

Slide 1

The 2009 Physician Quality Reporting Initiative (PQRI) & E-Prescribing Incentive Program

American College of Cardiology
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Slide 2: 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.

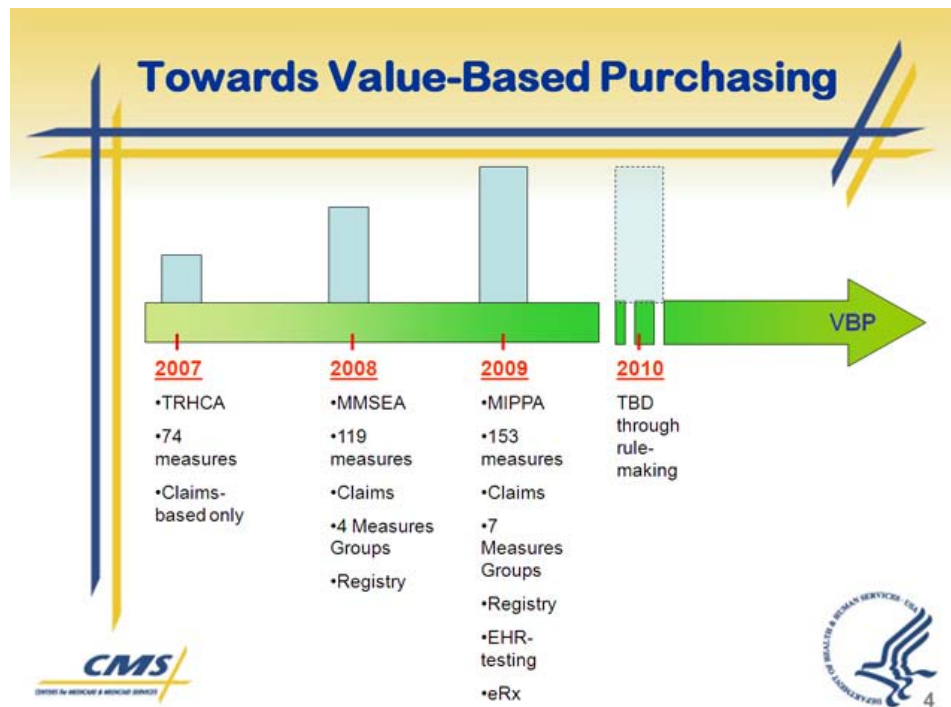
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Slide 3: Overview

- Value-Based Purchasing and PQRI
- PQRI Reporting: Measures & Codes
- Implementing PQRI
- Resources

Slide 4: Towards Value-Based Purchasing



Graphic – This frame displays a broad, green arrow originating at the left side of the frame and extending to the right side of the frame with the arrowhead on the right side. The arrow represents a continuum over time for the years 2007, 2008, 2009, and 2010. The green arrow is solid until it extends to 2010. At this point, there are three brief breaks in the arrow and then the arrow continues in a solid line to the arrowhead at the far right. The only text in the arrow is located in the arrowhead, which displays VBP (acronym for Value-Based Purchasing). Each year mark on the VBP arrow is labeled by year in red text and has a corresponding turquoise bar that extends upward vertically from the green horizontal VBP arrow. The heights of each vertical bar vary in height, increasing each year between 2007 (which is the shortest) and 2009. The vertical bars for these years are solid turquoise and bordered by solid black lines. For 2010, the height of the turquoise bar is the same as the one for 2009; however, the turquoise bar for 2010 contains some white dot shading and is bordered by a broken black line.

Text – The 2007 bar has three bullets located vertically under the VBP continuum arrow.
First bullet = TRHCA (acronym for Tax Relief and Health Care Act)
Second bullet = 74 measures
Third bullet = Claims-based only

