

Did You Know?

Physician Quality Reporting Initiative

By Dr. William Whibbs

Physician Quality Reporting Initiative (PQRI) is, to date, a voluntary quality reconnaissance program authorized by the Tax Relief and Health Care Act (TRHCA) passed in 2006, and administered through the Center for Medicare and Medicaid Services (CMS). This program provides a way for CMS to track the quality of the services provided to the beneficiaries of both Medicare and Medicaid (at this time, only Medicare is affected) by physicians. As PQRI stands now, CMS pays physicians incentive dollars based on the success of their reporting only.

The measures CMS/PQRI has chosen (roughly 119 to choose from for 2008) are well established, evidence based measures that multiple physician professional organizations have approved and accepted. And, these measures really do reflect the standards of care by which our network aspires.

Of the estimated 119 measures (side note: There are actually fewer than 119: TRHCA uses successive numbering and retired a number of measures from 2007. Rather than renumbering everything, they left the original numbers, striking through the dropped measures, and adding new ones at the end.), physicians may pick the measures they will report on. This makes good sense because a lot of the measures are very specific and/or applicable to only some practices (i.e. timing of prophylactic antibiotics in surgical cases where prophylaxis is appropriate).

To qualify for the incentive dollars, which amounts to an additional lump payment of 1.5 percent of all appropriate Medicare charges submitted during the recording period (paid out the middle of the following year), a practice must successfully report on only three measures.

While this sounds simple, successful reporting means documenting that the measure was applied 80 percent of the time, as appropriate. CMS does allow for exceptions. For example, a patient who refuses a colonoscopy, flex sig, or stool guaiac, will not be included in the denominator of the 80 percent calculation for the colon cancer screening measure (physicians must document refusal). Likewise, patients in whom beta blockers are contraindicated for medical reasons (again, document the reason), will not be included in the denominator for the 80 percent calculation for the measure of beta blocker use in patients with myocardial infarction.

Also, if for some reason resources are inaccessible to complete the measure (health care delivery system issues; coverage or payment issues, transportation issues, etc.) affected beneficiaries will not be included in the denominator of the 80 percent calculation for whatever the measure is.

There is also a reporting modifier that allows reporting a patient in whom the measure applied, but was not done, and there is no reason why. This seems onerous, but will allow capture of more data without a penalty (yet) for low performance on the measure itself. Because of the potential difficulty of achieving the 80 percent goal, CMS encourages physicians to report in as many categories as possible to increase their chances of achieving success in at least three, as well as to avoid a cap on the amount of bonus available if only three categories are reported (this cap is a complicated formula, and is in place to discourage physicians from choosing only the minimum number of categories that physicians feel are easiest to achieve). Also, the more categories reported, the richer the data pool that CMS has to work with in doing quality analysis.

Actual reporting requires the inclusion of a specific CPT II code (the specific measure) and code modifier (done, not done for a reason, not done and no reason) on the claim along with the ICD-9 code (the diagnosis) and the CPT I (the service being billed) when it is submitted. As a rule, the measure

code and modifier are a separate line item on the claim form, and require the inclusion of “\$0.00” in the charge field for that line. Otherwise, the data will not be captured and scored.

Bear in mind that at this time the bonus payments are strictly based on reporting, not meeting of the standard, which is yet to be spelled out. Most likely, in the near future, bonus payment will also hinge on the achievement of a minimum rate of performance, the formula for the Pay for Performance programs that most of the insurance providers have been struggling to implement.

If and when CMS is successful in implementing PQRI, other providers will likely follow suit. The measures will likely heavily overlap, if not be identical. And, while payers might not make participation mandatory, they could structure bonus systems such that not participating is significantly adverse to reimbursement.

Finally, as has always been the case, people cannot manage what they cannot count. The clinical corollary to this rule is that we can't count what we can't document. Electronic medical records will vastly simplify the task of counting and reporting; however, the use of EMR is still less than 15% in practices overall, and significantly less in smaller practices where resource allocation is most critical.

Of significance in the 2008 PQRI measures, CMS has included one measure that counts use of an EMR and another that counts use of e-prescribing. So, any practice currently using these types of systems has already achieved compliance on two of the required three measures to qualify for bonus payments.

Recent legislation mandates the deployment of EMRs and e-prescribing as a requisite for participating in full Medicare reimbursement with a target date is 2011 (although this date will likely be pushed back because of cost and logistics).

Congress has relaxed some of the Stark mandates to allow for easier financial collaboration between institutions and physicians specifically on Health Information Technology (HIT) investments. Congress has also mandated system interoperability so some of the hurdles to deployment of electronic systems and data exchange are easier to clear.

In the larger scheme of things, PQRI is as reasonable as any of the other quality reporting programs. CMS certainly has the presence in the health care delivery system to capture everyone's attention, and as experience has shown, where CMS goes, other payers follow. Pay for Performance is here, and PQRI is an introduction to the process that for the present is dependent on reporting only. It certainly will change the focus to a large extent on the importance of HIT, as well as encourage a more collaborative approach to the complex and costly transition to electronic systems that are capable of talking to one another.

PQRI is designed to measure and improve the quality of the health care product that physicians are largely responsible for, and it is built around evidence based medicine principles that physicians accept.

For more information on PQRI, visit the official CMS website at <http://www.cms.hhs.gov/pqri>.

MedLearn Matters Articles, the CMS educational resource for physicians and other healthcare providers on pertinent Medicare issues, also has two excellent articles on PQRI, which can be viewed at <http://www.cms.hhs.gov/mlnmattersarticles/downloads/mm5558.pdf> and <http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM5640.pdf>

Additionally, Health First Network will post future information on PQRI on its website at www.hfni.com. Physicians should also feel free to contact me (Dr. Whibbs) directly at 850.434.8147.