31, 2008)
  - 6 months (July 1 - December 31, 2008)
- Total of 9 PQRI Reporting Methods
  - 3 claims-based
  - 6 registry-based

Alternative Reporting Periods

- January 1, 2008 – December 31, 2008
- July 1, 2008 – December 31, 2008

3 Claims-Based Options

- Submit claims for PFS-covered services furnished during applicable reporting period
- **Reporting Options (3):**

  January 1, 2008 – December 31, 2008 (one-year)
  - Claims-based reporting of Individual PQRI Measures
    - Report each applicable measure:
      - if <3, report each for ≥80% of patients
      - if ≥3, report at least 3 for ≥80% of patients

  July 1, 2008 – December 31, 2008 (half-year)
  - Claims-Based Reporting of Measures Groups
    - 15 Consecutive Patients

    OR
  - Claims-Based Reporting by Measures Groups
    - for 80% of Eligible Patients

Note: claims-based reporting for 6-month reporting period only available for reporting of Measures Groups

Claims-Based: Individual PQRI Measures

Reporting Period: Jan 1, 2008 – Dec 31, 2008
Reference: 2008 PQRI Measures Specifications (12/31/07) • <3 quality measures report ≥80% of cases in which measure(s) was reportable • >3 quality measures report ≥80% of cases on 3 measures which were reportable **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to this reporting period

Claims-Based: Measures Groups

Reporting Period: Jul 1, 2008 – Dec 31, 2008
15 Consecutive Patients

Reference: 2008 PQRI Claims-Based Measures Groups Specifications

- Report one measures group by submitting group-specific G-code to indicate intent (e.g. submit G8485 on first diabetic patient to begin reporting Diabetes measures group):
    1. **Diabetes Mellitus - G8485**
    2. **ESRD - G8488**
    3. **CKD - G8487**
    4. **Preventive Care - G8486**

  Note: It is only necessary to submit the measures group-specific G-code one time

- Report measures within selected measures group on claims for 15 consecutive Medicare patients
- Initiate reporting of 15 consecutive patients -- July 1, 2008
- Report all measures in measures group applicable to 15 consecutive patients for whom measures of one measures group apply

- **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to this reporting period

Claims-Based: Measures Groups (cont)

Reporting Period: Jul 1, 2008 – Dec 31, 2008 80% of applicable patients
Reference: 2008 PQRI Claims-Based Measures Groups Specifications • Report measures within selected measures group on claims for 80% of Medicare patients during reporting period for whom measures of one measures group apply • **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to this reporting period

Claims-Based Measures Group Successful Reporting Scenario

Diabetes Mellitus Measures Group (#1, #2, #3, #117, #119)

Mr. Jones presents for office visit with Dr. Thomas

Mr. Jones has diagnosis of Diabetes Mellitus (DM)

Step 1:
Dr. Thomas selects DM measures group as a PQRI reporting option.

(Reporting period up to 6 months, beginning July 1, 2008)

HCPCS code G8485

Step 2:
Dr. Thomas reviews specifications for 5 measures in the DM measures group to identify measures applicable to Mr. Jones.

Dr. Thomas submits appropriate CPT II codes based on measures identified.

Step 3a:
Dr. Thomas reports 15 consecutive patients meeting denominator criteria starting with: (Mr. Jones = patient #1).

OR

Step 3b:
Dr. Thomas reports on at least 80% of patients during reporting period meeting denominator criteria for applicable DM measures

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CMS 1500 – Claims-Based Example: Initiating Measures Group Reporting

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 250 . 00
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER			E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	07	01	08	07	01	08	11		99213				1	50 00			NPI	0123456789
2	07	01	08	07	01	08	11		3048F				1	0			NPI	0123456789
3	07	01	08	07	01	08	11		G8485				1	0			NPI	0123456789
4																	NPI	
5																	NPI	
6																	NPI	

Measure #2

25. FEDERAL TAX I.D. NUMBER	SSN	EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
XX-01234567	☐	☐	987654321	☒ YES ☐ NO	$ 50 00	$	$ 50 00

Note: Measures group-specific G-code submitted on <u>first</u> diabetic patient (meeting the denominator for one or more measures within the Diabetes Mellitus measures group). Submitting G8485 (circled above) starts counting consecutive patients for Diabetes measures group.