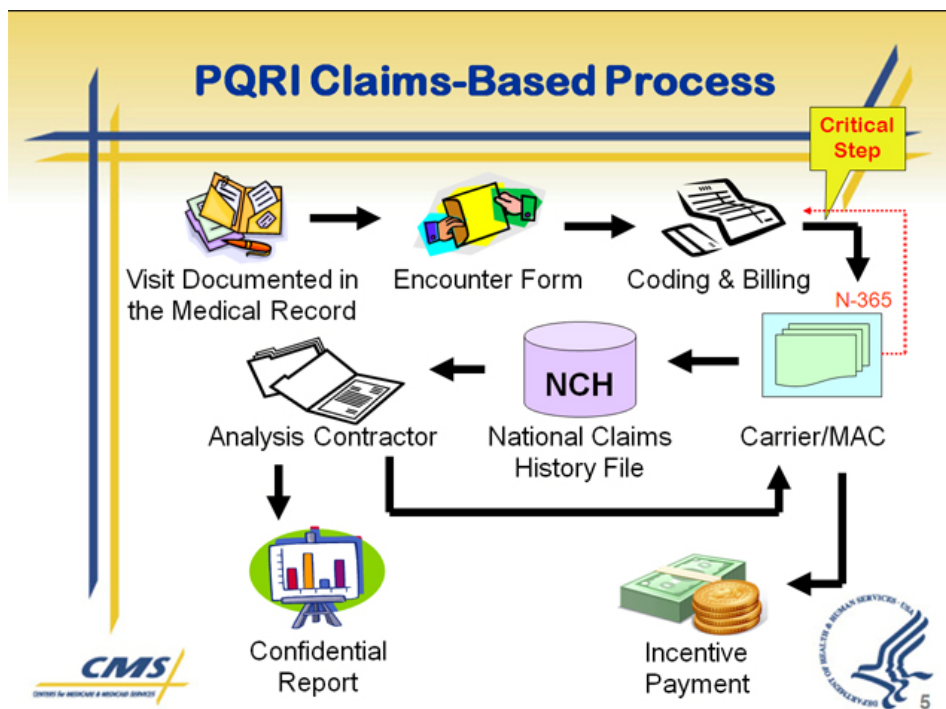
The 2008 bar has five bullets located vertically under the VBP continuum arrow.
First bullet = MMSEA (acronym for Medicare, Medicaid, and SCHIP Extension Act of 2007)
Second bullet = 119 measures
Third bullet = Claims
Fourth bullet = 4 Measures Groups
Fifth bullet = Registry

The 2009 bar has seven bullets located vertically under the VBP continuum arrow.

- First bullet = MIPPAA (acronym for Medicare Improvements for Patients and Provider Act)
- Second bullet = 153 measures
- Third bullet = Claims
- Fourth bullet = 7 Measures Groups
- Fifth bullet = Registry
- Sixth bullet = EHR-testing (acronym for electronic health record)
- Seventh bullet = eRx (acronym for electronic prescription)

The 2010 bar has no bullets located vertically under the VBP continuum arrow, but the following text displays: TBD (acronym for To Be Determined) through rule-making.

Slide 5: PQRI Claims-Based Process



Located in the upper left corner of the frame is the first graphic.

Graphic 1 – Folders with papers, clips, and a writing utensil

Label for Graphic 1 – Visit Documented in the Medical Record

A black arrow leads from the first graphic to the second graphic, which is located to the right of Graphic 1.

Graphic 2 – one hand transferring a folder/envelope to another person’s hand

Label for Graphic 2 – Encounter Form

A black arrow leads from the second graphic to the third graphic, which is located to the right of Graphic 2.

Graphic 3 – an unfolded statement with an envelope in the background

Label for Graphic 3 – Coding and Billing

A black arrow leads from the third graphic to the fourth graphic, which is located to the right of and below Graphic 3. A text box pointing at this arrow displays the following red text: Critical Step.

Graphic 4 – three pages

Label for Graphic 4 – Carrier/MAC N-365

Three arrows flow from this graphic: one is a red dotted line arrow that points back to Graphic 3; the second is a solid black arrow that leads from Graphic 4 to Graphic 5 (a lavender cylinder labeled National Claims History File), which is located to the left of Graphic 4; the third is a solid black arrow that leads from Graphic 4 to a money graphic labeled Incentive Payment. The Incentive Payment graphic is the first of two final process outcomes and is located in the bottom right corner of the frame.

A black arrow leads from the fifth graphic to the sixth graphic, which is located to the left of Graphic 5.

