



Medicare Physicians Quality Reporting Initiative Program Description

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Medicare Physicians Quality Reporting Initiative Program Description

Congress enacted a law in December 2006, the Tax Relief and Health Care Act, that established a voluntary program within Medicare that pays physicians a bonus for reporting on quality measures that apply to their patients from July 1 through December 31, 2007. The Centers for Medicare and Medicaid Services (CMS) worked diligently to develop this Medicare pay-for-reporting program, named the Physicians Quality Reporting Initiative (PQRI), consistent with the parameters established in the law and to disseminate PQRI information to physicians. Below is the College summary of the PQRI program.

Quality Measures

CMS will pay physicians for reporting on certain quality measures—which are intended to determine if physicians are performing evidence-based elements of care—that pertain to Medicare beneficiaries who have specific conditions and/or meet specific requirements. CMS has identified 74 quality measures that will be used in the PQRI. An example of a PQRI quality measure is:

Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus:

Percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had most recent LDL-C level in control (less than 100mg/dl)

The majority of the quality measures have been approved by the National Quality Forum (NQF), a membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting, and the AQA, a multi-stakeholder process co-founded by ACP that aims to effectively and efficiently improve performance measurement. ACP has consistently called for quality measures to be approved by both of these entities.

The CMS list of 74 “PQRI Quality Measures” is available at <http://www.cms.hhs.gov/PQRI/Downloads/PQRIMeasuresList.pdf>.

Reporting Quality Measures Through the Claims Process

Physicians are to report quality measures through the claims process, using Current Procedural Terminology (CPT) Category II codes, which are found in the back of the CPT code book, or CMS-maintained HCPCS alphanumeric “G” codes on the standard CMS claim form. In April 2007, CMS released the specific CPT Category II and/or G codes that physicians are to use to report PQRI quality measures. At that same time, CMS released the list of the CPT and International Classification of Diseases (ICD-9) codes to which each quality measure applies—together the CPT and ICD-9 codes will determine the cases/encounters in which a quality measure should be reported.

To illustrate, below are the code specifications for the Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus quality measure mentioned above. The specifications state that a physician is expected to report this measure a minimum of once during a 12-

month period. CMS is working on a mechanism for physicians to include that LDL-C was performed within 12 months but outside the PQRI six-month reporting period.

- To report most recent LDL-C performed, select:
 - CPT II 3048F: Most recent LDL-C < 100 mg/dL;
 - CPT II 3049F: Most recent LDL-C 100-129 mg/dL; or
 - CPT II 3050F: Most recent LDL-C ≥ 130 mg/dL.

Append modifier “1P” to CPT II code to report that LDL-C was not performed in the last 12 months for medical reasons

Append modifier “8P” to CPT II code to report that LDL-C was not performed in past 12 months for reasons not otherwise specified

- Eligible patients are those with diabetes—ICD-9 codes 250.00-250.93, 648.00-648.04
- Eligible encounters are:
 - Office visits, 99201-99215;
 - Nursing facility services, 99304-99310;
 - Domiciliary services, 99324-99337;
 - Home services, 99341-99345; and
 - Initial Preventive Physical Exam (“Welcome to Medicare Visit), HCPCS G0344

CMS instructs physicians to report the applicable quality measure code using the same claim form used to bill the Medicare payable, medically necessary service to which the quality measure pertains. This means that the CPT Category II or G codes are reported:

- For electronic claims using ASC X12N 837 professional health care claim transaction, submit in the SV1 “Professional Service” Segment of the 2400 “Service Line” Loop. The data element for the procedure code is SV101-2 “Product/Service ID.” Note that it is also necessary to identify in this segment that you are supplying a HCPCS code by submitting the “HC” code for data element SV101-1.
- For paper claims using the CMS 1500 form, enter the quality reporting code in field 24D.

You must enter a charge for the quality measure code on the claim form. You should enter the charge of \$0.00. If your billing system/clearinghouse system will not accept a \$0.00 charge, enter a nominal charge of \$0.01.