Review remaining DM measures within group and report QDCs for each applicable measure.

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6 Registry-Based Options

Reporting Period: **January 1, 2008 - December 31, 2008**	**Reporting Period:** **July 1, 2008 - December 31, 2008**
Individual Measures: •80% of applicable cases Minimum 3 measures	**Individual Measures:** •80% of applicable cases Minimum 3 measures
One Measures Group: •30 consecutive patients OR •80% of applicable cases	**One Measures Group:** •15 consecutive patients OR •80% of applicable cases

Registry-Based: Individual PQRI Measures

Reporting Period: Jan 1, 2008 – Dec 31, 2008
80% of applicable cases

Reference: 2008 PQRI Measures Specifications (12/31/07)

- On behalf of EPs, registries submit data for at least 3 measures on Medicare Part B-only patients
- Report data on measures for ≥80% of cases in which measures were reportable
  - Just as in claims-based reporting of individual measures
- **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to this reporting period

Registry-Based: Individual PQRI Measures (cont)

Reporting Period: Jul 1, 2008 – Dec 31, 2008 80% of applicable cases
Reference: 2008 PQRI Measures Specifications (12/31/07) • On behalf of EPs, registries must successfully submit <u>at least 3 measures</u> for Medicare Part B-only patients • Report data on measures for ≥80% of cases in which measures were reportable   – Just as in claims-based reporting of individual measures • **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to the portion of this reporting period for which the EP submitted data

Registry-Based: Measures Groups

Reporting Period: Jan 1, 2008 – Dec 31, 2008
30 Consecutive Patients

Reference: 2008 PQRI Claims-Based Measures Groups Specifications

1. **Diabetes Mellitus**
2. **ESRD**
3. **CKD**
4. **Preventive Care**

*Note: Use of a G-code **not** required for registry-based submission*

- On behalf of EPs, registries submit data for all measures within selected measures group for 30 consecutive patients for whom measures of one measures group apply
- Consecutive patients must include Medicare; may include some non-Medicare
- **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to this reporting period

Registry-Based: Measures Groups (cont)

Reporting Period: Jul 1, 2008 – Dec 31, 2008
15 Consecutive Patients

Reference: 2008 PQRI Claims-Based Measures Groups Specifications

1. **Diabetes Mellitus**
2. **ESRD**
3. **CKD**
4. **Preventive Care**

*Note: Use of a G-code **not** required for registry-based submission*

- On behalf of EPs, registries submit data for all measures within selected measures group for 15 consecutive patients who are eligible for one or more measures within the measures group
- Consecutive patients <u>must include Medicare; may include some non-Medicare</u>
- **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to this reporting period

Registry-Based: Measures Groups (cont)

Reporting Period: Jan 1, 2008 – Dec 31, 2008
80% of applicable patients

Reference: 2008 PQRI Claims-Based Measures Groups Specifications

1. **Diabetes Mellitus**
2. **ESRD**
3. **CKD**
4. **Preventive Care**

*Note: Use of a G-code **not** required for registry-based submission*

- On behalf of EPs, registries identify eligible Medicare patients based on denominator coding and submit data for 80% of applicable measures within selected measures group for whom the measures of one measures group apply
- **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to the portion of this reporting period for which the EP submitted data

Registry-Based: Measures Groups (cont)

Reporting Period: Jul 1, 2008 – Dec 31, 2008
80% of applicable patients

Reference: 2008 PQRI Claims-Based Measures Groups Specifications

1. **Diabetes Mellitus**
2. **ESRD**
3. **CKD**
4. **Preventive Care**

*Note: Use of a G-code **not** required for registry-based submission*

- On behalf of EPs, registries must identify eligible Medicare patients based on denominator coding and submit data for 80% of applicable measures within the selected measures group for whom the measures of one measures group apply
- **Financial incentive:** 1.5% of total allowed PFS charges for Part B covered services which apply to the portion of this reporting period for which the EP submitted data

Measures Groups

4 Clinically Related Measures Groups:

- Diabetes
  (5 measures)
- End Stage Renal Disease (ESRD)
  (4 measures)
- Chronic Kidney Disease (CKD)
  (4 measures)
- Preventive Care
  (9 measures)

