

Billing and Coding Overview: E & M and Coding for Quality Reporting or How to Receive Your 4% Bonus!

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How To Receive Your 4% Bonus in 2009

- Successfully participate in Physician Quality Reporting Initiative (PQRI) = 2%
- Successfully participate in Medicare Electronic Prescribing = 2%

WARNING!

It has taken me a month to figure this out

and

I'm going to explain it to you in 50 min!

YIKES!!

Basic Math of Getting Paid

Service or procedure code
(CPT – Current Procedural Terminology)

+

Modifier (if applicable)

=

Relative Value Unit

X

Conversion Factor

=

Price (dollars)

+

Diagnosis Code(s)

(ICD-9-CM International Classification of Diseases 9th Rev. Clinical
Modification)

=

Payment (maybe)

CPT Codes

- **Category I**
 - Service (E/M) or procedure
- **Category II**
 - Supplemental tracking codes
 - Used for performance measurement
 - 4 digits followed by alpha character
 - 0001F-6005F
- **Category III**
 - Temporary set of tracking codes for new technologies
 - Payment variable depending on payer, code, etc.
 - Numeric and alpha identifier
 - 0016T-0170T

Category II Codes

- Previously rarely used, but now a key part of PQRI
- Data collection codes
 - Used for pay for performance

G Codes

- HCPCS (Healthcare Common Procedure Coding System) Level II Codes describing professional services/procedures (temporary national codes)
- Codes created by CMS, NOT AMA
- Think of them as CPT Codes (HCPCS Level I Codes) without AMA copyright
- Can be a precursor to a CPT Code
- Used in PQRI in addition to CPT I, CPT II and ICD-9 Codes

What is Physician Quality and Reporting Initiative (PQRI)?

- Created by Congress in March 2007 to establish a financial incentive for eligible healthcare professionals to participate in a voluntary quality reporting program.

PQRI

- **Voluntary quality-reporting program**
- **CMS “First Step” to “Value-based Purchasing” or “Pay-for-Performance”**
- **Bonus is all or nothing – no partial payment for doing some of the work**

Value-Based Purchasing and PQRI

- Key mechanism for transforming Medicare from passive payer to active purchaser.
 - Current Medicare Physician Fee Schedule (PFS) is based on quantity and resources consumed, NOT quality or value of services.
- Value = Quality / Cost
 - Incentives can encourage higher quality and avoidance of unnecessary costs to enhance the value of care.
- 12/9/08 VBP Issues Paper: Development of a Plan to Transition to Medicare Value-Based Purchasing for Physician and Other Health Professional Services

<http://www.cms.hhs.gov/center/physician.asp>

Physician Quality Reporting Initiative (PQRI)

- **Successful reporting earns a 2 percent incentive payment under Medicare**
- **Voluntary -- For now**
- **Opportunity to gain experience with reporting quality metrics**
- **Medicare plans to publically report names of Physicians who successfully participate in 2009**

2006 Tax Relief and Health Care Act (TRHCA) (P.L. 109-4312)

- **Required establishment of a Physician Quality Reporting System**
- **Includes incentive payments**
- **CMS named the program “Physician Quality Reporting Initiative (PQRI)”**

Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)

(P.L. 110-173)

- **Established 2 alternative reporting periods for reporting of PQRI Data:**
 - **January 1, 2009-December 31, 2009**
 - **July 1, 2009-December 31, 2009**
- **Established option of reporting on a group of clinically-related measures (Measures Groups) and through registries**

The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (P. L. 110-275)

- Made PQRI program permanent, but only authorized incentive payments through 2010
- 2009 Incentive payment of 2.0% of total allowed charges for physician fee scheduled covered professional services furnished during 2009
- Do not need to sign-up or preregister in order to participate – just submit quality data codes (HCPCS G Codes or CPT Category II Codes)
- Section 132 e-Prescribe Incentive Program – authorized separate 2% incentive payment to successful e-prescribers

Basic Concept

- **Select quality measures that are important to your practice and patients**
- **Establish processes to systematically report the quality measures for each eligible patient**
- **Reporting mainly done by including a quality code on claim or through registries**
- **Receive feedback on extent to which patient got the recommended care described in the quality measure**
- **Receive modest payment for effort**
- **Use process improvement to validate practice and patient care improvements**

Focus on Quality & Improvement

- PQRI reporting focuses attention on quality of care
 - Foundation is evidence-based measures developed by professionals.
 - Reporting data for quality measurement is rewarded with financial incentive.
 - Measurement enables improvements in care.
 - Reporting is the first step toward pay-for-performance.
- Measures address various aspects of quality care
 - Prevention
 - Chronic Care Management
 - Acute Episode of Care Management
 - Procedural Related Care
 - Resource Utilization
 - Care Coordination

2009 PQRI: Eligible Professionals

- **Physicians**
 - MD/DO
 - Podiatrist
 - Optometrist
 - Oral Surgeon
 - Dentist
 - Chiropractor
- **Therapists**
 - Physical Therapist
 - Occupational Therapist
 - Qualified Speech-Language Pathologist
- **Practitioners**
 - Physician Assistant
 - Nurse Practitioner
 - Clinical Nurse Specialist
 - Certified Registered Nurse
 - Anesthetist
 - Certified Nurse Midwife
 - Clinical Social Worker
 - Clinical Psychologist
 - Registered Dietician
 - Nutrition Professional
 - Audiologist

PQRI – Understanding the Measure Construct

- Quality measures consist of a unique denominator (eligible case) and numerator (clinical action) = % of a defined patient population that receive a particular process of care or achieve a particular outcome.

PQRI - Denominator

- **Describes eligible cases for a measure**
- **Use CPT Category I Codes and ICD-9 Diagnosis Codes**

PQRI - Numerator

- Describes the clinical action required by the measure for reporting and performance
- Use quality data codes which are HCPCS codes comprised of specified CPT Category II Codes and/or G-Codes
- Five alphanumeric characters ending with the letter “F”

PQRI - Numerator

- CPT II Codes can have unique modifiers - help identify circumstances when use of an exclusion modifier may be appropriate

(note: Pay for reporting model - get credit for reporting, even if the clinical action was not performed)

PQRI - Numerator

- CPT II Modifiers Two Categories
 - Exclusion modifiers (**1P**, **2P**, **3P**)
 - **8P** Reporting modifier
- Exclusion modifiers appended to a CPT II Code to indicate the action specified in the measure was not provided due to medical (**1P**), patient (**2P**), or system (**3P**) reason(s) documented in the medical record.
- **8P** Reporting Modifier used when an action described in a measure is not performed and the reason is not specified.