Your reporting the quality measure code on the same claim as the payable service, e.g. an E/M service code, to which it pertains enables Medicare to track reporting while avoiding an increase in the number of physician claims that it must process. However, this precludes a physician from later submitting a quality measure he or she failed to submit with a claim for the corresponding

payable, service and/or from back auditing and submitting all quality measure codes for all eligible encounters at the end of the reporting period.

Physicians will not need to report the same quality measure for subsequent eligible encounters during the reporting period. For example, a physician would not have to report the LDL-C Category II code when a diabetic beneficiary receives an office visit service after the physician previously reported the LDL-C level for that patient when billing an earlier eligible encounter.

CMS will determine whether individual physicians are eligible for the bonus payment by tracking physician reporting through each physician's National Provider Identifier (NPI) number. The National Provider Identifier (NPI) is the single, unique identifier that the government has selected to comply with the administrative simplification provisions in the Health Insurance Portability and Accountability Act (HIPAA). CMS requires physicians to apply for and receive their NPI by May 23, 2007. Physicians will use their NPI in place of all other previously-assigned commonly used identifiers, e.g. the Physician Identification Number (PIN), assigned by state/regional Medicare carriers, the Unique Provider Identification Number (UPIN), a national number assigned by CMS. The individual physician who performed a billed service is identified on the standard CMS claim form. This is the case even if the payment for the service is made directly to the group practice to which the individual belongs. Group practices will also receive an NPI, however, each individual physician in the group will maintain his or her individual NPI that will remain the same even that physician leaves the group. It is imperative that the NPI of the physician who performed the service be properly listed on the claim form so that CMS can make an accurate determination on the physician's quality measure reporting.

No 2007 Direct Reporting through Registry or Electronic Health Record

CMS will not be able to accept quality measure reporting extracted from an electronic health record (EHR) and/or reported to a registry in 2007. CMS can only accept quality measures reported on the standard claim form. CMS is investigating use of these reporting mechanisms for 2008.

No Registration Needed to Participate

Physicians will not have to register to participate in the PQRI. CMS will know which physicians are participating in this voluntary program when Medicare processes the claims that physicians are billing for their services—claims that will or will not include quality measures.

Medicare Participation Status has No Effect on PQRI

Physicians are able to participate in the PQRI and qualify for the bonus payment whether they are Medicare participating or non-participating. Further, non-participating physicians who take part in the PQRI should report quality measures as appropriate even when they submit non-assigned claims.

Qualifying for the Reporting Bonus Payment

To receive the 1.5% PQRI bonus payment, a physician must report on the number of quality measures applicable to his or her practice up to a maximum of three measures. Specifically:

- A physician for which one quality measure is applicable must report on that one measure
- A physician for which two quality measures are applicable must report on those two measure
- A physician for which three quality measures are applicable must report on those three measure
- A physician for which more than three quality measures are applicable must report on any three measures

CMS will make its determination as to who qualified for the PQRI bonus on the individual physician level, meaning that all physicians in a group practice do not need to participate. Each individual physician must report on at least 80% of his or her own applicable cases/encounters for each quality measure up the maximum of three measures (or fewer if less apply).

Accordingly, it is imperative that the NPI of the physician who provided the service be listed on the claim form. The number of eligible cases/encounters—as determined by ICD-9 and CPT codes—determine the denominator in the reporting score calculation equation. The number of times you report the quality measure when it is appropriate for a case/encounter is the numerator. The reporting score is percentage derived from dividing the numerator by the denominator.