Measures Groups (cont)

Diabetes Mellitus:

1 – Hgb A1c Poor Control

2 – LDL Control

3 – High Blood Pressure Control

117 – Dilated Eye Exam

119 – Urine Screening for Microalbumin

Measures Groups (cont)

End Stage Renal Disease (ESRD):

78 - Vascular Access for hemodialysis (HD) patients

79 - Influenza Vaccination

80 - Plan of Care for patients with anemia

81 - Plan of Care for inadequate HD

Measures Groups (cont)

Chronic Kidney Disease (CKD):

120 – ACE or ARB

121 – Testing for Ca, Phos, IPTH, Lipids

122 – Blood Pressure Management

123 – Plan of Care: Elevated Hgb for patients on ESA

Measures Groups (cont)

Preventive Care:

39 - Screening/Therapy for Osteoporosis in Women

48 - Assessment of Urinary Incontinence in Women

110 - Influenza Vaccination

112 - Screening Mammography

111- Pneumonia Vaccination for Patients 65 Years and Older

113 - Colorectal Cancer Screening

114 - Inquiry Regarding Tobacco Use

115 - Advising Smokers to Quit

128 - Weight Screening and Follow-up

2008 PQRI Registry Timeline

- Mar - Aug 2008: Testing submission mechanism per 2008 PFS Rule
- Apr 30, 2008: CMS to post registry requirements for payment
- Aug 31, 2008: CMS will announce qualified registries
- Dec 2008 - Feb 2009: Submission for payment will be accepted

2008 Registries

- CMS testing 2 options in 2008
  - 1st: Registry collects and sends claims-type information; CMS calculates reporting/ performance rates
  - 2nd: Registry calculates and reports provider's reporting/performance rates to CMS
- Testing will allow CMS to validate registry data in the first year

PQRI 2008 Registry Pilot Testing Participants

The following registries have been selected to participate in pilot testing:

- The Society of Thoracic Surgeons
- Cedaron
- University of Wisconsin Medical Foundation
- ICLOPS
- The National Cardiovascular Data Registry
- Cielo MedSolutions
- American Osteopathic Association
- Rush Health Associates
- Wellcentive
- Wisconsin Collaborative for Healthcare Quality
- General Electric
- Phytel

Payment

- EP must satisfactorily report under one method to qualify for 1.5% incentive
- CMS will review data submitted via all methods to determine satisfactory reporting and eligibility
  - Maximum incentive payment = 1.5% of total allowed PFS charges for Part B covered services for the applicable reporting period
- If qualify for more than one 2008 PQRI reporting method -- receive incentive for longest reporting period

2008 PQRI Goals

- Expand Participation in PQRI
  - Expand measures for 2009
  - Implement registry-based reporting
  - Implement alternative reporting criteria
  - Implement alternative reporting periods
  - Prepare to accept EHR-reported measures for 2009

2008 Participation Consideration

- Not Too Late to Begin Reporting
  - Alternative half-year reporting period
    (July 1, 2008 – December 31, 2008)
  - 60 measures reported only once per reporting period (patient-level measures)
  - Registry-based reporting options

2008 Participation Consideration (cont)

- Successful reporting:
  - 8 Additional Reporting Options for 2008
    - Alternative reporting periods
    - Alternative reporting criteria
    - Registry-based reporting
      - Does not depend on claims
  - No Cap
    - 1.5% for all Medicare Part B services in reporting period

2008 Participation Consideration (cont)

- Claims-based submission for services performed in 2008 ends 2/28/2009 (claims with 2008 dates of service must be processed by 2/28/2009)
- Registry-based submission for services performed in 2008 ends 2/28/2009

Physician Quality Reporting Initiative (PQRI)

- Outreach and Education
  - Engagement through communication
    - Website at: https://www.cms.hhs.gov/PQRI
    - Medicare Carrier/Medicare Administrative Contractor (MAC) inquiry management
    - Speakers' Bureau
  - Education for participants and their office staff
  - Tools to support successful reporting

Additional PQRI Resources

For more information on PQRI you may contact your Regional Office, Carrier, or visit http://www.cms.hhs.gov/pqri

Thank you!