

National Provider Call:

Physician Quality Reporting System

(Physician Quality Reporting, previously known as PQRI)

and

Electronic Prescribing (eRx) Incentive Program

March 8, 2011

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Agenda



- CMS Updates/Announcements
- Presentation
 - How to Get Started with Physician Quality Reporting and eRx – Jacquelyn Kosh-Suber
 - Keys to Successful Reporting – Kimberly Schwartz
- Question and Answer Session

Physician Quality Reporting – **How to Get Started**

2011 Physician Quality Reporting System Overview



- 1% incentive payment
- Reporting mechanisms for individual eligible professionals
 - Claims
 - Qualified registry
 - Qualified EHR
- Reporting periods for individual eligible professionals
 - 12 months: January 1–December 31, 2011
 - 6 months: July 1-December 31, 2011 (claims and registry-based reporting only)
- Individual eligible professionals may report individual Physician Quality Reporting System measures or measures groups

Understanding Physician Quality Reporting



- You are not required to register for Physician Quality Reporting prior to submitting quality data
- However, there are preparatory steps eligible professionals should take prior to beginning Physician Quality Reporting

Understanding Physician Quality Reporting (cont.)



- Recommend the eligible professionals and staff establish an office work flow that allows accurate identification of each denominator-eligible Medicare Part B beneficiary visit
 - i.e., visits for services listed in the denominator coding section of each measure specification

Getting Started: Step 1



- Determine Eligibility: A list of eligible professionals who are able to participate in Physician Quality Reporting by reporting on individual measures or measures groups is available on the Physician Quality Reporting webpage at <http://www.cms.gov/PQRI>
 - Read this list carefully as not all are considered eligible because they may be reimbursed by Medicare under methods or fee schedules other than the Physician Fee Schedule (PFS)

Getting Started: Step 2



- Determine which reporting option(s) best fits your practice
 - claims-based or registry-based
 - individual measures or measures groups
 - reporting period (12 months or 6 months where applicable)
- Refer to the *2011 Physician Quality Reporting System Participation Decision Tree* in Appendix C of the **2011 Physician Quality Reporting System Implementation Guide**, which is available as a download in the Measures Codes section of the Physician Quality Reporting web page at <http://www.cms.gov/PQRI> on the CMS website

Getting Started: Step 3



- Determine which measures apply by reviewing the **2011 Physician Quality Reporting System Measures List**, located on the Measures Codes section of the Physician Quality Reporting web page at <http://www.cms.gov/PQRI>
 - Select at least 3 measures to submit to attempt to qualify for a Physician Quality Reporting incentive payment. If fewer than 3 measures are reported, CMS will apply a measure-applicability validation (MAV) process when determining incentive eligibility
 - Eligible professionals who choose to report 2011 Physician Quality Reporting measures groups should select at least 1 measures group to submit to attempt to qualify for an incentive payment. Refer to the **Measures Groups Specifications Manual** to review measures group(s) applicable to your practice

Getting Started: Step 3 (cont.)



- If you have already been participating in Physician Quality Reporting, there is no requirement to select new/different measures for the 2011 program year
 - Please note that all Physician Quality Reporting measure **specifications are updated** and posted prior to the beginning of **each program year**; therefore, eligible professionals will need to review the most current version for any revisions

Getting Started: Step 4



Individual Physician Quality Reporting Measures

- Once you have selected the measures (at least 3), carefully review the following documents located in the Measures Codes section of the Physician Quality Reporting web page at <http://www.cms.gov/PQRI>:
 - **2011 Physician Quality Reporting System Measure Specifications Manual for Claims and Registry** for instructions on how to report claims-based or registry-based individual measures
 - **2011 Physician Quality Reporting System Implementation Guide** which describes important reporting principles underlying claims-based reporting of measures and includes a sample claim in Form CMS-1500 format

Getting Started: Step 4 (cont.)



- Each of the measures has a quality-data code (QDC) (a Current Procedural Terminology [CPT] II code or G-code) associated with it
 - Several measures allow the use of CPT II modifiers: 1P, 2P, 3P, and the 8P reporting modifier
 - Only allowable CPT II modifiers may be used with a CPT II code
 - Eligible professionals should use the 8P reporting modifier judiciously for applicable measures they have selected to report

Getting Started: Step 4 (cont.)



