Medicare 2008 Pay-for-Reporting Program
Physicians Quality Reporting Initiative

General, Detailed Description

Congress enacted a law in December 2006 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. CMS is now following through on its intent to continue the PQRI program in 2008 using the structure it established for the 2007 program. The potential existed that Congress would strip the funding for the 2008 program before it started but legislation passed by Congress at the end of December 2007 affirmed the continuation of PQRI for 2008, while making some relatively minor changes to the program. Below is the College summary of the 2008 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 119 quality measures that will be used in the PQRI., up from the 74 included in the 2007 program. 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)

All 119 quality measures have been endorsed by the National Quality Forum (NQF), a membership organization created to develop and implement a national strategy for healthcare quality measurement and reporting, or endorsed by the AQA, a multi-stakeholder process co-founded by ACP that aims to effectively and efficiently improve performance measurement. A large number of measures have been blessed by both entities. CMS has indicated that it will later remove measures that are not endorsed NQF. ACP has consistently called for quality measures to be approved by both of these entities.

The CMS list of 119 "PQRI Quality Measures" is available http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIMeasureSpecs.pdf. The list of measures is included at the very beginning of this 300+ page document. The document is lengthy because the "specifications" for each measure follow the simple list of measures. The specifications for each measure include information should as: detailed measure definition; the quality measure codes that are to be reported on claims; and Current Procedural Terminology (CPT) and International Classification of Diseases (ICD-9) codes that indicate an eligible encounter.

Reporting Quality Measures Through the Claims Process

Physicians are to report quality measures through the claims process, using 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. The CMS list of the specific CPT Category II and/or G codes that physicians are to use to report PQRI quality measures is at http://www.cms.hhs.gov/PQRI/Downloads/2008PQRIMeasureSpecs.pdf. The document available at this link also contains the list of the CPT and 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, which is the length of the reporting period for 2008.

- 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 "8P" to CPT II 3048F 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
    - Medical nutrition therapy services, HCPCS G0270-G0271

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 evaluation and management (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 required 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 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. While it is

possible to report on fewer than three quality measures and still quality for the bonus payment, general internists and internal medicine subspecialists typically will need to report on three measures. This is because the PQRI program contains numerous measures that pertain to the patient conditions that internists often treat. You can choose the three measures that are most relevant to your practice and report on those.

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.

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 is unlikely to provide feedback on the accuracy of reporting during the 2008 reporting period (and those who participated in the 2007 program will not receive feedback on their effort until mid-2008). Medicare will notify the physician of the percentage to which he or she successfully reported on each measure after the reporting concludes on December 31, 2008. 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 January 1 – December 31, 2008 reporting period—not just the allowed charges for the services for which you reported a quality measure. CMS will determine the amount of allowed charges attributed to the physician by using claims for services performed during 2008 that are accepted into the CMS contractor claims systems by February 29, 2009 (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, 2009); 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 is prohibited by law 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, the internist would receive a $3,000 reporting bonus—an amount equal to 1.5% of the $200,000 in revenue.

PQRI 2007 bonus payments were subject to a monetary cap that was determined for each individual based on a complicated formula that was meant to limit the bonus amount to a physician who reported relatively few quality measure codes during the reporting period. The law Congress passed in December 2007 eliminated this cap. A physician who successfully reports will receive 1.5% of his or her 2008 revenue regardless of the number of quality measures reported during the year.

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 expects to make 2008 PQRI bonus payments in around mid-2009.

Congress directed CMS to consider calculating successful reporting at the group practice through the law in passed in December 2007. As this would be a rather complex change, we are uncertain whether CMS can come up with a viable mechanism to determine bonus eligibility at the group practice level fast enough to have impact on the 2008 PQRI.

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 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. CMS does not attempt to validate that measures that apply to broad patient populations, including: screening for future fall risks; medication reconciliation; advance care planning; and the structural measures of adoption/use of an electronic health record and adoption/use of e-prescribing. 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.

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-2009. 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.

It is likely that CMS will require physicians to complete an identity-verification process to obtain a login identification and password to facilitate a secure interface that provides access to confidential feedback reports.

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.

Direct Reporting through Registry or Electronic Health Record

CMS will test accepting physician quality measure reporting extracted from an electronic health record (EHR) and/or reported to a registry in 2008. CMS states that physicians who participate in these tests by reporting quality data through these mechanisms will still need to successfully report quality measure codes on the claims they submit to Medicare to receive a bonus payment. The law Congress passed in December 2007 provides CMS some flexibility to determine bonus eligibility through EHR or registry-based reporting alone but we are unclear as to whether CMS will be able to establish a process quick enough for this to have an impact on the 2008 PQRI.

CMS Educational Information

CMS continues to provide educational information pertaining to the PQRI, at http://www.cms.hhs.gov/pqri/.