Understanding the Measures: PQRI Quality-Data Codes (QDCs)

QDCs translate clinical actions so they can be captured in the administrative claims process – they describe whether:

- the measure requirement was met

OR

- the measure requirement was not met due to documented allowable performance exclusions (i.e., using CPT II performance exclusion modifiers)

OR

- The measure requirement was not met and the reason is not documented or is not consistent with an acceptable performance exclusion (i.e., using the **8P** reporting modifier)

PQRI

**Reporting
Performance**

=

CPT II Code and/or G-code +
CPT II modifier (if applicable)
CPT I Code + ICD-9 Code(s)

Example Using Measure #83

- Hepatitis C: Testing for chronic Hepatitis C - Confirmation of Viremia

% \geq 18y/o Hepatitis C seen for an initial evaluation who had HCV RNA testing ordered or previously performed

=

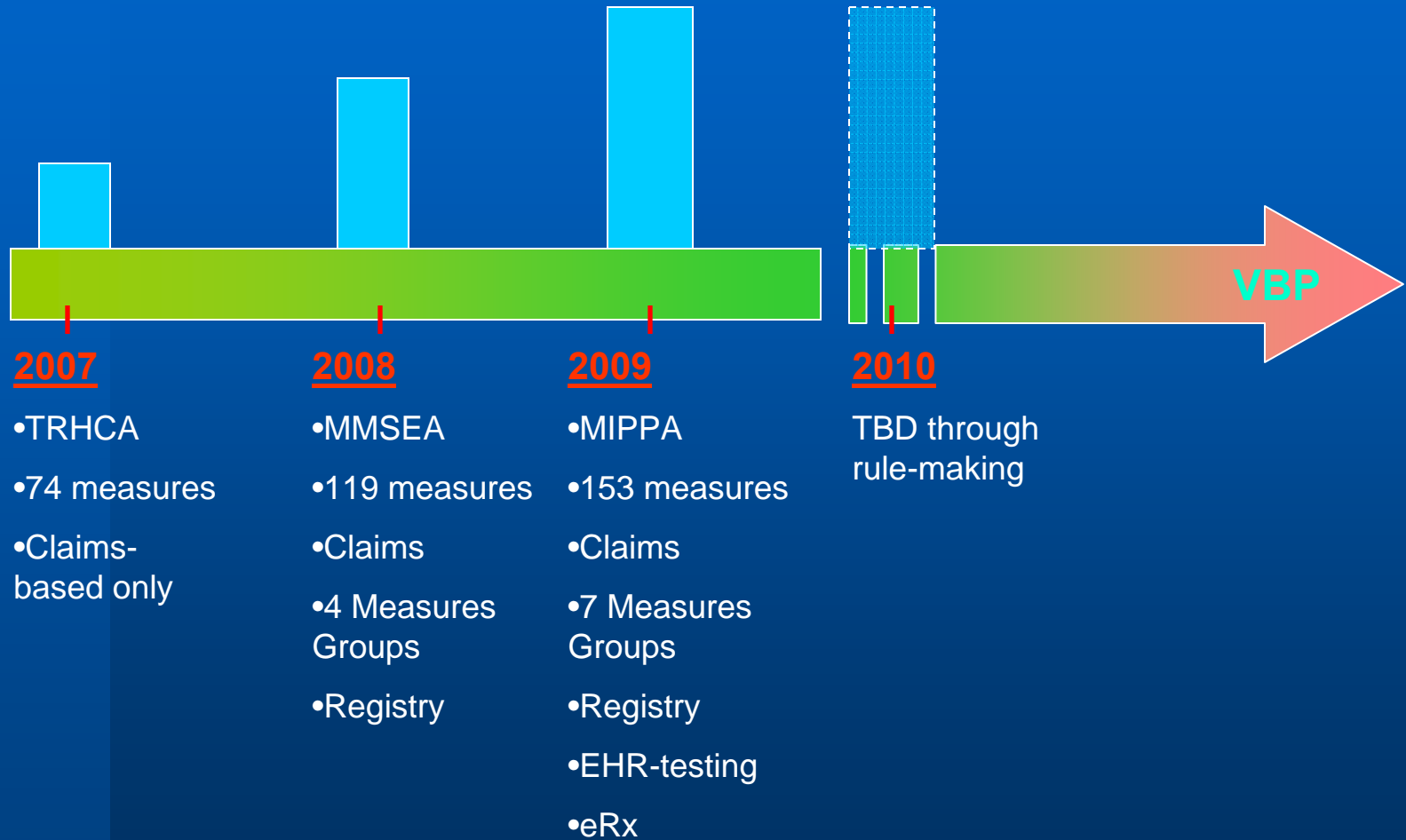
HCV RNA testing ordered or previously performed

All PTS \geq 18y/o with Hepatitis C seen for initial evaluation

PQRI

- **2007 – 74 Quality Measures (Implemented July 1, 2007)**
- **2008 – 119 Quality Measures and 4 Measures Groups**
- **2009 – 153 Quality Measures and 7 Measures Groups**

Towards Value-Based Purchasing



Development of the Quality Measures Consensus-Based Process

- **AMA Physician Consortium for Performance Improvement (PCPI)**
- **National Committee for Quality Assurance (NCQA)**
- **Physician Specialties**

Definition of “Patients” in PQRI

- Part B Medicare Fee-For-Service (FFS) Patients
- Non-FFS Medicare (e.g., Medicare Part C Patients including those enrolled in private FFS plans) and/or non-Medicare patients may only be included in registry based reporting under the consecutive patient criteria

PQRI 2009

- **9 Options for reporting Quality Measures Data**
 - Reporting periods
 - Claims based or approved Clinical Registry
 - Individual measures or Measures Groups

PQRI Measure Specifications 2009

- 27 Measures of 153 may apply to ID – will depend on service mix and patient population
- Some measures have an age, gender, or frequency limitation, such as patients with a chronic illness for whom a particular process of care is provided only periodically
- See List for ID – www.idsociety.org with links to each measures specifications
- See handout for list and example measure specifications (pp 1- 4)

Measures Groups

- **Aggregate several measures that address similar clinical conditions**
- **Report all applicable measures in a measure group for a specified number of patients to qualify for incentive payment**
- **Submission by either claims-based or registry-based mechanisms**
- **Reporting can be done for 12 months or 6 months**

Measure Groups

- For 2009: Seven Options
 - **Diabetes** (see handout pp 15-29)
 - **CKD**
 - **Preventive Services**
 - **Back Pain**
 - **CABG**
 - **Rheumatoid Arthritis**
 - **Perioperative Care**

(none applicable to ID)

PQRI Measure Selection Considerations: Where to Begin

- Review 2009 PQRI measures
- Select measures that apply to your practice
- Review individual quality measures participation tools (see handout pp 8-13)
- Determine method of submission: claims based or registry
- Determine reporting option: individual measures or measures group
- Determine reporting period: 1/1/09 to 12/31/09 or 7/1/09 to 12/31/09

ACP PQRI Resources to Aid Participation

Coding Tools

Physician Quality Reporting Initiative
Coding Tool for Internal Medicine

Patient Name: _____
Patient MR#: _____
Date of Visit: _____

METRIC () = PQRI Measure #	Circle CPT II Code Selection & Modifier (If Needed)			Not Done			
HbA1c (DM G)	<7.0%	7.0 - 9.0%	>9.0%				
	3044F	3045F	3046F	3046F- 8P			
LDL (DM G)	<100	100-129	≥130				
	3048F	3049F	3050F	3048F- 8P			
Blood Pressure (DM G)	<i>Report both systolic and diastolic</i>						
	<130	130-139	≥140				
	3074F	3075F	3077F				

I want to participate in 2009 PQRI for Incentive Payment (Select Reporting Method)

12-Month Reporting Period
1/1/09-12/31/09

6-Month Reporting Period
7/1/09-12/31/09

Claims

Registry

Claims

Registry

Report \geq 80% of eligible patients on at least 3 individual measures or on each measure if $<$ 3 measures apply to the EP