- To qualify for the incentive, the correct numerator QDC must be reported
 - 80% of eligible instances if reporting via a registry for each selected measure
 - 50% of the eligible instances if reporting via claims for each selected measure
 - A claim is considered “eligible” in Physician Quality Reporting when the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis and the CPT Category I service codes on the claim match the diagnosis and encounter codes listed in the denominator criteria of the measure specification

Getting Started: Step 4 (cont.)



- Each measure has a reporting frequency or timeframe requirement (called a “measure tag” in Physician Quality Reporting analysis) for each eligible patient seen during the reporting period by each individual eligible professional
- The reporting frequency (i.e., report each visit, once during the reporting period, each episode, etc.) is found in the Instructions section of each measure specification

Getting Started: Step 4 (cont.)



- As an alternative to reporting 3 individual measures, you can select to report 1 or more Physician Quality Reporting System Measures Groups
 - Once you have selected a measures group(s) to report, carefully review the following documents located in the Measures Codes section of the Physician Quality Reporting web page at <http://www.cms.gov/PQRI>
 - *2011 Physician Quality Reporting System Measures Groups Specifications Manual* for claims-based or registry-based reporting of measures groups
 - *Getting Started with 2011 Physician Quality Reporting of Measures Groups* is the implementation guide for reporting measures groups

Additional Reporting Option - EHR



- For information regarding reporting 2011 Physician Quality Reporting via a qualified EHR, please see documents located in the Downloads section of the Alternative Reporting Mechanisms page of the CMS Physician Quality Reporting website

Group Practice Reporting Option (GPRO)



- For information regarding reporting 2011 Physician Quality Reporting via GPRO I or II, please see documents located in the Downloads section of the Group Practice Reporting Option page of the CMS Physician Quality Reporting website

Reminders



- Be sure your medical record documentation supports what is reported
- Feedback reports and incentive (if eligible) will be made available during the following program year

Reporting Tips



- For measures that require capturing clinical values for coding, make sure these clinical values are available to those who are coding claims for Physician Quality Reporting (i.e., HgA1c value)
- Some measures have specified patient demographics, such as age parameters and gender, for denominator inclusion
- For measures selected to report, carefully review all ICD-9-CM diagnoses (if applicable) and CPT service (encounter) codes that will qualify claims for inclusion in Physician Quality Reporting measurement calculations (i.e., claims that are denominator-eligible) and to ensure that each claim includes the appropriate QDC(s) or QDC with the allowable CPT II modifier with the individual eligible professional's NPI in the rendering provider ID field on the claim

Reporting Tips (cont.)



- For measures that require more than one QDC (CPT II or G-code), please ensure that **all** codes are captured on the claim
- If all billable services on the claim are denied for payment by the Carrier/MAC, the QDCs will not be included in Physician Quality Reporting analysis
- QDCs should be submitted on the line item of the claim as a zero charge. A nominal amount such as a penny may be entered if billing software does not permit a zero charge line item. The submitted charge field (\$charges) cannot be left blank

Reporting Tips (cont.)



- The Remittance Advice (RA) with denial code N365 is your indication that the Physician Quality Reporting codes were passed into the National Claims History (NCH) file for use in calculating incentive eligibility
- Check RA notices regularly to ensure receipt of a remark code N365 for each QDC submitted denoting that QDCs for individual measures and/or measures groups were passed into the NCH
- This remark does not confirm QDC accuracy

Common Reporting Errors Associated with Claims-based Reporting



- No QDC submitted on an eligible claim
- Missing eligible encounters
- Reporting on encounter not meeting denominator criteria

Physician Quality Reporting Resources



- Visit the Physician Quality Reporting webpage on the CMS website at <http://www.cms.gov/PQRI> for documents with additional information regarding participating in Physician Quality Reporting
 - Link to Frequently Asked Questions

eRx Incentive Program –
How to Get Started

2011 eRx Incentive Program Details



- 1% incentive payment
- Reporting mechanisms:
 - Claims
 - Qualified* registry
 - Qualified* EHR
- Reporting period:
 - January 1 - December 31, 2011
- No need to register for eRx Incentive Program

*For a list of CMS qualified registries and EHRs, please visit the Alternative Reporting Mechanisms page on the CMS Physician Quality Reporting site at <http://www.cms.gov/pqri>.