Graphic 6 – open folder with report pages

Label for Graphic 6 – Analysis Contractor

Two arrows flow from this graphic: one is a solid black arrow that leads from Graphic 6 to Graphic 7 (an easel displaying a bar graph labeled Confidential Report) which is located below Graphic 6. Confidential Report is the second of two final process outcomes and is located in the lower left corner of the frame. The second arrow is a solid black arrow that leads from Graphic 6 back to Graphic 4 (Carrier/MAC) and then to the Incentive Payment money graphic.

Slide 6: 2009 PQRI Measures/Codes/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

Slide 7: 2009 PQRI Resources

http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage

- **Registry-based Reporting**
 - Individual Measures
 - Measures Groups
- **List of Qualified Registries**

http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage

- MLN Matters Articles

- Fact Sheets
- Tip Sheets
- **2009 PQRI Patient-Level Measures List**

Slide 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 - NPI/TIN)

All diagnoses reported on the base claim will be included in PQRI analysis.

Claims may **NOT** be resubmitted simply to add or correct 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.

Slide 9: Claims-Based Reporting Principles (continued from previous slide)

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 and 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.

Slide 10: CMS-1500 Claim Example

CMS-1500 Claim Example
 Example of an individual NPI reporting on a single CMS-1500 claim. See <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf> for more information.

21. Review applicable PQRI measures related to ANY diagnosis (Dx) listed in Item 21. Up to 8 Dx may be entered electronically.

24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier as needed.

QDC codes must be submitted with a line-item charge of \$0.00. Charge field cannot be blank.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION / ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER		24. PROCEDURE, SERVICE OR SUPPLIES (Explain Unusual Circumstances) (CPT/HCPCS, MODIFIER)		25. CHARGES		26. RENDERING PROVIDER I.D.#		
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	
250.00																				
414.00																				

NEDC Instruction Manual available at: www.nedc.org APPROVED CMB-0938-0999 FORM CMS-1500 (08/06)

• 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. This includes putting the individual NPI on the QDC line-items as well.
 • The Tax ID associated with the NPI(s) on this claim is shown in Item 25.

Text – Description of CMS-1500 Claim Example

This frame displays an example of an individual NPI reporting on a single CMS-1500 claim, items 21 through 33. See <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf> for more information. Some item fields contain sample data and associated text box comments. Item numbers and titles, sample data, and corresponding notes are displayed as follows:

Item – 21. Diagnosis or Nature of Illness or Injury (Relate Items 1, 2, 3, or 4 to Item 24E by Line)

Sample data – 1 displays 250.00 for Diabetes Mellitus. 2 displays 414.00 for CAD. 3 and 4 contain no sample data.

Text box note – Review applicable PQRI measures related to ANY diagnosis (DX) listed in Item 21. Up to 8 Dx may be entered electronically.

Note: The “ANY” text is underlined and capitalized.

Item – 22. Medicaid Resubmission Code / Original Ref. No.

Sample data – None

Note – None

Item – 23. Prior Authorization Number

Sample data – None

Note – None

Item – 24.A. Date(s) of Service, From MM/DD/YY, To MM/DD/YY

Sample data – All dates displayed for Lines 1 through 6 are 07/11/08

Note – Vertical numerals 1 through 6 identify claim line-items containing the sample data “From MM/DD/YY” and “To MM/DD/YY” dates.

Item – 24.B. Place of Service

Sample data – All lines display 11

Note – None

Item – 24.C. EMG

Sample data – None

Note – None

Item – 24.D. Procedures, Services, or Supplies (Explain Unusual Circumstances), CPT/HCPCS / Modifier

Text box note – 24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier as needed

Sample data for CPT/HCPCS, Modifier cells – Line 1 = 99213, Line 2 = 3048F (DM-PQRI number 2), Line 3 = 3074F BP less than 130 mmHg-PQRI number 3), Line 4 = 3078F (CAD-PQRI number 6), Line 5 = 4011F (BP less than 80 mmHG-PQRI number 3), Line 6 = 1090F (UI Assessed-PQRI number 48)

Item – 24.E. Diagnosis Pointer

Sample data – Lines 1 through 4 display 1. Lines 5 and 6 display 2.