Measures Groups

Submit data on \geq 80% of eligible patients on at least 3 individual measures

Measures Groups

Measures Groups

Measures Groups

Submit data on \geq 80% of eligible patients on at least 3 individual measures

Report one Measures Group for 30 consecutive patients

Report \geq 80% of eligible patients (minimum 30) for a Measures Group

Submit data on 100% of 30 consecutive eligible patients any time within 12 months (may include some non-Medicare patients)

Report \geq 80% of eligible patients (minimum 15) for a Measures Group

Submit data on \geq 80% of EP's eligible patients for the full 12 months (minimum 30 patients)

Submit data on \geq 80% of EP's eligible patients for the full 6 months (minimum 15 patients)

Claims-Based Reporting

- Submission of specific quality code on same claim containing associated procedure and diagnosis code(s)
- Quality codes are generally specific to select procedure or diagnosis codes and some are limited by age and/or gender
 - Criteria found in measure specifications documents – this determines an “applicable” case

Claims-Based Reporting

- To be validly submitted on the claim the quality code must apply to the patient according to the measure specifications
 - Age, gender, diagnosis, and procedure

Claims Based Reporting Principles

- Specifically created CPT II Codes submit with routine bills
- CPT Category II Code(s) and/or G-Code(s) must be reported:
 - On same claim
 - For same beneficiary
 - For same date of service
 - For same provider (NPI) within the holder of the tax ID number

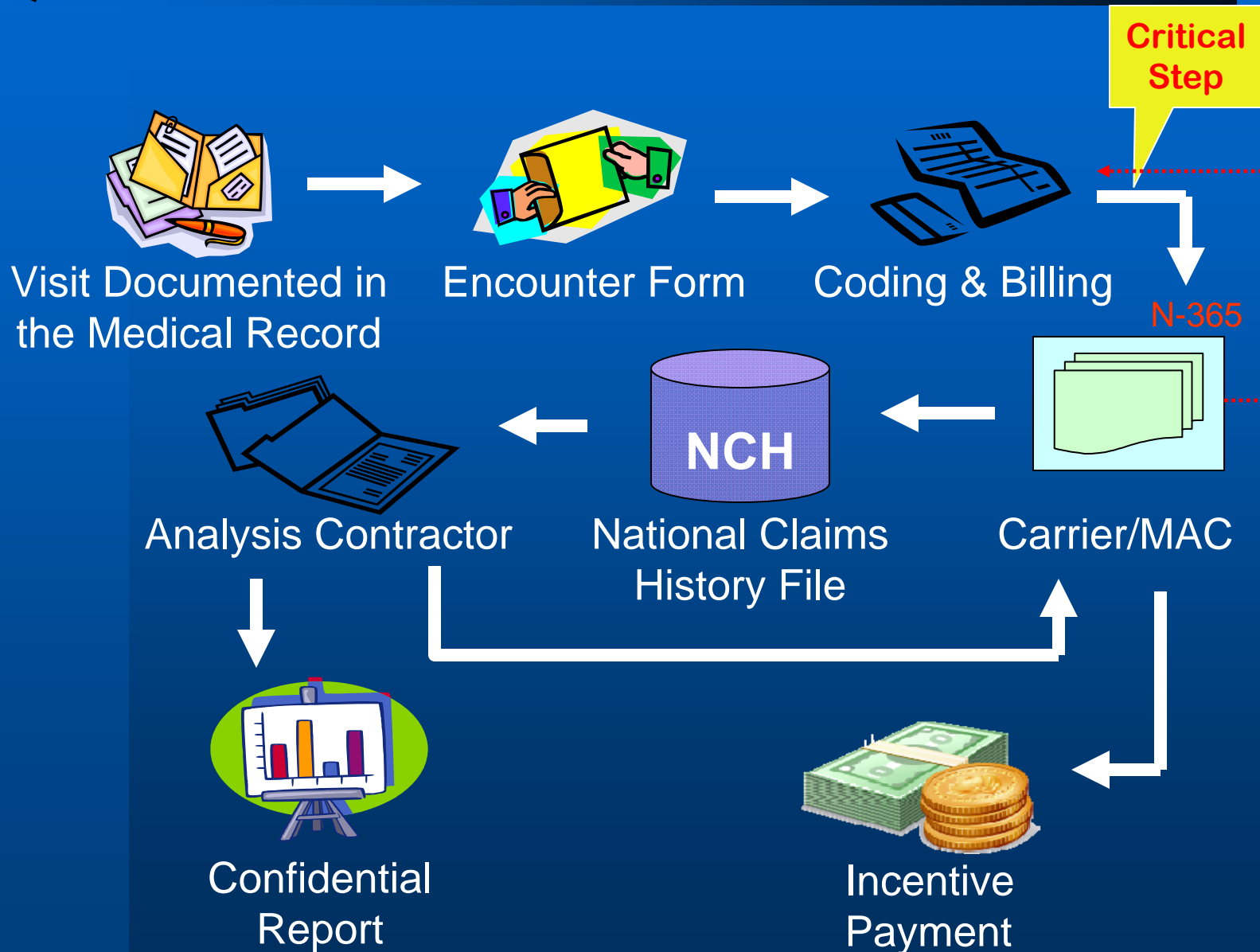
Claims Based Reporting Principles

- All diagnoses reported on the base claim will be included in PQRI analysis- as some measures require reporting more than one on a claim
- Quality Data Codes (QDC) must be submitted with a line item charge of zero dollars (\$0.00)
- QDC line items will be denied for payment, but are passed through for analysis
- You will receive a remittance advice and a “N365” message – “not payable- for reporting information purposes only”

Claims-Based Reporting Principles

- **Submission through Carriers/Medicare Administrative Contractors either:**
 - **Electronic – using ASC x 12N Health care claim transaction (version 4010A1) **or****
 - **Paper-based - CMS- 1500 Claim form (version 08-05)**
- **Claim submission deadline by 2/28/10**

PQRI Claims-Based Process



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.

Identifies claim line-item

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)										22. MEDICAID RESUBMISSION CODE		ORIGINAL REF. NO.											
1. 250 00 Diabetes Mellitus																							
2. 414 00 CAD																							
24. DATE(S) OF SERVICE										D. PROCEDURES, SERVICES, OR SUPPLIES		E. DIAGNOSIS		F. \$ CHARGES		G. DAYS OR UNITS		H. ICD-9-CM		I. QUAL.		J. RENDERING PROVIDER ID. #	
From To PLACE OF SERVICE EMP.										(Explain Unusual Circumstances) CPT/HCPCS MODIFIER		POINTER											
07	11	08	07	11	08	11				99213		1	47	00			NPI	0123456789					
07	11	08	07	11	08	11				3048F	DM-PQRI #2	1	0	00			NPI	0123456789					
07	11	08	07	11	08	11				3074F	BP<130 mmHg-PQRI #3	1	0	00			NPI	0123456789					
										AND													
07	11	08	07	11	08	11				3078F	CAD-PQRI #6	1	0	00			NPI	0123456789					
07	11	08	07	11	08	11				4011F	BP< 80 mmHg-PQRI #3	2	0	00			NPI	0123456789					
07	11	08	07	11	08	11				1090F	UI Assessed-PQRI #48	2	0	00			NPI	0123456789					
25. FEDERAL TAX I.D. NUMBER				SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT?		28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE							
XX-XXXXXXX				<input checked="" type="checkbox"/> <input type="checkbox"/>		XXXXXX				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		\$ 47 00		\$		\$ 47 00							
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)						32. SERVICE FACILITY LOCATION INFORMATION						33. BILLING PROVIDER INFO & PH #											
SIGNED						DATE						a. XXXXXXXXXXXX											

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

Solo practitioner - Enter individual NPI here

- 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.