Participating in eRx



- This portion of the presentation will provide you with the steps to follow to determine eligibility and reporting the eRx measure
- Additional information is available on the How to Get Started section of the eRx page on the CMS website at <http://www.cms.gov/ERxIncentive/>

Determining Participation:

Step 1



- Determine whether or not you are eligible to participate in the program. A list of professionals who are eligible and able to receive an incentive for participating in the eRx Incentive Program is available on the CMS eRx website at:
<http://www.cms.gov/ERxIncentive>

Determining Participation: Step 2



- Review the *2011 eRx Measure Specification*, which is available as a download in the E-Prescribing Measure section of the CMS eRx website, to determine if this measure applies to your practice

Determining Participation:

Step 3



- Determine if your practice has the resources needed to participate:
 - Do you have a “qualified” eRx system/program that is being used routinely?
 - Generates a complete active medication list incorporating electronic data received from applicable pharmacies and pharmacy benefit managers (PBMs), if available
 - Selects medications, prints prescriptions, electronically transmits prescriptions, and conducts all alerts
 - Provides information related to lower-cost, therapeutically appropriate alternatives, if any (the availability of an eRx system to receive tiered formulary information would meet this requirement for 2011)
 - Provides information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient’s drug plan, if available

Determining Participation: Step 3 (cont.)



- Do you expect your Medicare Part B PFS charges for the codes in the denominator of the measure (listed below) to make up at least 10% of your total Medicare Part B PFS allowed charges for 2011*?
 - Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) G-codes:
 - 90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 90862, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99345, 99347, 99348, 99349, 99350, G0101, G0108, G0109

* This will not preclude you from participating but would preclude you from receiving an incentive

Reporting eRx



- Once you have decided to participate in the 2011 eRx Incentive Program, follow these steps when reporting the measure

Reporting eRx: Step 1



- You must bill one of the CPT or HCPCS G-codes listed in the measure for the patient you are seeing

Reporting eRx: Step 2



- If appropriate, report the following G-code (or numerator code) on the claim form that is submitted for the Medicare patient visit:
 - G8553 - At least one prescription created during the encounter was generated and transmitted electronically using a qualified eRx system

Reporting eRx: Step 3



- A “successful electronic prescriber”, eligible to receive an incentive payment, must generate and report one or more electronic prescriptions associated with a patient visit
 - A minimum of 25 unique visits per year is required
 - Each visit must be accompanied by the eRx G-code attesting that during the patient visit at least one prescription was electronically prescribed
 - Electronically generated refills without a patient visit do not count and faxes do not qualify as eRx
 - New prescriptions not associated with a code in the denominator of the measure specification are not accepted as an eligible patient visit and do not count towards the minimum 25 unique eRx events

Reporting eRx: Step 4



- 10% of an eligible professional's Medicare Part B PFS charges must be comprised of the codes in the denominator of the measure to be eligible for an incentive

How Group Practices Can Qualify for the 2011 eRx Incentive



- Participate in the 2011 Physician Quality Reporting System under GPRO I or GPRO II
- Become a successful electronic prescriber
 - Depending on the group's size, report the eRx measure for 75-2,500 unique eRx events for patients in the denominator of the measure
- At least 10% of eligible professional's charges based on codes in the denominator of the measure

Feedback Reports



- Feedback reports and incentive (if eligible) will be made available during the following year

eRx Resources



- Visit the Educational Resources section of the eRx webpage on the CMS website at <http://www.cms.gov/ERxIncentive/> for documents with additional information regarding getting started with eRx
 - *2011 eRx Incentive Program Made Simple Fact Sheet* (coming soon)
 - *What's New for 2011 eRx Incentive Program* (coming soon)
 - Link to Frequently Asked Questions

Need Help?



