| CMS Manual System | Department of Health & Human Services (DHHS) |
|---|---|
| Pub 100-20 One-Time Notification | Centers for Medicare & Medicaid Services (CMS) |
| **Transmittal 277** | **Date: MAY 18, 2007** |
| | **Change Request 5640** |

**Subject: Physician Quality Reporting Initiative (PQRI) Coding & Reporting Principles**

**I. SUMMARY OF CHANGES:** This Change Request transmits overview-level information on the Physician Quality Reporting Initiative (PQRI) Coding and Reporting Principles. The carriers and Part A/B MACs will find this information helpful in responding to provider inquiries about the PQRI.

**New / Revised Material**
**Effective Date: May 18, 2007**
**Implementation Date: May 18, 2007**

*Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.*

**II. CHANGES IN MANUAL INSTRUCTIONS:** (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

| R/N/D | Chapter / Section / Subsection / Title |
|---|---|
| N/A | |

**III. FUNDING:**
Funding for implementation activities will be provided to contractors through the regular budget process.

**IV. ATTACHMENTS:**

**One-Time Notification**

**Unless otherwise specified, the effective date is the date of service.*

**Attachment – One-Time Notification**

| Pub. 100-20 | Transmittal: 277 | Date: May 18, 2007 | Change Request: 5640 |
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**SUBJECT: Physician Quality Reporting Initiative (PQRI) Coding & Reporting Principles -- Informational Only**

**Effective Date**: May 18, 2007

**Implementation Date:** May 18, 2007

## I. GENERAL INFORMATION

**A. Background:** The Centers for Medicare and Medicaid Services (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. 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.

**B. Policy: 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 (hereafter referred to as *Specifications*) is posted on the CMS PQRI Web site (www.cms.hhs.gov/pqri ). This document 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).

The *Specifications* describe 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* contains descriptions for each PQRI quality measure and includes instructions on how to code each measure's numerator and denominator as described below.

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).

Individual PQRI quality-data codes can be associated with more than one measure or can require a specific modifier. Determining which quality-data codes and modifiers to report as a line item on a claim requires that the eligible professional understand the measures they have selected to report.

PQRI measures may require that the eligible professional 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. 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 is required.

CPT II Modifiers fall into two categories:

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 for those eligible professionals who 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.
- Quality-data codes on **rejected claims** *will not* be passed onto to the National Claims History (NCH) File by the Carrier/MAC. Rejected claims will need to be re-submitted with all corrections required by the Carrier/MAC, including all quality-data code line items.
- Quality-data code line items must be submitted with a **charge of zero dollars** ($0.00). If a system does not allow a $0.00 line item charge, use a small amount such as $0.01.

- The Carrier/MAC 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 denominator of the measure.
- **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** with 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.
- **Previously submitted claims** that are resubmitted only to add PQRI quality-data codes will be treated by claims processing systems as duplicate claims and will not be included in the PQRI analysis.

**NPI Requirement for Participation in 2007 PQRI**
To participate in PQRI, the eligible professional must have a (NPI). The individual NPI of the participating eligible professional must be 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.

**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. Claims for services furnished toward the end of the reporting period should be filed promptly.

**PQRI Analysis**
Analysis of PQRI claims will not be conducted by the carrier or the MAC. An independent PQRI analysis contractor will receive claims data from NCH and will 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 the following information, arranged in alphabetical order by clinical condition, to assist eligible professionals to:

- 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 for each measure that will describe how to code and report a measure under circumstances that may arise that are unique to a measure.

## II. BUSINESS REQUIREMENTS TABLE

*Use "Shall" to denote a mandatory requirement*

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DMERC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| 5640.1 | NOTE: This document is for educational purposes only. | X | | | X | | | | | | | |

## III. PROVIDER EDUCATION TABLE

| Number | Requirement | Responsibility (place an "X" in each applicable column) | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | A/B MAC | DME MAC | FI | CARRIER | DMERC | RHHI | Shared-System Maintainers | | | | OTHER |
| | | | | | | | | FISS | MCS | VMS | CWF | |
| 5640.2 | A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv.<br>Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. | X | | | X | | | | | | | |

## IV. SUPPORTING INFORMATION

**A. For any recommendations and supporting information associated with listed requirements, use the box below:**
*Use "Should" to denote a recommendation.*

| X-Ref Requirement Number | Recommendations or other supporting information: |
|---|---|
| | |

**B. For all other recommendations and supporting information, use this space:**

## V. CONTACTS
**Pre-Implementation Contact(s):**

Sylvia Publ, (312) 353-9815
Dr. Susan Nedza (312) 886-5341

**Post-Implementation Contact(s):** Carriers and A/B MACs should follow the inquiry flow process outlined in JSM/TDL-07278 post implementation.

## VI. FUNDING
**A.** ***For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC)*:**
Funding for implementation activities will be provided to contractors through the regular budget process.

**B.** ***For Medicare Administrative Contractors (MAC):***

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.