I want to participate in 2009 PQRI for Incentive Payment

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2009 PQRI)

Choose Claims-Based Reporting Options

Registry Reporting

<3 Individual Measures apply

3 or More Individual Measures Apply

Only option is to report claims for 12 month reporting period 1/1/09-12/31/09 Report each measure $\geq 80\%$ of applicable patients

Subject to Measure-Applicability Validation (MAV)

Choose to report on ≥ 3 individual measures for 12 months 1/1/09-12/31/09

Report $\geq 80\%$ of applicable patients on at least 3 measures

Choose to report Measures Group for 30 consecutive patients 12 months 1/1/09-12/31/09

Choose to report Measures Group for 12 months 1/1/09-12/31/09

Report $\geq 80\%$ of eligible patients (minimum 30 pts) for a measures group the full 12 months

Choose to report Measures Group for 6 months 7/1/09-12/31/09

Report $\geq 80\%$ of eligible patients (minimum 15 pts) for a measures group the full 6 months

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Claims-Based Reporting Options

January-December 31, 2009	July 1-December 31, 2009
<p>Individual Measures</p> <p>3 measures (or 1-2 measures if less than 3 apply) 80% of applicable Medicare cases</p> <p>Include appropriate quality data codes (CPT II or G-Codes) on all applicable claims</p>	
<p>Measures Groups*</p> <p>All measures in one Measure Group 30 consecutive Medicare patients</p> <p style="text-align: center;">OR</p> <p>80% of applicable Medicare cases (30 patient minimum)</p> <p>Include appropriate Measures Group G-code in the initial claim AND the appropriate quality data code(s) (CPT II or G-code) for each measure in the Measures Group on all applicable claims, including the initial claim</p>	<p>Measures Groups*</p> <p>All measures in one Measure Group 80% of applicable Medicare cases (15 patient minimum)</p>

*There are no PQRI measure groups that apply to ID physicians during the 2009 reporting periods.

Claims-Based Reporting Options

January-December 31, 2009	July 1-December 31, 2009
Individual Measures	
3 measures (or 1-2 measures if less than 3 apply) 80% of applicable Medicare cases Include appropriate quality data codes (CPT II or G-Codes) on all applicable claims	
Measures Groups*	Measures Groups*
 All measures in one Measure Group 30 consecutive Medicare patients OR 80% of applicable Medicare cases (30 patient minimum) Include appropriate Measures Group G-code in the initial claim AND the appropriate quality data code(s) (CPT II or G-code) for each measure in the Measures Group on all applicable claims, including the initial claim 	 All measures in one Measure Group 80% of applicable Medicare cases (15 patient minimum)

*There are no PQRI measure groups that apply to ID physicians during the 2009 reporting periods.

Claims-Based Reporting Options

- **Individual Measures**
 - <3 measures- only option is report for 12 months each measure $\geq 80\%$ of applicable patients (subject to measure-applicability validation)
 - ≥ 3 measures for 12 months on $\geq 80\%$ of applicable patients on at least 3 measures
- **Measures Group**
 - 30 consecutive patients for 12 months or
 - $>80\%$ of eligible patients for 12 months (minimum 30 patients) or 6 months (minimum 15 patients)

Claims-Based Reporting Options

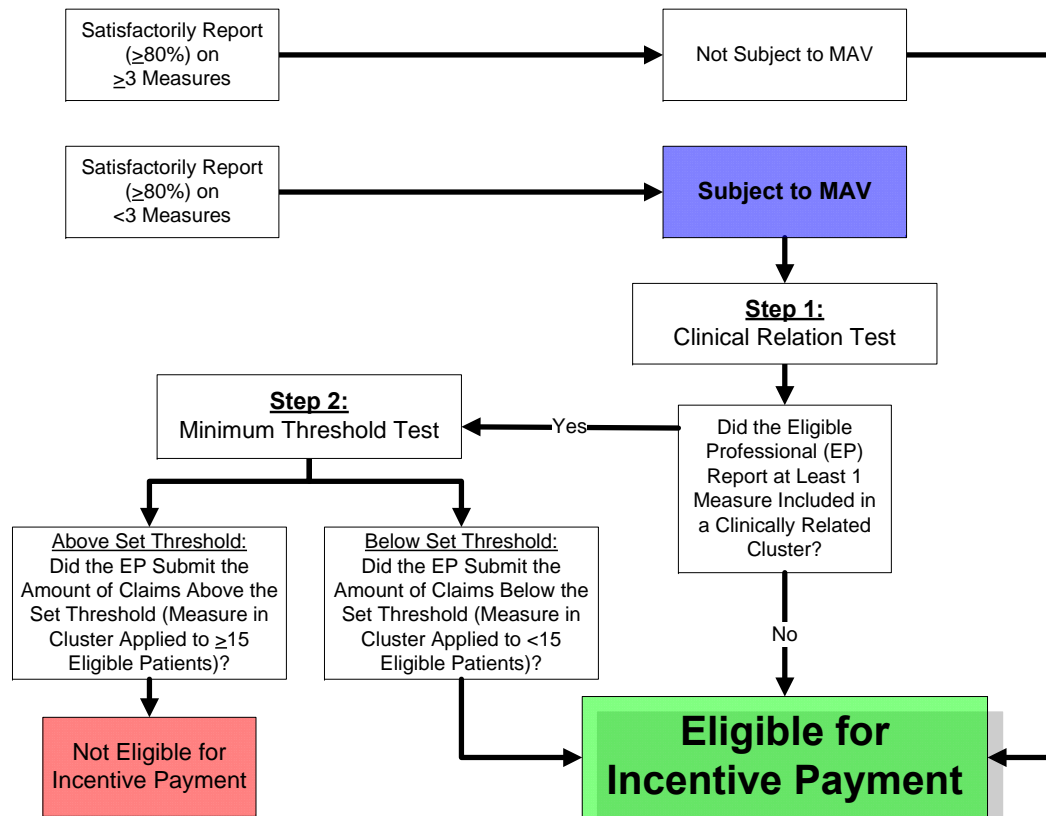
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 - ~~>80% of eligible patients for 12 months (minimum 30 patients) or 6 months (minimum 15 patients)~~

Reporting Methods for Claim-Based Submissions – Individual Measures

- If < 3 measures – need to report for 12 months each measure $\geq 80\%$ of applicable patients
 - Subject to MEASURES- APPLICABILITY VALIDATION
 1. Clinical relation test “Clusters”
 2. Minimum threshold test (≤ 15 patients)
- If ≥ 3 measures for 12 months on $\geq 80\%$ of applicable patients on at least 3 measures
- No 6 months reporting period options

Measure-Applicability Validation

2009 PQRI Measure-Applicability Validation (MAV) Process



Refer to the detailed 2009 PQRI Measure-Applicability Validation Process for Claims-Based Reporting of Individual Measures document for more information.

http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage

Claims-Based Individual Measures Successful Reporting Scenario

Measure #83: Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia (see handout pp 5-10)



Mr. Jones presents for office visit with Dr. Thomas



Mr. Jones has diagnosis of Hepatitis C

Step 1:

Dr. Thomas selects Hepatitis C individual measure #83 as a PQRI reporting option. (Reporting period beginning January 2009)

Step 2:

Dr. Thomas reviews specifications for measure #83. (see handout pp 5-8)

Dr. Thomas submits appropriate CPT II codes measure #83.