- ◆ Please contact the **QualityNet Help Desk** at **866-288-8912** (available 7:00 a.m. to 7:00 p.m. CST Monday through Friday) or via e-mail at qnetsupport@sdps.org (or TTY 1-877-715-6222)

Physician Quality Reporting -

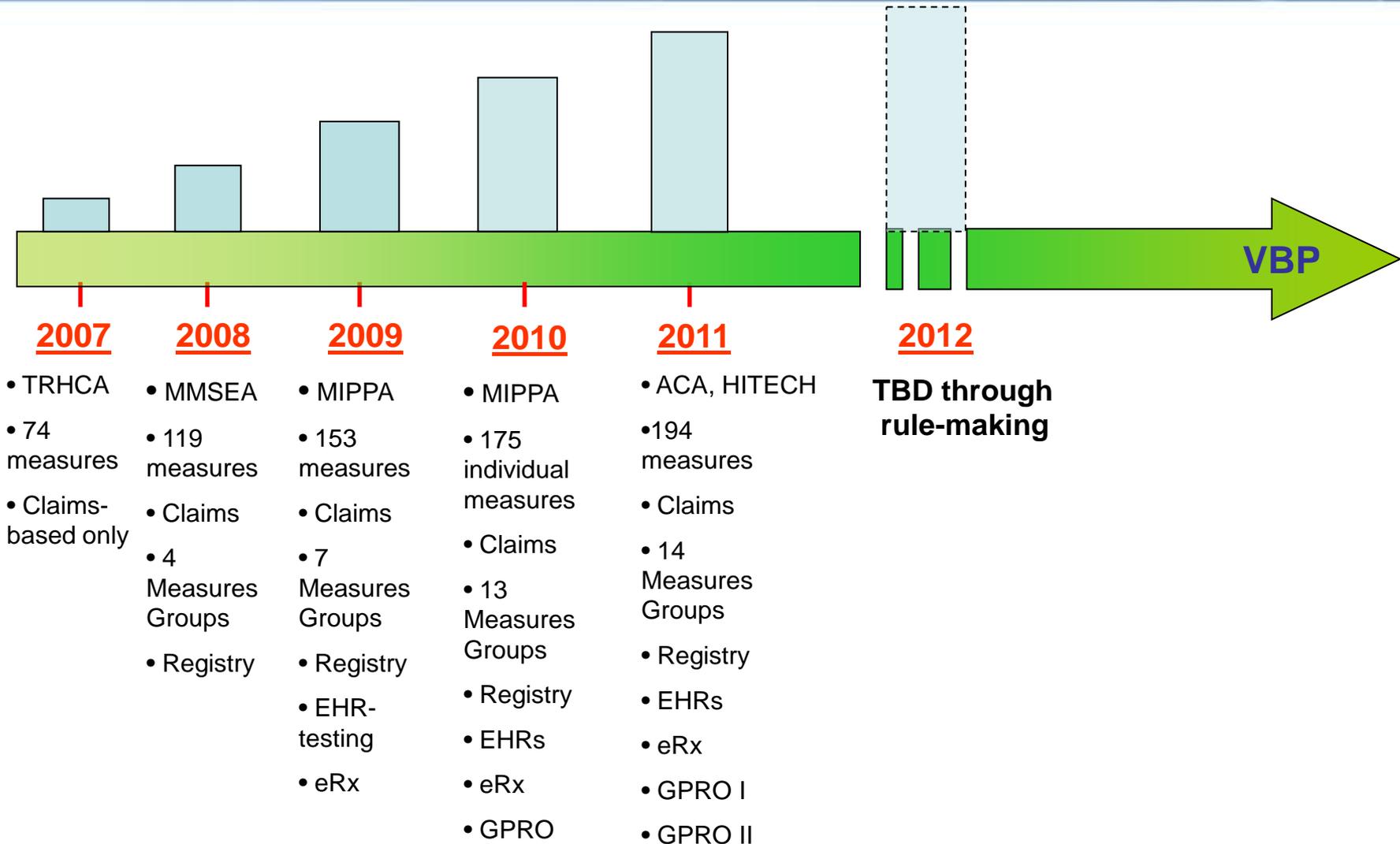
Keys to Successful Reporting

What is Physician Quality Reporting?



