# Dollars for Quality

by Cindy Parman, CPC, CPC-H, RCC

With the constant threat of a reduced conversion factor for physician reimbursement under the Medicare Physician Fee Schedule (PFS), smart tracking of quality measures under the Physician Quality Reporting Initiative (PQRI) may help to increase physician practice reimbursement.

The 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system that included an incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries. For each program year, CMS implements PQRI through an annual rulemaking process published in the *Federal Register.*

Eligible professionals (EPs) are not required to sign-up or pre-register to participate in the PQRI. However, each eligible professional must meet the reporting criteria outlined by CMS. Remember that the PQRI requirements and measurement specifications may differ from one year to the next.

Professionals eligible to participate in the PQRI program include physicians (MD, DO, DPM, OD, DDS, DDM, DC), practitioners (PA, NP, CNS, CRNA, AA, CNM, CSW, clinical psychologist, registered dietician, nutrition professional, audiologist), and therapists (physical therapist, occupational therapist, qualified speech-language therapist).

New for 2010 is group practice reporting, which applies to medical practices that include a minimum of 200 eligible professionals. These groups must self-nominate to CMS, and EPs reporting at the group level cannot also report at an individual level.

## 2010 PQRI

To participate in the 2010 PQRI, EPs may report information on individual PQRI quality measures or measure groups to:

- CMS on its Medicare Part B claims
- A qualified PQRI registry
- CMS via a qualified electronic health record (EHR) product.

Currently, there are no measure groups for oncology.

In addition, EPs can choose to participate in one of two reporting periods:

- January 1 through December 31, 2010 (12 months)
- July 1 through December 31, 2010 (6 months).

Due to the limited availability of transmission via electronic health record (only 10 quality measures are available for EHR transmission in 2010), medical oncology and hematology practices will use direct submission via individual claim forms or select a qualified PQRI registry.

At the time this article was published, 31 vendors were listed as CMS qualified registries. To be "qualified," registries are required to go through a self-nomination and vetting process and meet certain technical and other requirements established by CMS.

## Incentive Payments

Individual EPs (and group practices of at least 200 EPs) who meet the criteria for correct submission of PQRI quality measures data for services furnished during a 2010 PQRI reporting period will qualify to earn a PQRI incentive payment equal to 2 percent of their total estimated Medicare Part B PFS allowed charges for covered professional services performed during that same reporting period.

The incentive payments for each program year are issued separately as a single consolidated incentive payment in the following year. The incentive payment, with the remittance advice (RA), will be issued by the Carrier or A/B Medicare Administrative Contractor (MAC) and identified as a lump-sum PQRI incentive payment. The physician or practice also has access to online PQRI Feedback Reports for every tax identification number under which at least one EP submitted at least one valid PQRI measure during the reporting period.

## How Does it Work?

Physicians and other eligible professionals should review the PQRI Quality Measure Specifications and related instructional materials, such as the PQRI Coding for Quality Handbook on the CMS website. At least three measures that are directly applicable to the patient population should be selected. The detailed specifications for each measure describe when that measure is reportable and which quality-data code (QDC) to report.

QDCs are non-payable HCPCS codes including CPT Category II codes and/or Level II HCPCS G-codes that describe the clinical action required by a specific measure. The CPT II codes consist of five alphanumeric characters in a string ending with the letter "F" and they will not be changed during the reporting period.

In addition to the CPT II code, it may be necessary to report an exclusion modifier if the measure was *not* performed for an individual patient:

- **1P**: Performance measure exclusion modifier due to medical reasons
- **2P**: Performance measure exclusion modifier due to patient reasons
- **3P**: Performance measure exclusion modifier due to system reasons
- **8P**: Action not performed, reason not otherwise specified.

CMS states that the 8P modifier

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should be reported with care; it would not be appropriate to append this modifier on a regular basis to meet reporting criteria for the bonus, without regard for quality care.

In addition, each measure specification includes a reporting frequency for each eligible patient during the reporting period. For example, while some measures require reporting once for each occurrence, others will only be reported once per reporting period.

When claims are submitted, all diagnosis codes listed on the claim are considered for the quality-data codes listed. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically. The line item containing the QDC should point to one of the diagnosis codes already present on the claim for the payable service.

According to CMS, satisfactory reporting for the PQRI depends on the number of quality measures that apply to the services furnished by the EP during the reporting period. If there are no more than three quality measures applicable to the services provided by the EP, then each measure must be reported for at least 80 percent (for each individual measure) of the cases in which the measure was reportable. If there are four or more quality measures applicable to the services provided by the EP, then at least three measures, selected by the EP, must be reported for least 80 percent of the cases in which each measure applied.

