

CMS Physician Quality Reporting Initiative (PQRI) Nuts and Bolts of Participation

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Overview

- PQRI basic concepts
- How to participate (and get paid)
- Radiology measures
- Coding
- Reporting Options
- Q&A

PQRI Background

- **“Quality” reporting program with financial incentive**
 - Initially authorized by TRHCA in 2006 for 2007 implementation
 - MMSEA continued bonus incentive in 2008
 - MIPPA authorized incentive payments through 2010
 - 2% total allowable Medicare Part B charges for reporting period
 - Voluntary program
- Remains a **“Pay for Reporting”** program in 2010
- Report measures through claims or registries

Why Participate?

- **Collect clinical information at point of care**
- **Measures can act as reminders for certain care actions or documentation of best practice**
- **Receive modest payment (2% bonus)**
- **Reporting quality codes on claims is minimally burdensome once systems are in place**
- **Gain experience in reporting and measuring against quality measures**
- **PQRI experience could inform and be a part of broader quality improvement strategy**

PQRI Key Points

- **No enrollment or registration - can just submit claims**
- **Requirements are to report at least 3 measures unless only 1 or only 2 apply to practice**
- **Reporting/payment at individual provider level**
 - **Must include NPI**
- **Bonus applies to TC as well as PC if billed globally under PFS**
- **CMS makes aggregate payments to groups under single TIN**
- **Analysis and feedback will assess QM reporting rate and actual performance rate**

Getting Started

- **Review CMS PQRI Implementation Guide**

- http://www.cms.hhs.gov/PQRI/Downloads/2009_PQRI_ImplementationGuide_062209_508.pdf

- **Select quality measures applicable to individuals in your group practice**

- **Determine # of measures reportable by each individual**

- **Decide to report through claims or CMS “qualified” registry**

- **List of qualified registries (available for radiology measure reporting highlighted):**

http://www.acr.org/SecondaryMainMenuCategories/quality_safety/p4p/FeaturedCategories/P4PInitiatives/ValueBasedPurchasing/pqri/CMSQualifiedRegistriesfor2009.aspx

Getting Started (cont)

- Establish team/processes to systematically report QM for each patient
 - Billing/coding staff involvement key
 - IT support for developing coding edits for clearinghouse may be needed
- Develop process for radiologist to communicate which claims, what codes should be reported
 - Dictation macros for including measure reporting requirements
 - Develop process to make sure coding/billing staff capturing info from reports to process on claims
 - Workflow sheets such as AMA's
 - See PQRI tools at:
http://www.acr.org/SecondaryMainMenuCategories/quality_safety/p4p/FeaturedCategories/P4PInitiatives/ValueBasedPurchasing/pqri.aspx
- Ensure billing software/clearinghouse can report measure codes on claims to carrier/AB MAC
 - Submit quality codes with zero dollar amount (or \$.01)
 - RA comes with denied payment

How, What and When to Report

- Eligible cases for reporting have ICD9 and/or CPT I codes in measure denominator
- Measures are reported using “Quality Data Code” (CPT II or G-codes) on claims for service applicable to each measure
- Report QDC modifier if appropriate
 - Exclusion modifiers: 1P (medical), 2P(patient) or 3P (system)
 - Reporting modifier: 8P (action not done)
- Report QDC on at least 80% of eligible cases/claims
- Measures Groups – may be option for Interventional Radiologists

PQRI Measures – 2009

- 175 measures in 2009
- 5 measures largely applicable to diagnostic radiologists

- **Measure 10 Stroke Imaging – CT/MRI Reports**

Percentage of final reports for CT or MRI studies of the brain for patients with diagnosis/symptoms of TIA or ischemic stroke that include documentation of the presence or absence of hemorrhage and mass lesion and acute infarction

- **Measure 11 Stroke Imaging – Carotid Imaging Reporting**

Percentage of final reports for carotid imaging studies for patients with the diagnosis of ischemic stroke or TIA that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement

- **Measure 145 Radiology – Fluoroscopy Time Recorded:**

Percentage of final reports for procedures using fluoroscopy performed for patients that include documentation of radiation exposure or exposure time.