- Physician Quality Reporting is a voluntary reporting program that began in 2007 (originally called PQRI)
- Eligible professionals (or group practices) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries will qualify to earn an incentive payment
 - The incentive is a percentage of the eligible professional's (or group's) estimated total Medicare Part B PFS allowed charges
- Over time, the program has expanded the number of measures and reporting options to facilitate quality reporting by a broad array of eligible professionals

Moving Toward Value-Based Purchasing (VBP)



Eligible Professionals



- A list of eligible professionals who are able to participate in Physician Quality Reporting and/or the eRx Incentive Program is available on both the program websites at www.cms.gov/PQRI and www.cms.gov/eRxIncentive
 - Not all entities are considered eligible as they may be reimbursed by Medicare under methods or fee schedules other than the Physician Fee Schedule (PFS)
 - e.g., Federally Qualified Health Centers are not eligible to report Physician Quality Reporting data because they are not reimbursed under the PFS
 - Eligible professionals include physicians, nurse practitioners, clinical nurse specialists, physician assistants, physical therapists, and many other health care professionals

2011 Physician Quality Reporting System Measures



- There are currently 194 measures including:
 - 5 new measures for claims and registry reporting
 - 11 new registry-only measures
 - 10 additional EHR measures
- Other reportable quality measures include:
 - 20 EHR measures
 - 14 measures groups

The 2011 Measures List is available at: www.cms.gov/PQRI

2011 Physician Quality Reporting Measures Groups



- Measures groups include reporting on a group of clinically-related measures identified by CMS for use in Physician Quality Reporting, either through claims-based and/or registry-based submission.
- A complete list of Measures Groups is available at:
http://www.cms.gov/PQRI/15_MeasuresCodes.asp

2011 Physician Quality Reporting Measures Groups (cont.)



- 14 measures groups
 - Diabetes Mellitus
 - Chronic Kidney Disease (CKD)
 - Preventive Care
 - Rheumatoid Arthritis
 - Perioperative Care
 - Back Pain
 - Hepatitis C
 - Ischemic Vascular Disease (IVD)
 - Community-Acquired Pneumonia (CAP)
 - Asthma (new)
 - Coronary Artery Bypass Graft (CABG) (registry only)
 - Heart Failure (HF) (registry only)
 - Coronary Artery Disease (CAD) (registry only)
 - HIV/AIDS (registry only)

Steps for Selecting Measures



1. Choose measures based on your method of reporting (Claims, Registry & EHR reporting options)
2. Determine if measures are applicable to your practice by reviewing:
 - Clinical conditions usually treated
 - Types of care typically provided (e.g., preventive, chronic, acute)
 - Applicable clinical settings
 - Supports the practice's quality improvement goals

Using a Measure Specification Example



Measure #226:

Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months **AND** who received cessation counseling intervention if identified as a tobacco user

http://www.cms.gov/PQRI/15_MeasuresCodes.asp

Using a Measure Specification Example (cont.)



Who can report on this measure?

1. Eligible professionals (as defined by CMS)
2. Eligible professionals who bill under PFS and provide services as described by the following denominator codes:

90801, 90802, 90804, 90805, 90806, 90807, 90808,
90809, 90810, 90811, 90812, 90813, 90815, 90845,
90862, 92002, 92004, 92012, 92014, 96150, 96151,
96152, 97003, 97004, 99201, 99202, 99203, 99204,
99205, 99212, 99213, 99214, 99215

How Measures Are Reported



Determine what ***clinical actions*** were performed as detailed in the patient's health record and report the applicable numerator quality data codes (QDC) listed in the measure specification.

The ***Measure Coding Decision Algorithm*** on the next slide assists in numerator code selection.

Measure Coding Decision Algorithm



Is there documentation of a tobacco use screening AND cessation counseling, if patient is identified as a tobacco user?