For physicians for whom more than three quality measures apply, each physician can choose the three measures that are relevant to his or her practice and report on those. A physician can choose to report on more than three measures. As internists typically treat patients with many of the conditions addressed in these 74 quality measures, they will likely need to successfully report on three quality measures to receive the bonus. CMS will calculate the percentage reporting score on each quality measure and use the three highest scores to determine if the physician meets the 80% minimum requirement to qualify for the bonus. An internist may want to report on more than three measures to provide some leeway in case he or she fails to meet the 80% threshold needed for reporting on the any of the selected measures. This approach may be beneficial especially considering that Medicare will provide no feedback on the accuracy of reporting during the reporting period. Medicare will only notify the physician of the percentage to which he or she successfully reported on each measure after the reporting concludes on December 31, 2007. For example, a physician would qualify for the 1.5% bonus if CMS determined that he or she reported on: measure 1 – 90%; measure 2 – 87%; measure 3 – 77%; and measure 4 – 95%.

Calculating the Bonus Amount

The PQRI bonus payment is 1.5% of the sum of your Medicare allowed charges for the July 1 – December 31, 2007 reporting period—not just the allowed charges for the services for which you reported a quality measure. As required by the law, CMS will determine the amount of allowed charges attributed to the physician by using claims for services performed during the July – December 2007 reporting period that are accepted into the CMS contractor claims systems by

February 29, 2008 (in technical terms, this means that the claims have made it into the CMS Medicare Claims File History). Contractors accept “clean” claims into their system shortly after the physician submits them. Clean claims are those that contain all of the necessary information for the claim to be accepted by the automated claims processing system for adjudication, i.e. claims that are not returned to the physician as incomplete, or “unprocessable.” The reporting bonus is calculated based on the Medicare allowed charge amount for services furnished during the reporting period (and submitted by February 29, 2008); and not on claims submitted during the reporting period. The CMS aggregate allowed charges amount will be the number off which the 1.5% reporting bonus is calculated.

Medicare rules allow physicians a minimum of 12 months after the date a service is actually provided to submit a claim for that service. While few physicians wait anywhere near that long to submit their claims, the PQRI program provides another incentive to submit your claims shortly after providing the services.

Services Included in Total Allowed Charges Computation

A physician’s total allowed charges will be the sum of services paid to the physician under the Medicare physician fee schedule—E/M services, procedures, tests (including both the technical and professional components). Laboratory tests will not count as they are paid under the lab fee schedule. CMS reports that law precludes the agency from counting Health Professional Shortage Area (HPSA) and Physician Scarcity Area bonus payments toward the total physician allowed charges from which the bonus payment amount is determined.

A Hypothetical Bonus Payment to Qualifying Internist

Using an example where an internist who qualifies for the reporting bonus and receives \$200,000 in Medicare revenue, i.e. allowed charges, a year, the internist would receive a reporting bonus of 1.5% of the estimated \$100,000 in Medicare revenue for the six-month reporting period July – December 2007—meaning the internist’s bonus would be \$1,500.

Bonus Payment Cap

The law imposes a cap on the amount of the bonus payment made to a physician. The law specifies a formula that CMS is to use to determine a payment cap for each individual physician. CMS states that the intent of the cap is to encourage instances of reporting—as the more measures a physician reports the higher that physician’s cap, or conversely, to prevent those who report quality measures infrequently but still qualify for the reporting bonus from getting the maximum amount to which they would otherwise be entitled.

The Cap Calculation

The law requires CMS to calculate an “average per measure payment amount.” The law instructs CMS to calculate this amount as:

- Total amount of allowed charges for all services with which a quality measure is reported by all physicians (eligible professionals) during the reporting period; divided by the
- Total number of quality measures reported on by all physicians during the reporting period

CMS will use national, all physician reporting figures to calculate the average payment per measure.

The law states that the per physician bonus payment cap is:

- Total number of times a physician reports on quality measures from July – December 2007; multiplied by
- 300% of the “average per measure payment”

CMS states that it cannot conduct a reasonable simulation to determine an expected average per measure payment amount that internists and other physicians could use to determine if they may be affected by the cap because there are too many variables.