PQRI Measures – 2009 (cont)

- **Measure 146 Radiology – Inappropriate Use of BIRADS 3:**

Percentage of final reports for screening mammograms that are classified as BIRADS Category 3, “probably benign”

- **Measure 147 Nuclear Medicine – Correlation of Bone Studies**

Percentage of final reports for all patients undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (eg, x-ray, MRI, CT, etc.) that were performed

PQRI Measures – 2009

- **Another 7 may be applicable to interventional radiologists**
 - **Measures 20-23 Perioperative Care Set**
 - #20 – Timing of Antibiotics – Ordering Physician
 - #21 – Selection of Antibiotic
 - #22 – Discontinuation of Antibiotic
 - #23 – VTE Prophylaxis
 - **Measure 24 Osteoporosis – Communication Following Fracture**
 - **Measure 40 Osteoporosis – Management Following Fracture**
 - **Measure 76 Critical Care – Maximum Sterile Barrier Technique**

PQRI Measures – 2009 (cont)

- **7 applicable to radiation oncologists**
 - **Measure 71 Oncology – Hormonal Therapy**
 - **Measure 102 Prostate Cancer – Bone Scan Overuse – Staging**
 - **Measure 104 Prostate Cancer – Adjuvant Hormonal Therapy**
 - **Measure 105 Prostate Cancer – 3D Radiotherapy**
 - **Measure 143 Oncology – Pain Intensity Quantified**
 - **Measure 144 Oncology – Plan of Care for Pain**
 - **Measure 156 Oncology – Tissue Dose Constraints**

PQRI – 2010 Changes

- **Fee Schedule Updates – waiting for Final Rule**
- **No major changes for diagnostic radiology measures**
- **Measure #11 revised, included under new measure #**
 - **Applies to all carotid imaging, not just for stroke patients**
- **Measure #10 specifications revised – clarification on when to report (24 hour arrival rule, outpatient imaging)**
- **Oncology measures 143/144 may be dropped – CMS considered analytically challenging**
- **Potentially one new oncology measure – Cancer Stage Documented**
- **General – participants must report at least 15 cases on at least one measure**

Coding/Dictation Guidance Example

Measure # 11– Carotid Imaging Reporting

| | |
|--|---|
| <p>Step #1: Is patient eligible?</p> | <ul style="list-style-type: none"> ✓ Medicare patient aged 18 years or older ✓ A carotid imaging study is performed (70498, 70547, 70548, 70549, 75660, 75662, 75665, 75671, 75676, 75680, 93880, 93882) ✓ Patient has diagnosis of ischemic stroke or TIA (in 2009: 433.01, 433.11, 433.21, 433.31, 433.81, 433.91, 434.01, 434.11, 434.91, 435.0, 435.1, 435.2, 435.3, 435.8, 435.9) <p style="text-align: center;">(2010 all ICD9 diagnoses codes)</p> <p>If yes, continue.</p> |
| <p>Step #2: Does patient meet or have acceptable reasons for not meeting measure?</p> | <ul style="list-style-type: none"> ✓ Does report include direct or indirect reference to measurements of distal internal carotid diameter as denominator for stenosis measurement? <p style="padding-left: 40px;">If yes, report CPT II 3100F</p> <p style="padding-left: 40px;">If no and reason not provided, report CPT II 3100F-8P</p> |

Reporting Options Overview

- **Alternate reporting periods and criteria increases participation/reporting options**
 - January 1 – December 31
 - July 1 – December 31
- **Total of 9 reporting methods**
 - 3 claims-based
 - 6 registry based

Claims Based Options

- **Reporting period: January 1 – December 31**
 - Only option for reporting individual quality measures through claims
 - Report 80% of eligible cases
- **Reporting period: July 1 – December 31**
 - Report a measure group for 15 consecutive eligible patients
 - Report a measure group for 80% of eligible patients over six month period
 - Interventional radiologists could report Perioperative Care Measure Group
- **Potentially could still report individual quality measures for 2009**
 - Registry reporting only option
 - Individual must be able to report 3 measures to use registry

Bonus Payment and Feedback Reports

- **2% bonus paid for successful reporting**
 - 80% of eligible claims submitted with accurate CPT II codes (using claims based individual reporting method)
 - If only 1 or only 2 measures reported, individual physician claims subject to “measure applicability validation” process
- **Analysis begins in March following report year**
 - Bonus paid in October timeframe to group TIN/NPI combinations
 - Check comes from Carrier
 - Feedback reports include reporting rate and performance rate
 - Reports accessed through CMS “IACS” system (Individuals Authorized Access to CMS Computer Services), must register

Resources

- **CMS Website:**

- http://www.cms.hhs.gov/PQRI/01_Overview.asp#TopOfPageRegistry
qualifications

- **ACR Website:**

- http://www.acr.org/SecondaryMainMenuCategories/quality_safety/p4p/FeaturedCategories/P4PInitiatives/ValueBasedPurchasing/pqri.aspxMeasures
groups

- **RBMA Forum for coders/billing staff**

- **Questions:**

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