If YES, select **CPT II 4004F**

If NO is answered to either tobacco screening or cessation counseling above, select one of the following codes:

CPT II 1036F = Current tobacco non-user

CPT II 4004F with IP = Documentation of medical reason(s) for not screening for tobacco use (e.g., limited life expectancy)

CPT II 4004F with 8P = Tobacco Screening not performed, reason not otherwise specified

Measure Specification Construct



NUMERATOR

CPT II 4004F

CPT II 1036F

CPT II 4004F *with IP*

CPT II 4004F *with 8P*

(**Clinical action** required for performance)

DENOMINATOR

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809,
90810, 90811, 90812, 90813, 90815, 90845, 90862, 92002,
92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004,
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214,
99215

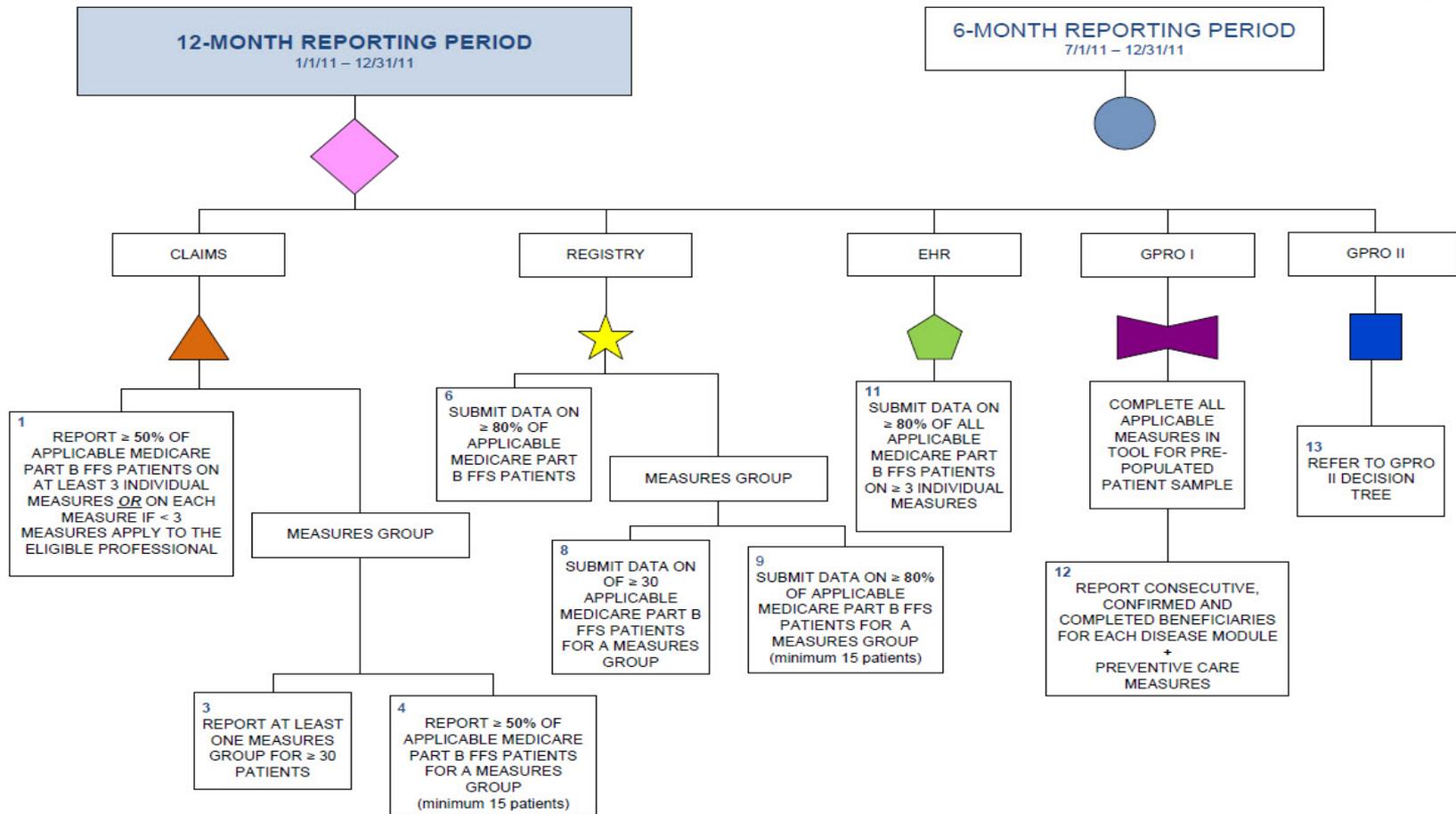
(Describes **eligible cases** for which a **clinical action** was performed: the eligible patient population as defined by denominator specification)