Hypothetical Cap Examples

ACP, however, has developed a few hypothetical examples to give internists and those who practice in internal medicine subspecialties a sense as to whether the cap may apply to them. These examples show that the cap almost certainly will not limit the bonus paid to an internist. Further, the cap is unlikely to affect physicians who practice other specialties even if they report quality measures infrequently. See the examples below for details.

Individual Internist Example #1

- Average Per Measure Amount
 - \$75,000,000 in allowed charges; divided by 1,000,000 services = average per measure amount of \$75
- An internist reports on 500 PMs during the six month reporting period July – December 2007
- Internist’s Cap: The internist’s bonus payment amount cap the is 500 services multiplied by 300% of the average per measure payment of \$75, or \$225, (500 x \$225) meaning **the internist’s cap is \$112,500**
- Internist’s Bonus Amount: Using an assumption that an internist receives approximately \$200,000 in Medicare revenue, i.e. allowed charges a year, an internist who qualifies for the reporting bonus would receive 1.5% of the estimated \$100,000 in Medicare revenue for the six-month reporting period—meaning the **internist’s bonus would be \$1,500**—substantially under the \$112,000 hypothetical cap.

Internist Example #2

What if the average per service amount is lowered from the \$75 estimated above to the national average-Medicare allowed charge for a 99213, a mid-level established patient office visit, the

most commonly reported service and the service likely to be billed when reporting many of the PQRI quality measures, of approximately \$60? The cap is still extremely unlikely to adversely affect internists.

- An internist would not be affected by the cap even if he or she was able to qualify for the bonus by reporting as few as 50 quality measures. Using the lower average per measure payment of \$60, the internist's cap would be \$9,000 (50 services x \$180, which is the average per measure payment of \$60 x 300%). An internist would be fortunate to have to worry about the cap.

Non Internal Medicine Example

Despite the Congress' intent to limit the bonus payment for those who report on a small number of measures, it seems likely that the cap would apply to any physician only in extreme circumstances.

- An orthopedic surgeon would not be adversely affected by the cap even under the extreme hypothetical example of the orthopedic surgeon qualifying for the bonus despite reporting a quality measure only 10 times during the six-month reporting period. This extreme orthopedic surgeon example shows:
 - Estimated Medicare revenue: \$175,000 for full year, meaning \$84,125 for six-month period
 - 1.5% Reporting Bonus: \$1,262
 - Hypothetical number of quality measures reported on: 10
 - Cap: 10 x \$180 = \$1,800

Assuming that the minimum amount of quality measures a physician must report to qualify for the bonus is 10, he or she would have to generate in excess of \$120,000 in Medicare revenue in the six-month period to be adversely affected by the cap.

Making Bonus Payments; Cutting the Bonus Check

Medicare will make the bonus payment at the practice level as the law requires that CMS make bonus payments to the Tax Identification Number—typically the employer identification number (EIN), which is listed on the claim form on which the quality measure is reported. An EIN is assigned by the Internal Revenue Service (IRS) to a practice (practice can be an individual physician or multiple physicians). This means that Medicare will pay the bonus earned by a physician who is in a solo practice to that physician and pay the bonus earned by a physician in a group practice to the group practice as an entity. The practice will receive a single check for an amount equal to the sum of the bonus earned by each member of the group (which could be one or multiple physicians) in mid-2008. CMS states that the “check stub” will list the reporting score of each individual in the group and the bonus amount earned by each group member who qualified for the bonus.

Physicians who practice in multiple sites during the reporting period will have their quality measure-reporting assessed for each site. The amount of the bonus that a physician earns at each

site will be identified when the group practices receives the bonus payment check for the collective successful reporting done by the physicians at that site.

CMS states that it cannot make the payment prior to mid-2008 because it must consider claims with the date of service between July – December 2007 that Medicare contractors accept into their claims processing system up until February 29, 2008 to determine the per-physician allowed charges on which the bonus is based.