Note – None

Item – 24.F. Dollar Charges

Sample data – Line 1 displays 47.00. Line 2 through 6 display 0.00.

Note – Quality Data Codes (QDCs) must be submitted with a line-item charge of 0.00 dollars. Charge field cannot be blank.

Item – 24.G. Days or Units

Sample data – None

Note – None

Item – 24.H. EPSOT Family Plan

Sample data – None

Note – None

Item – 24.I. ID. Qual.

Sample data – Lines 1 through 6 display NPI

Note – None

Item – 24.J. Rendering Provider ID. Number

Sample data – Lines 1 through 6 display 0123456789

Note – For group billing, the rendering NPI number of the individual Eligible Professional (EP) who performed the service will be used from each line-item in the PQRI calculations.

Item – 25. Federal Tax ID. Number, SSN/EIN

Sample data – XX-XXXXXXX, SSN is marked

Note – None

Item – 26. Patient’s Account No.

Sample data – XXXXX

Note – None

Item – 27. Accept Assignment? (For govt. claims, see back), Yes/No

Sample data – Yes is marked

Note – None

Item – 28. Total Charge, Dollars

Sample data – 47.00

Note – None

Item – 29. Amount Paid, Dollars

Sample data – None

Note – None

Item – 30. Balance Due, Dollars

Sample data – 47.00

Note – None

Item – 31. Signature of Physician or Supplier Including Degrees or Credentials (I certify that the statements on the reverse apply to this bill and are made a part thereof.) Signed/Date

Sample data – None

Note – None

Item – 32. Service Facility Location Information, a./b.

Sample data – None

Note – None

Item – 33. Billing Provider Info and Phone Number (including area code), a./b.

Sample data – None

Note – a. Solo practitioner – Enter individual NPI here

Footer 1 – NUCC Instruction Manual available at www.nucc.org

Footer 2 – Approved OMB-0938-0999 Form CMS-1500 (08/05)

Beneath the claim example, eight bulleted statements display as follows:

First bullet = 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:

Second bullet = Measure number 2 (LDL-C) with QDC 3048F plus diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);

Third bullet – Measure number 3 (BP in Diabetes) with QDCs 3074F plus 3078F plus diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);

Fourth bullet = Measure number 6 (CAD) with QDC 4011F plus CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and

Fifth bullet = Measure number 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.

Sixth bullet = 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.

Seventh bullet = NPI placement: Item 24J must contain the NPI of the individual provider that rendered the service when a group is billing. This includes putting the individual NPI on the QDC line-items as well.

Eighth bullet = The Tax ID associated with the NPI(s) on this claims is shown in Item 25.

Slide 11: 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

Determine PQRI reporting period

Slide 12: 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 eligible professional (See **Patient Level Measures List**).

Review **2009 PQRI Measures Specifications Manual for Claims and Registry & Release Notes** for selected measures carefully to understand reporting instructions, coding, and frequency of reporting.

Slide 13: Selection of 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” is a tool designed to help practices select a reporting method (see **Appendix 2009 PQRI Implementation Guide**)

Slide 14: 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 with EDI vendors.
- **Read and discuss** with staff: reporting principles and specifications for each of the measures selected for reporting in PQRI.

Slide 15: Prepare to Participate in PQRI

Develop a process for concurrent data collection so that all eligible claims and PQRI quality data codes (QDC) are correctly identified and submitted

Regularly review the **Remittance Advice** notices from the Carrier/AB MAC to ensure you receive **N365** remark code for each QDC submitted

Slide 16: 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>

Slide 17: Contributing Factors

Split claims

Diagnosis Pointer

Missing NPI

QDC reported on denied claim

Missing QDC on eligible claim (eg, incident to billing)

Shared codes (#7, #8) (#8 changed to G codes for 2008)

Slide 18: 2008 PQRI Aggregate QDC Error Report- Pre-Analytic Fix

<http://www.cms.hhs.gov/PQRI/Downloads/2008QDCError3rdQuarter.pdf>

Measure	# Submitted	% Valid
#5 HF-ACE/ARB	215,291	53.0% <i>(incorrect Dx)</i>
#6 CAD- Antiplatelet	858,708	77.5% <i>(incorrect Dx/HCPCS)</i>
#7 CAD-Beta-blocker	274,452	15.06% <i>(incorrect Dx/HCPCS)</i>
#8 HF-Beta-blocker	116,911	61.0% <i>(incorrect Dx)</i>