2011 Decision Tree

I WANT TO PARTICIPATE IN 2011 PHYSICIAN REPORTING FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2011 Physician Reporting)

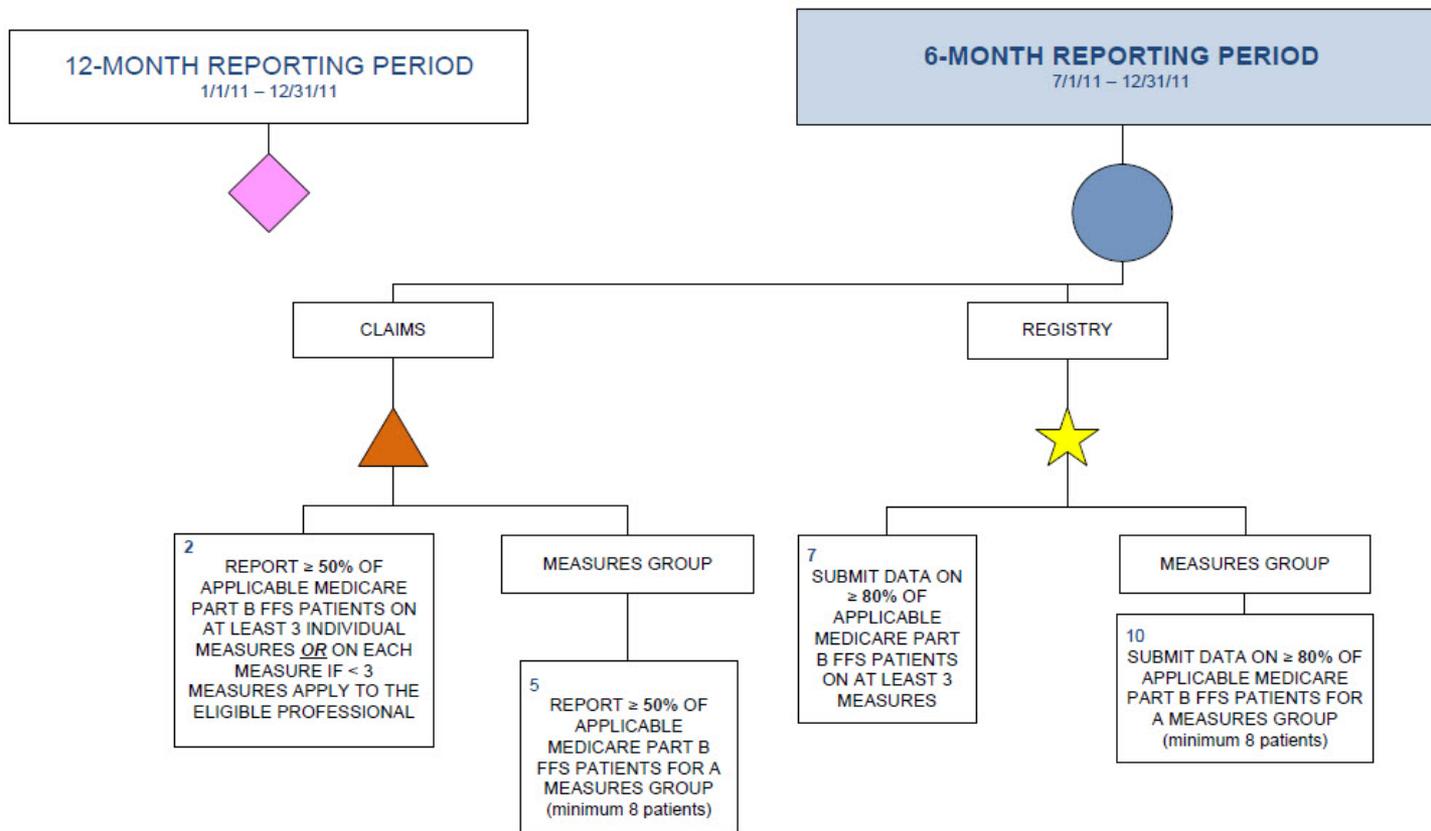


2011 Decision Tree (cont.)

I WANT TO PARTICIPATE IN 2011 PHYSICIAN REPORTING FOR INCENTIVE PAYMENT

SELECT REPORTING METHOD

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2011 Physician Reporting)



Claims Based Reporting Principles



- The following principles apply to the reporting of QDCs for Physician Quality Reporting measures:
- The CPT Category II code(s) and/or G-code(s), which supply the numerator, must be reported:
 - on the same claim as the denominator billing code(s)
 - for the same beneficiary

Claims-Based Reporting Principles (cont.)



- by the same Eligible Professionals (individual NPI) who performed the covered service as the payment codes, usually ICD-9-CM, CPT Category I or HCPCS codes, which supply the *denominator*
- for the same date of service (DOS)

Registry Submission



- What is a registry?
 - Captures and stores clinically related data submitted by the eligible professional (or group practice)
 - Registry submits information on Physician Quality Reporting System individual measures or measures groups (or eRx measure) to CMS on behalf of eligible professionals (or group practice)
- Registries provide CMS with calculated reporting and performance rates at the end of the reporting period
 - Data must be submitted to CMS via defined .xml specifications
- CMS qualifies registries annually
 - A list of qualified registries for 2011 Physician Quality Reporting/eRx will be available at:
http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp by Summer 2011

EHR Submission



- CMS qualifies EHR vendors annually
 - List of ***Qualified EHR Vendors for the 2011 Physician Quality Reporting and eRx Incentive Programs*** (including the specific product(s) and version(s) that are qualified) is available at:
http://www.cms.gov/PQRI/20_AlternativeReportingMechanism.s.asp#TopOfPage > ***Downloads***