Step 3

STEP 2: Claims-Based Individual Measure Successful Reporting Scenario

Measure #83: Hepatitis C: Testing for Chronic Hepatitis C – Confirmation of Hepatitis C Viremia

Dr. Thomas reviews specifications for measure #83.
Dr. Thomas submits appropriate CPT II codes measure #83.

Hepatitis C

Step 2a: Is patient eligible for this measure?

1. 18 y/o on date of encounter
2. Diagnosis of Hepatitis C
3. CPT E/M Code for visit

NO

STOP

Do not report CPT II Code

YES

Step 2b: Other Requirements?

1. Is this an initial eval. for Hepatitis C?

NO

Report 1121 F
(subsequent evaluation for condition)

STOP

YES

Report 1119F

Step 2c: Does patient meet or have an acceptable reason for not meeting measure?

- HCV RNA test done: **Report 3265F**
- Not done for medical reason (not indicated): **Report 3265F – 1P**
- Not done for patient reason (declined): **Report 3265F – 2P**
- Not done, not documented – no reason specified: **Report 3265F – 8P**

Claims-Based Individual Measures Successful Reporting Scenario

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Step 2:

Dr. Thomas reviews specifications for measure #83.

Dr. Thomas submits appropriate CPT II codes measure #83.

Step 3:

Dr. Thomas reports on at least 80% of all Hepatitis C patients \geq 18 y/o with Hepatitis C seen for initial evaluation during reporting period.

I want to participate in 2009 PQRI for Incentive Payment

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2009 PQRI)

Choose Claims-Based Reporting Options

Registry Reporting

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I want to participate in 2009 PQRI for Incentive Payment (Select Reporting Method)

12-Month Reporting Period
1/1/09-12/31/09

6-Month Reporting Period
7/1/09-12/31/09

Claims

Registry

Claims

Registry

Report \geq 80% of eligible patients on at least 3 individual measures or on each measure if $<$ 3 measures apply to the EP

Measures Groups

Submit data on \geq 80% of eligible patients on at least 3 individual measures

Measures Groups

Measures Groups

Measures Groups

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12-Month Reporting Period
1/1/09-12/31/09

6-Month Reporting Period
7/1/09-12/31/09

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~~Measures Groups~~

Submit data on \geq 80% of eligible patients on at least 3 individual measures

~~Report one Measure Group for 30 Consecutive patients~~

~~Report \geq 80% of eligible patients (minimum 30) for a Measures Group~~

~~Submit data on 100% of 50 consecutive eligible patients any time within 12 months (may include some non-Medicare patients)~~

~~Report \geq 80% of eligible patients (minimum 15) for a Measures Group~~

~~Submit data on \geq 80% of EP's eligible patients for the full 12 months (minimum 30 patients)~~

~~Submit data on \geq 80% of EP's eligible patients for the full 6 months (minimum 15 patients)~~

I want to participate in 2009 PQRI for Incentive Payment

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2009 PQRI)

Claims-Based Reporting

Choose Registry Reporting

Registry submits data on 80% of eligible patients on at least 3 individual measures

Registry submits data on one Measures Group

Choose to report
12 months
1/1/09-12/31/09

Choose to report
6 months
7/1/09-12/31/09

Submit
12 months
1/1/09-
12/31/09

Submit
6 months
7/1/09-
12/31/09

Submit data on 100% of 30 consecutive eligible patients within 12 months (may include some non-Medicare patients)

Submit data on 80% of EP's applicable patients for the Measures Group (minimum 30 patients)

Submit data on 80% of EP's eligible patients for a Measures Group (minimum 15 patients)

I want to participate in 2009 PQRI for Incentive Payment

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2009 PQRI)

Claims-Based Reporting

Choose Registry Reporting

Registry submits data on 80% of eligible patients on at least 3 individual measures

~~Registry submits data on one Measures Group~~

Choose to report
12 months
1/1/09-12/31/09

Choose to report
6 months
7/1/09-12/31/09

~~Submit
12 months
1/1/09-
12/31/09~~

~~Submit
6 months
7/1/09-
12/31/09~~

~~Submit data on
100% of 30
consecutive
eligible patients
within 12
months (may
include some
non-Medicare
patients)~~

~~Submit data on
80% of EP's
applicable
patients for the
Measures
Group
(minimum 30
patients)~~

~~Submit data
on 80% of
EP's eligible
patients for a
Measures
Group
(minimum 15
patients)~~

Registry-Based Reporting

- Allows 3rd party databases to also collect and submit PQRI data to CMS
- Many of the existing clinical registries are specialty or site-specific
- Providers do not need to select CPT II codes since the registry performs the measure calculations and performance data is submitted separately from the billing process
- Probably need to pay for this service

Qualified Registries for PQRI Reporting

- 32 Registries in 2008 successfully completed the CMS vetting process
- HIV/AIDS Measures (159-162) only reportable via a registry
- Other ID related measures reportable via a registry or claims-based
- Two registries accept ID related measures:
 - Outcome: www.outcome.com/programs-total-quality.htm
 - Patient 360: www.patient360.com

Registry Reporting Options

- Individual Measures
 - At least 3 measures on $\geq 80\%$ of eligible patients for either the 6 month or 12 month reporting period
- Measures Group
 - 30 consecutive patients (may include some non-Medicare FFS)
 - $>80\%$ of eligible patients for measure group for 12 months (minimum 30 patients) or 6 months (minimum 15 patients)

Registry Reporting Options

- Individual Measures

- At least 3 measures on $\geq 80\%$ of eligible patients for either the 6 month or 12 month reporting period

- ~~Measures Group~~

- ~~30 consecutive patients (may include some some non-Medicare FFS)~~
- ~~>80% of eligible patients for measure group for 12 months (minimum 30 patients) or 6 months (minimum 15 patients)~~

Reporting Methods for Registry-Based Submissions – Individual Measures

- At least 3 measures on $\geq 80\%$ of eligible patients for either 6 months or 12 months reporting period

Registry-Based Reporting Options

January-December 31, 2009	July 1-December 31, 2009
Individual Measures	Individual Measures
At least 3 measures 80% of applicable Medicare cases (HIV measures reporting group)	At least 3 measures 80% of applicable Medicare Cases (HIV Measures reporting group)
Measures Groups*	Measures Groups*
All measures in one Measures Group 30 consecutive patients (Consecutive patients may include <u>some</u> non-Medicare) OR 80% of applicable Medicare cases (30 patient minimum)	All measures in one Measures Group 80% of applicable Medicare cases (15 patient minimum)

*There are no PQRI measure groups that apply to ID physicians during the 2009 reporting periods.