Slide 19: Common Errors

Individual rendering NPI was not listed on the claim, therefore, that claim was not included in PQRI analysis

Missed reporting QDC on eligible claim (e.g., incident to claims)

Reporting a QDC on a claim for a diagnosis that was not listed in the denominator for the measure

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 1 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 to be reported

Reporting a QDC with a CPT1 modifier

Reporting a QDC on a claim for a service that was not covered by Medicare (or claim was denied by carrier)

Slide 20: Benefits of PQRI Participation

Receive confidential feedback reports to support quality improvement

Earn a bonus incentive payment

Make an investment in the future of the practice

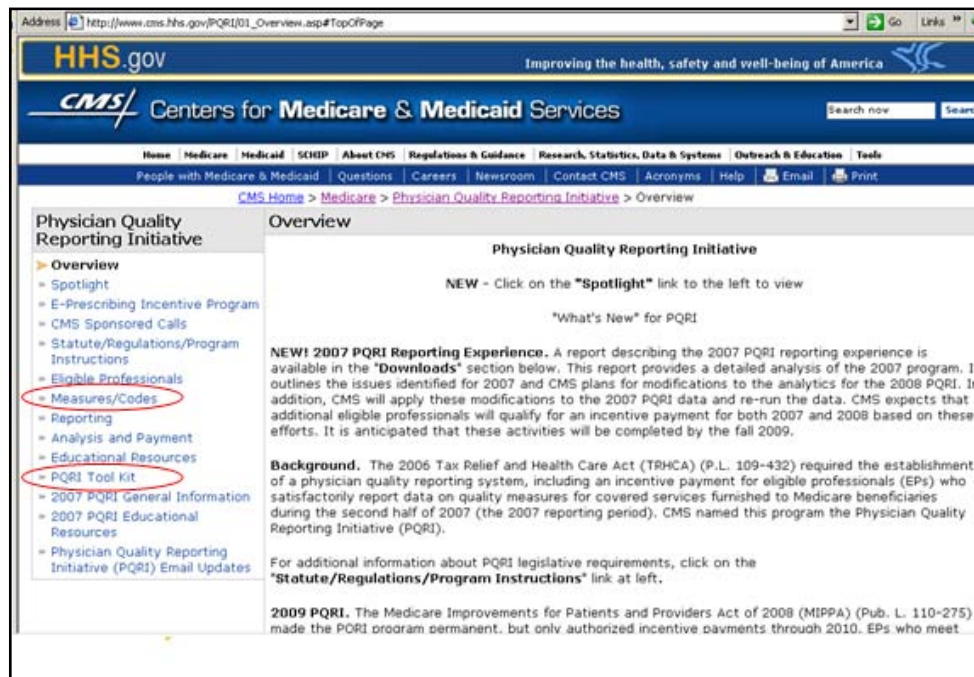
Prepare for higher bonus incentives over time

Prepare for pay-for-performance

Prepare for public reporting of performance results

Slide 21: Resources: PQRI Website

www.cms.hhs.gov/pqri



Graphic – This frame displays the top portion of a screen print from <http://www.cms.hhs.gov/PQRI/>

The text on the screen print is divided into two columns.

The column on the left covers approximately one-third of the frame and is titled Physician Quality Reporting Initiative. A list of bulleted text below this displays the following:

Bullet = Overview

First sub-bullet = Spotlight

Second sub-bullet = E-prescribing Incentive Program

Third sub-bullet = CMS Sponsored Calls

Fourth sub-bullet = Statute/Regulations/Program Instructions

Fifth sub-bullet = Eligible Professionals

Sixth sub-bullet = Measures/Codes (encased in a red oval)

Seventh sub-bullet = Reporting

Eighth sub-bullet = Analysis and Payment

Ninth sub-bullet = Educational Resources (encased in a red oval)

Tenth sub-bullet = PQRI Toolkit (encased in a red oval)