- Using a qualified EHR, eligible professionals submit raw clinical data to CMS and measures are calculated by CMS

Group Practice Reporting Options (GPRO)



- To participate, a group practice must:
 - Submit self-nomination letter to CMS – information is posted on the Group Practice Reporting Option section of the Physician Quality Reporting website
 - Meet certain technical and/or other requirements
 - Be selected to participate

2011 GPRO I



- GPRO I: self-nominated group practices with 200 or more eligible professionals
 - Must have self nominated by January 31, 2011
 - Complete pre-populated data collection tool for an assigned set of Medicare beneficiaries
 - 26 total measures (4 disease modules + 4 individual preventive care measures)
 - Access to tool no later than first quarter of 2012
 - 2011 data submitted in 2012

2011 GPRO II (cont.)



- GPRO II: group practices with 2-199 eligible professionals (new for 2011)
 - Must have self nominated by January 31, 2011
 - CMS will select approximately 500 groups meeting the eligibility requirements
 - Reported via claims (unless only applicable measures group(s) is registry-only)
- No data collection tool; will use:
 - *2011 Physician Quality Reporting System Individual Measure Specifications for Claims and Registry*
 - *2011 Physician Quality Reporting System Measures Groups Specifications Manual*

Resources



- Visit the *How to Get Started* section of the CMS Physician Quality Reporting System website at <http://www.cms.gov/pqri>
- Frequently Asked Questions
- Supplemental education materials
- National Provider Calls
- Special Open Door Forums

Reminder: Be sure to use the measure specifications for the correct program year and method of reporting!

Need Help?



- Please contact the **QualityNet Help Desk** at **866-288-8912** (available 7:00 a.m. to 7:00 p.m. CST Monday through Friday) or via e-mail at qnetsupport@sdps.org (or TTY 1-877-715-6222)

Thank You



- Questions?