EPs are encouraged to report on all quality measures that apply to the services provided and reporting on as many measures as practicable increases the probability of reaching the 80 percent satisfactory reporting level.

## Which Measures to Use?

For calendar year 2010, there are 179 quality measures (175 individual quality measures and the 4 measures in the Back Pain measures group, which are not reportable as individual PQRI quality measures). The Measures Codes section of the CMS website provides tables and files that outline reporting requirements for each QDC, and includes a link to the 2010 PQRI Implementation Guide. The following factors should be considered when selecting measures for reporting:

1. Clinical conditions treated
2. Care provided (preventive, chronic, acute)
3. Physician or practice personal quality improvement goals for 2010.

Each measure consists of two major components: a denominator that describes the eligible patient population for the measure and a numerator that identifies the clinical action required to report the specific measure. The American Medical Association (AMA) publishes PQRI Participation Tools that provide a complete description of each measure, a data collection sheet, and coding specifications.

In addition to general information related to PQRI, CMS also provides a series of questions and answers on its website to help practices meet all reporting requirements and obtain their incentive payment. A key question always surrounds which of the PQRI measures are most applicable to a certain specialty. CMS consistently responds that specialty-specific questions should be addressed to the relevant professional organization or specialty association. According to CMS, these organizations are generally represented on measurement development work groups and will have detailed specialty information.

## Potential Measures for Oncology

While the exact measures to be reported may vary from one practice to another, the following are some common PQRI measures used in hematology and/or oncology care:

- **47**: Advance Care Plan
- **67**: MDS and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
- **68**: MDS and Acute Leukemias: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
- **69**: Multiple Myeloma: Treatment with Bisphosphonates
- **70**: CLL: Baseline Flow Cytometry
- **71**: Breast Cancer: Hormonal Therapy for Stage IC-IIIC ER/PR Positive Breast Cancer
- **72**: Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
- **76**: Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol
- **102**: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients
- **104**: Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients
- **105**: Prostate Cancer: Three-Dimensional (3D) Radiotherapy
- **124**: Health Information Technology (HIT): Adoption and Use of Electronic Health Records (EHR)
- **130**: Documentation and Verification of Current Medications in the Medical Record
- **136**: Melanoma: Follow-Up Aspects of Care*
- **137**: Melanoma: Continuity of Care – Recall System*
- **138**: Melanoma: Coordination of Care*
- **143**: Oncology: Medical and Radiation – Pain Intensity Quantified*

- **144**: Oncology: Medical and Radiation – Plan of Care for Pain*
- **154**: Falls: Risk Assessment
- **155**: Falls: Plan of Care
- **156**: Oncology: Radiation Dose Limits to Normal Tissues
- **194**: Oncology: Cancer Stage Documented.+

* These measures can only be reported via a registry (not on individual claims). +Measure 194 (Oncology: Cancer Stage Documented) is new for calendar year 2010.

## Troubleshoot!

Providers need to work with their clearinghouses or other vendors regarding line limitations for claims. Make certain that the clearinghouse or billing software vendor does not drop either diagnosis codes or QDCs. In addition, the QDC must often be listed on the same claim as the billable service it links to, which may require some manipulation of the billing software.

The billing provider must track PQRI cases to verify QDCs reported against the remittance advice notice to ensure that all codes were successfully communicated to the Medicare contractor. Last, the year-end financial reports should be reviewed to ensure correct incentive payment.

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## Resources


1. Overview: Physician Quality Reporting Initiative. Available online at: *www.cms.hhs.gov/PQRI*. Last accessed March 15, 2010.
2. Qualified Registries for the 2010 PQRI and Electronic Prescribing Incentive Programs. Available online at: *http://www.cms.hhs.gov/PQRI*. Last accessed March 15, 2010.
3. PQRI Measures Codes. Available online at: *www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage*. Last accessed March 15, 2010.
4. PQRI FAQs. Available online at: *http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?%20p_pv=3.945&p_prods=8%2C61%2C945&p_cats=&p_hidden_prods=&prod_lvl1=8&prod_lvl2=61&prod_lvl3=945*. Last accessed March 15, 2010.
5. Participation Tools: Individual Quality Measures for 2010 PQRI. Available online at: *www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/participation-tools-individual-2010.shtml*. Last accessed March 15, 2010.