Eleventh sub-bullet = 2007 PQRI General Information

Twelfth sub-bullet = 2007 PQRI Educational Resources

The column on the right covers approximately two-thirds of the frame and is labeled Overview. The following text is displayed in this section:

Physician Quality Reporting Initiative

NEW – Click on the “Spotlight” link to the left to view “What’s New” for PQRI

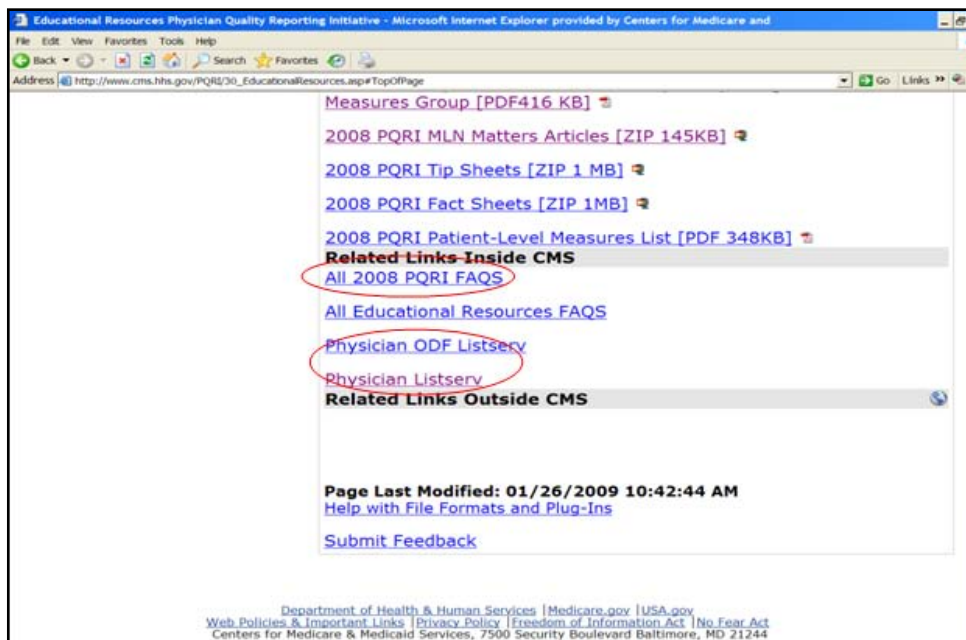
NEWS! 2007 PQRI Reporting Experience. A report describing the 2007 PQRI reporting experience is available in the “Downloads” section below. This report provides a detailed analysis of the 2007 program. It outlines the issues identified for 2007 and CMS plans for modifications to the analytics for the 2008 PQRI. In addition, CMS will apply these modifications to the 2007 PQRI data and re0run the data. CMS expects that additional eligible professionals will qualify for an incentive payment for both 2007 an 2008 based on these efforts. It is anticipated that these activities will be completed by the fall 2009.

Background. The 2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-432) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPS) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI).

For additional information about PQRI legislative requirements, click on the “Statute/Regulations/Program Instructions” link at the left.

2009 PQRI. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) Pub. L. 110-275) made the PQRI program permanent, but only authorized incentive payments through 2010. EPs who meet

Slide 22: FAQs, Listserv



Graphic – This frame displays a screen print of http://cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage, which includes the following items and links:

Measures Group [PDF416 KB]
2008 PQRI MLN Matters Articles [ZIP 145KB]
2008 PQRI Tip Sheets [ZIP 1 MB]
2008 PQRI Fact Sheets [ZIP 1 MB]
2008 PQRI Patient-Level Measures List [ZIP 1 MB]

Category – Related Links Inside CMS

All 2008 PQRI FAQs – Note: This is circled in red.
All Educational Resources FAQs
Physician ODF Listserv – Note this is circled in red.
Physician Listserv – Note this is circled in red.

Category – Related Links Outside CMS

Page Last Modified: 01/26/2009 10:42:44 AM
Help with File Formats and Plug-Ins
Submit Feedback

Slide 23: Thank You

For questions about PQRI contact:

- Carrier
- Regional Office or
- Submit through the PQRI mailbox: pqri_inquiry@cms.hhs.gov

For questions regarding measure construct contact measure developer identified on **2009 PQRI Measures List**