Registry-Based Reporting Options

January-December 31, 2009	July 1-December 31, 2009
Individual Measures At least 3 measures 80% of applicable Medicare cases (HIV measures reporting group)	Individual Measures At least 3 measures 80% of applicable Medicare Cases (HIV Measures reporting group)
 Measures Groups* All measures in one Measures Group 30 consecutive patients (Consecutive patients may include <u>some</u> non-Medicare) OR 80% of applicable Medicare cases (30 patient minimum) 	 Measures Groups* All measures in one Measures Group 80% of applicable Medicare cases (15 patient minimum)

*There are no PQRI measure groups that apply to ID physicians during the 2009 reporting periods.

I want to participate in 2009 PQRI for Incentive Payment

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2009 PQRI)

Claims-Based Reporting

Choose Registry Reporting

Registry submits data on 80% of eligible patients on at least 3 individual measures

Registry submits data on one Measures Group

Choose to report
12 months
1/1/09-12/31/09

Choose to report
6 months
7/1/09-12/31/09

Submit
12 months
1/1/09-
12/31/09

Submit
6 months
7/1/09-
12/31/09

Submit data on 100% of 30 consecutive eligible patients within 12 months (may include some non-Medicare patients)

Submit data on 80% of EP's applicable patients for the Measures Group (minimum 30 patients)

Submit data on 80% of EP's eligible patients for a Measures Group (minimum 15 patients)

I want to participate in 2009 PQRI for Incentive Payment

Select Reporting Method

(Refer to the appropriate Measure Specifications for the specific reporting method(s) chosen for 2009 PQRI)

Claims-Based Reporting

Choose Registry Reporting

Registry submits data on 80% of eligible patients on at least 3 individual measures

~~Registry submits data on one Measures Group~~

Choose to report
12 months
1/1/09-12/31/09

Choose to report
6 months
7/1/09-12/31/09

~~Submit
12 months
1/1/09-
12/31/09~~

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6 months
7/1/09-
12/31/09~~

~~Submit data on
100% of 30
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months (may
include some
non-Medicare
patients)~~

~~Submit data on
80% of EP's
applicable
patients for the
Measures
Group
(minimum 30
patients)~~

~~Submit data
on 80% of
EP's eligible
patients for a
Measures
Group
(minimum 15
patients)~~

I want to participate in 2009 PQRI for Incentive Payment (Select Reporting Method)

12-Month Reporting Period
1/1/09-12/31/09

6-Month Reporting Period
7/1/09-12/31/09

Claims

Registry

Claims

Registry

Report \geq 80% of eligible patients on at least 3 individual measures or on each measure if $<$ 3 measures apply to the EP

Measures Groups

Submit data on \geq 80% of eligible patients on at least 3 individual measures

Measures Groups

Measures Groups

Measures Groups

Submit data on \geq 80% of eligible patients on at least 3 individual measures

Report one Measures Group for 30 consecutive patients

Report \geq 80% of eligible patients (minimum 30) for a Measures Group

Submit data on 100% of 30 consecutive eligible patients any time within 12 months (may include some non-Medicare patients)

Report \geq 80% of eligible patients (minimum 15) for a Measures Group

Submit data on \geq 80% of EP's eligible patients for the full 12 months (minimum 30 patients)

Submit data on \geq 80% of EP's eligible patients for the full 6 months (minimum 15 patients)

I want to participate in 2009 PQRI for Incentive Payment (Select Reporting Method)

12-Month Reporting Period
1/1/09-12/31/09

6-Month Reporting Period
7/1/09-12/31/09

Claims

Registry

Claims

Registry

Report \geq 80% of eligible patients on at least 3 individual measures or on each measure if $<$ 3 measures apply to the EP

~~Measures Groups~~

Submit data on \geq 80% of eligible patients on at least 3 individual measures

~~Measures Groups~~

~~Measures Groups~~

~~Measures Groups~~

Submit data on \geq 80% of eligible patients on at least 3 individual measures

~~Report on Measures Group for 30 Consecutive patients~~

~~Report \geq 80% of eligible patients (minimum 30) for a Measures Group~~

~~Submit data on 100% of 30 consecutive eligible patients any time within 12 months (may include some non-Medicare patients)~~

~~Report \geq 80% of eligible patients (minimum 15) for a Measures Group~~

~~Submit data on \geq 80% of EP's eligible patients for the full 12 months (minimum 30 patients)~~

~~Submit data on \geq 80% of EP's eligible patients for the full 6 months (minimum 15 patients)~~

Example 1

After reviewing the 2009 PQRI measure specifications, you have determined that the four HIV/AIDS measures (159-162) are applicable to your practices. **No claims-based reporting options apply for the HIV/AIDS measures.** Under the registry-based reporting option of individual measures, you must report at least 3 of the 4 HIV/AIDS measures in 80 percent of the applicable Medicare cases to be eligible for the 2.0 percent incentive payment.

Example 2

After reviewing the 2009 PQRI measure specifications, you have determined that four HIV/AIDS measures (159-162) and the nine Hepatitis C measures (83-90 & 183-184) are applicable to your practice. Under the claims-based report options, you must report at least three of the nine Hepatitis C measures in 80 percent of the applicable Medicare cases to be eligible for the 2.0 percent incentive payment. No claims-based reporting options apply for the HIV/AIDS measures. Under the registry-based reporting option of individual measures, you can report any combination (but at least three) of the HIV/AIDS and Hepatitis C measures in 80 percent of the applicable Medicare cases to be eligible for the 2.0 percent incentive payment.

Example 3

After reviewing the 2009 PQRI measure specifications, you have determined that the Medication Reconciliation (46) measure is the only measure applicable to your practice. Under the claims-based reporting option, you must report this measure in at least 80% of the applicable cases in order to earn a cumulative 2.0 percent incentive payment. Registry-based reporting of individual measures is not applicable if less than three measures apply to your practice.

Prepare to Participate in PQRI

- **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 vendors.
- **Read and discuss** with staff: reporting principles and specifications for each of the measures selected for reporting in PQRI.
- **Develop a process** for concurrent data collection so that eligible claims and PQRI codes 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.

PQRI Basics

- Read the directions
 - www.cms.hhs.gov/pqri
 - www.idsociety.org
- Train your staff
- Keep it simple
 - Report on 3 measures
 - Consider adding 1 extra as safety net

PQRI Basics

- **Choose measures wisely**
 - Pick ones you do anyway and not tightly linked to patient adherence
- **Bounce-proof your billing service**
 - Are the billing service's practices compatible with PQRI's reporting rules?
(e.g. Accept a zero in the dollar amount line?)