Validation

While CMS will presume that a quality measure is applicable to a physician if the physician reports on it, the law requires the agency to validate—by “sampling or other means”—that a physician has reported on applicable quality measures. CMS interprets this to mean that if a physician reports on less than three quality measures, the agency must check to make sure that additional measures do not apply to that physician. The law prohibits CMS from making a bonus payment to a physician it determines has failed to report at least 80% of the time on applicable quality measures up to three measures. Physicians who report successfully on three or more quality measures will not be subject to validation. Internists are less likely to be affected by the validation effort as many will have to report on at least three quality measures because of the nature of their patient population. CMS has yet to define the PQRI validation process.

No Beneficiary Co-Payment on Bonus Payment to Physician

Beneficiaries will not have to pay a 20% co-payment on the amount of the reporting bonus paid to a physician. Also, a physician cannot charge a beneficiary related to reporting measures on claims (even if the physician’s billing system requires him or her to enter a nominal charge because it cannot accept a \$0.00 charge) or related to the any reporting bonus he or she receives.

Confidential Educational Feedback on Reporting and Quality

CMS will provide a confidential feedback report to each individual participating physician at or near the time that the lump sum bonus payments are made in mid-2008. There will be no interim feedback during 2007. The confidential feedback report will indicate the physician’s success in reporting on each measure (including whether the 80% minimum score needed for the measure to count toward qualifying for the bonus payment was met) and how well he or she performed against the quality indicator described in the measure. For example, using the quality measure Low Density Lipoprotein (LDL) Control in diabetics provided earlier, CMS would provide the percentage of the time that the physician reported the measure for eligible diabetics and the percentage of the time that the LDL level was less than 100mg/dl. CMS will also have the ability to provide a report to each group practice by aggregating the reporting and performance scores to determine group percentages. CMS will provide the reporting and performance score reports confidentially to physicians/groups—the agency will not make physician reporting and performance scores available publicly.

CMS has yet to determine, however, the format that the feedback report(s) will take.

Access to confidential feedback reports may require physicians to complete an identity-verification process to obtain a login identification and password for a secure interface. However, this process is not required, i.e. a physician could qualify for and be paid a reporting bonus even if he or she chose not to access the feedback report.

PQRI CMS Decision Appeal Process

CMS will provide a process for individual physician who want to appeal a CMS determination related to: the quality measures applicable to his or her practice; satisfactory reporting; the payment cap; and the payment amount.

No Administrative or Judicial Review

The law prohibits lawsuits pertaining to essentially every aspect of the PQRI, including: the CMS selection of quality measures for the program; determination of satisfactory reporting; determination of the bonus cap; and determination of the bonus payment amount. Physicians will, however, be able to appeal CMS decisions pertaining to their participation in the PQRI.

Potential for Pay-for-Reporting Program in 2008

The legislation that established the PQRI provides an expectation that the program will continue in some form in 2008, although the law fails to specifically fund a 2008 program. Congress likely will need to take action to fund a 2008 program. While it is certainly possible that Congress could revise—perhaps substantially—the program, the experience of participating in the PQRI in the last half of 2007 is likely to be beneficial regardless of how the program changes in 2008 or beyond.

CMS Educational Information

CMS has initiated an on-going effort to educate physicians regarding the PQRI. The most helpful educational information CMS has released to date is listed below.

- The 74 quality measures CMS identified for the PQRI are at <http://www.cms.hhs.gov/PQRI/Downloads/PQRIMeasuresList.pdf>.
- The coding and other specifications that pertain to each of the 74 measures is at http://www.cms.hhs.gov/PQRI/Downloads/Specifications_2007-02-04.pdf
- A CMS PowerPoint presentation, an article describing the PQRI, and other educational resources are under the heading “Downloads” at http://www.cms.hhs.gov/PQRI/30_EducationalResources.asp#TopOfPage
- CMS answers to frequently asked questions are accessible through the link under the “Related Links Inside CMS” heading at www.cms.gov/pqri.
- CMS intends to make data-capture worksheets and other tools to assist participation available at www.cms.gov/pqri.