Results of 2007 PQRI

- 16% of eligible providers participated
- Approx. 50% of participants got a bonus
- Avg. \$600 individual, \$4700 group
- Comments:
 - Easy to do
 - No appeal process
 - Successful reporting through the billing system can be tricky

PQRI 2007 Problems

- Generally easily avoidable
- Report incorrect ICD-9
- Report incorrect age or sex
- Fail to include provider identifiers on claim
- Billing software split a claim into smaller claims
 - Quality codes on one, CPT E/M, ICD-9 on other)
- Billing software reject \$0.00 on the dollar amount line

What to Expect if You Succeed

EXAMPLE:

Total *Allowable** Medicare Charges 2009
reporting Period = \$100,000

Multiply X 2 % Incentive Bonus = **\$2000**

* (Estimate based on what % Medicare usually pays of
the practice's established fee schedule)

Resources

- www.idsociety.org
- www.acponline.org
- www.cms.hhs.gov/pqri
- www.outcome.com/pqri.htm

Resources Available

Physician Quality Reporting Initiative:

<https://www.cms.hhs.gov/pqri>

CMS Quality Initiatives - General Information:

<http://www.cms.hhs.gov/QualityInitiativesGenInfo/>

12/9/08 Issues Paper: Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physician and Other Professional Services

<http://www.cms.hhs.gov/center/physician.asp>

Hospital Quality Reporting:

www.hospitalcompare.hhs.gov

Open Door Forums:

<http://www.cms.hhs.gov/OpenDoorForums/>

National Provider Identifier:

<https://nppes.cms.hhs.gov/NPPES/Welcome.do>

Demonstrations:

<http://www.cms.hhs.gov/DemoProjectsEvalRpts/>

Additional Resources

American Medical Association – Physician Consortium for Performance Improvement

<http://www.ama-assn.org>

National Committee on Quality Assurance

<http://www.ncqa.org/>

National Quality Forum

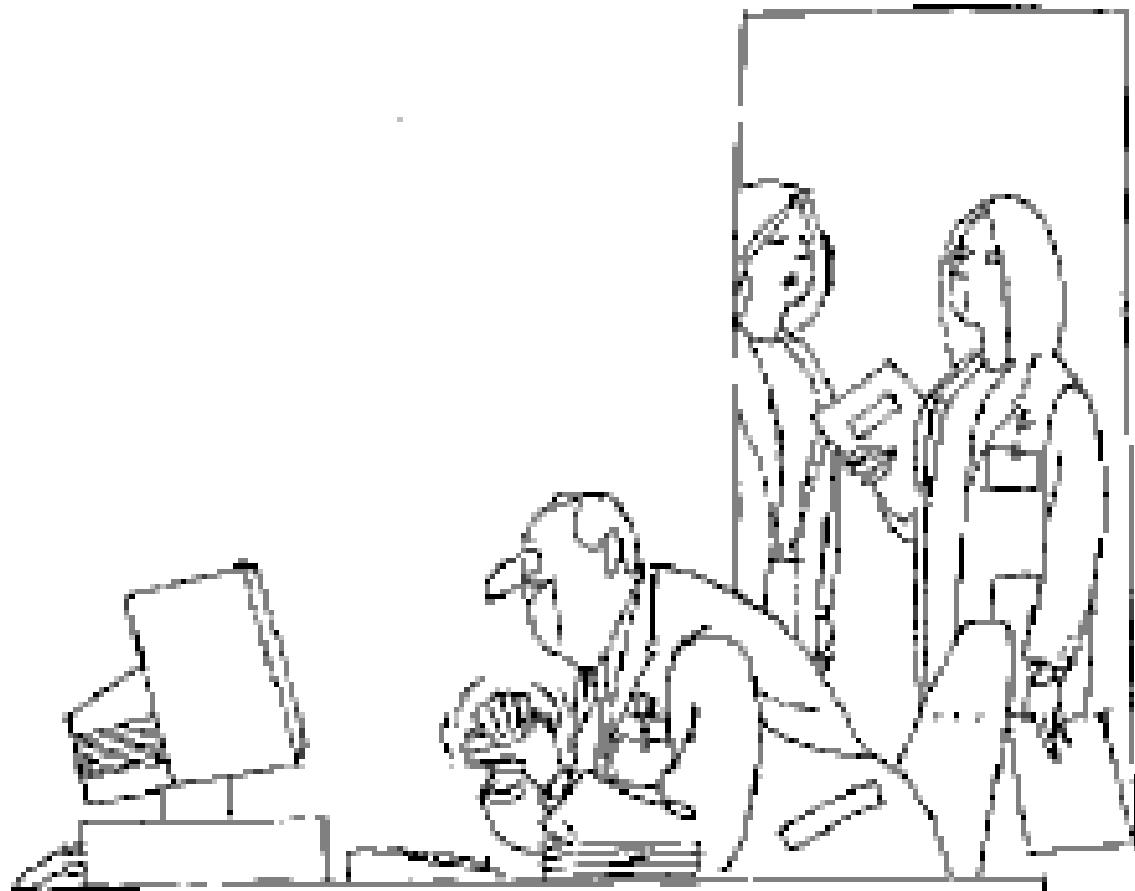
<http://www.qualityforum.org>

Medicare Payment Advisory Commission

<http://www.medpac.gov>

National Academies Press – *Pathways to Quality Health Care* series – performance measurement and improvement

<http://www.nap.edu>



*"The doctor's going to try e-prescribing.
Alert all the pharmacists."*

What is the Medicare E-Prescribing Program?

- New program authorized under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
- Begins January 1, 2009
- Based on former (2008) PQRI Measure #125, but specifications are different
- If you are a successful prescriber, you receive a 2% incentive payment of total allowable Part B Medicare charges.

Are You Eligible for e-Rx?

- Estimated allowed Medicare Part B charges for e-prescribing measure codes are at least 10% of your total Medicare Part B allowed charges

Example

You have \$100,000 in estimated allowed Medicare Part B charges, at least \$10,000 of these charges must be based on the HCPCS Codes that are in the denominator of the e-Rx Measure (new pt 99201-99205, estab. 99211-99215, consults 99241-99245, plus oph, psych, gyn screen, etc.)

See handout (p 34)

What Is a “Successful e-Prescriber” - 2009

- **Must report the e-Rx quality measure through your Medicare Part B claims on at least 50% of applicable cases during the reporting year**

MIPPA Legislation - PQRI

- **The Medicare Improvements for Patients and Providers Act (MIPPA), passed in July 2008, contained several new authorities and requirements for quality reporting and PQRI for 2009 and beyond**
- **Section 132 contains the new electronic prescribing incentive provisions**

Electronic Prescribing Measure in 2008 PQRI

- Currently eligible professions (EPs) can report that they electronically prescribe (eRx) medications using a qualified program as defined in PQRI measure #125 Adoption/Use of e-Prescribing by reporting one of the G-codes in the measure
- You must have and regularly use an electronic prescribing program to report the measure
- The electronic prescribing program must meet ALL of the requirements listed in PQRI measure # 125
- If you have not adopted an electronic prescribing system that meets the specifications of the measure you cannot report on this measure.

Qualified Electronic Prescribing Systems – Measure #125

- The measure assessed eligible professional's use of electronic prescribing using a qualified system
- As a qualified system, the program must be able to perform the following tasks:
 - Generate a medication list
 - Selecting medications, transmitting prescriptions electronically and conducting safety checks*
 - Providing information on lower cost alternatives
 - Providing information on formulary or tiered formulary medications, patient eligibility and authorization requirements received electronically from the patient's drug plan\

*Safety checks include: automated prompts that offer information on the drug being prescribed, potential inappropriate dose or route of administration of the drug, drug-drug interactions, allergy concerns, and warnings/cautions.

Successful Reporting of the eRx Measure for 2009

- The measure is intended to be reported on for **EVERY** patient visit in the denominator
- Successful reporting is defined as reporting the measure on at least 50% of eligible patients
 - Limitation: CPT codes that make up the denominator **MUST** account for at least 10% of the provider's total allowed charges for Medicare Part B covered services

Incentives for Successful Electronic Prescribing Under MIPPA

- A 2% payment incentive for successful use of e-prescribing is available for 2009 & 2010
- In 2011 and 2012 the payment incentive drops to 1% of covered Medicare Part B charges
- In 2013 the incentive drops to 0.5% of the covered Medicare Part B charges

E-Prescribing Incentive Program

Year	Successful	Not Successful
2009	+2.0 percent	--
2010	+2.0 percent	--
2011	+1.0 percent	--
2012	+1.0 percent	-1.0 percent
2013	+0.5 percent	-1.0 percent
2014 (& subsequent years)	--	-2.0 percent

How to Report the e-Rx Incentive Program Measure

- Step 1: bill on the approved CPT I and G-Codes (eg. Established office 99213) – **denominator**
- Step 2: Report one of the three G-Codes on more than 50% of applicable cases – **numerator**
- Each of 3 codes count toward eRx Incentive

E-prescribing Incentive Program

Quick Reference : G-Codes

If You....	Report
Used a qualified e-prescribing system for all of the prescriptions	G8443
Had a qualified e-prescribing system, but didn't generate any prescriptions during this encounter	G8445
Had a qualified e-prescribing system, but prescribed narcotics or other controlled substances	G8446
Had a qualified e-prescribing system, and state or Federal law required you to phone in or print the prescriptions	G8446
Had a qualified e-prescribing system, and the patient asked that you phone in or print the prescriptions	G8446
Had a qualified e-prescribing system, and the pharmacy system can't receive electronic transmission	G8446

Electronic Prescribing Program

- Can earn incentive pay even if no medications were prescribed or if E-RX for the drug are prohibited by law (controlled substances) as long as appropriate numerator codes are on the claim.

Reporting Scenarios

E-Prescribing



A 70-year old male patient presents to the clinician's office for medical care.

Scenario 1:

The clinician discusses current medications and prescribes new medication, updates active medication list in eRx system, transmits prescription electronically to pharmacy.

Reports G8443

Scenario 2:

Patient uses a pharmacy that cannot accept eRx and asks for a hard copy.

OR

Prescription is for a controlled substance. Physician updates meds in eRx system, eRx system provides hard copy of prescription to patient.

Reports G8446

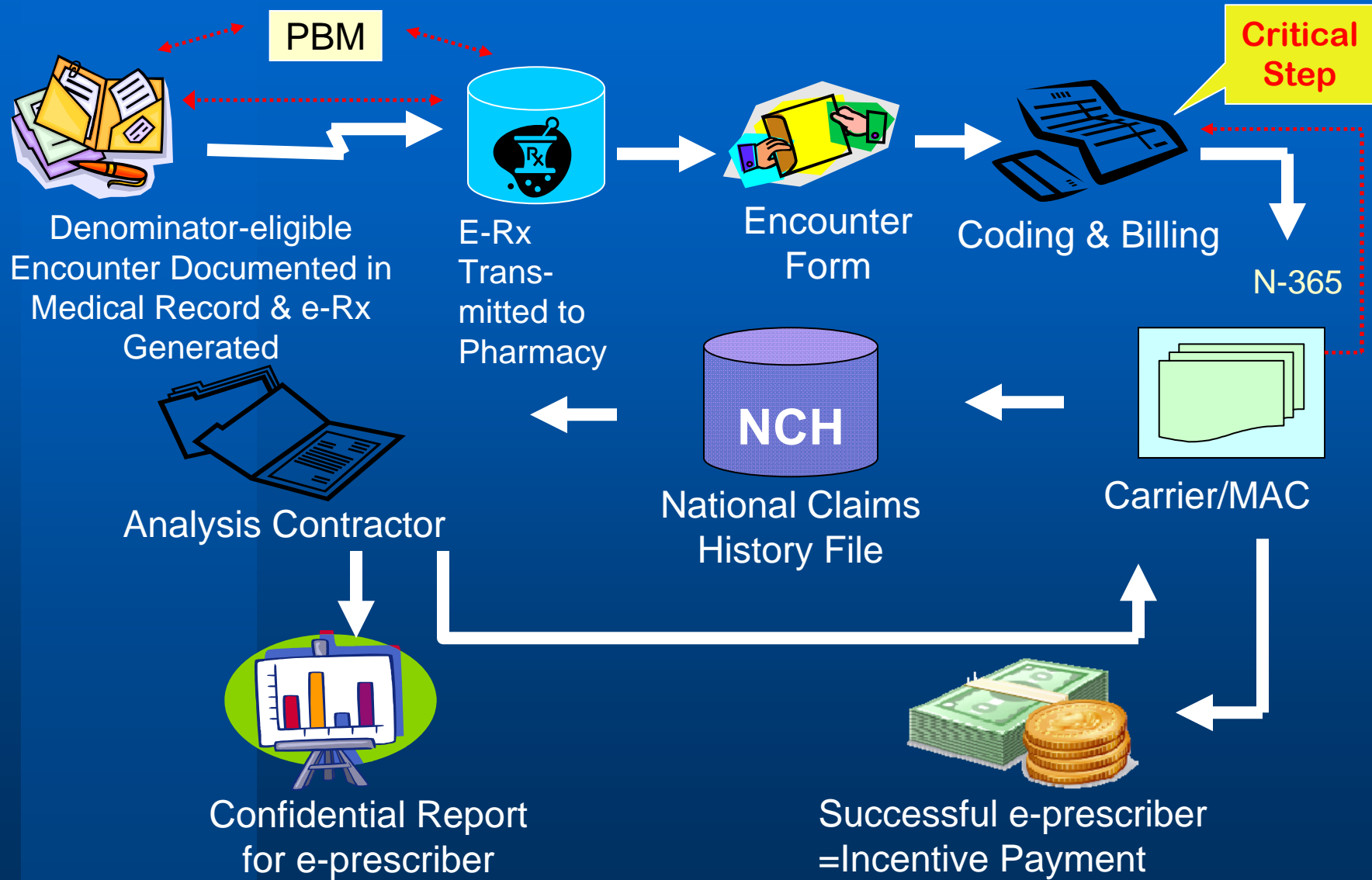
Scenario 3:

The clinician documents there were no prescriptions generated; provider does have access to a qualified eRx system.

Reports G8445

All of these scenarios represent successful 2009 reporting

How the E-Prescribing Incentive Program Works



NEPSI ~ www.nationalerx.com

- **National e-Prescribing Patient Safety Initiative**
- **Largest, most significant coalition of key healthcare stakeholders ever to address issue of medication errors.**
- **Available at no cost to every physician**
- **Provides the equivalent of Yahoo! or Google web-based e-mail (not the MS Outlook or Lotus Notes e-mail space)**

NEPSI Requirements

- **Connection to the Internet**
- **Modern web browser (Internet Explorer, Firefox) (no complicated installs)**
- **Almost any device (PC, Macintosh, cell phone, wireless, PDA)**
- **It is Web based, requires no downloads, no new hardware, minimal training**

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New wireless telephone poles

Support

- “Help” on the website – “click Help with this screen anytime”
- Free flash tutorials, online
- Free FAQs
- Free e-mail support
- Regional supporter(s)

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If pharmacists spoke like doctors wrote.

Resources

<http://www.cms.hhs.gov/partnerships/downloads/11399.pdf>

<http://www.ehealthinitiative.org/erx/clinicians.msp>

www.cms.hhs.gov/eprescribing

www.nationalerx.com

www.surescripts.com

www.acponline.org

Thank you for your attention!

NOW.....go get that 4 %!

Questions?