Fundamentals of the Physician Quality Reporting Initiative - Frequently Asked Questions About PQRI*

*This CME-certified activity can be found in its entirety at: http://cme.medscape.com/viewprogram/31766. This PDF handout has been provided as an educational tool as a reference and to help learners apply the information to their daily practice.
What is the Physician Quality Reporting Initiative, or PQRI?
The Physician Quality Reporting Initiative, a voluntary program of the Centers for Medicare and Medicaid Services (CMS), provides financial incentives for physicians and other eligible professionals to report data related to their performance on standardized quality measures. These measures represent common and important healthcare services, such as antiplatelet therapy for patients with coronary artery disease or routine foot screening for patients with diabetes.

Launched in April 2007, the PQRI program provides feedback to physicians on their performance and has been widely viewed as the precursor to a Medicare pay-for-performance (P4P) program, similar to those offered by private health plans. However, CMS does not have Congressional authorization for a P4P program. The recently enacted Patient Protection and Affordable Care Act (PPACA) establishes a value-based purchasing program for hospitals, but not for physicians.

What will affect physicians in the future are the PPACA provisions that authorize CMS to test Medicare payment bundling and start a shared-savings program for what are known as “accountable care organizations.” Physicians who begin to measure and report quality data now will be in a good position when these new reimbursement methods arrive.

How much can I earn from PQRI?
Under the PQRI regulations for 2010, eligible professionals or group practices that submit the required data can qualify to receive bonuses equal to 2% of their Medicare allowed charges for the reporting period.

When will I get paid?
You will receive a single payment in the year following your reporting period.

Who is an eligible professional?
To be eligible for PQRI incentives, a healthcare provider must care for Medicare patients and have a national provider identifier (NPI), but not all those who meet these criteria are eligible. Among the eligible professionals (EPs) are the following:

- MD or DO physician
- Podiatrist
- Optometrist
- Oral surgeon
- Dentist
- Chiropractor
- Physician assistant
- Nurse practitioner

A complete list of EPs is available at: https://www.cms.gov/PQRI/Downloads/EligibleProfessionals.pdf

Do I have to fill out a form?
No. You can begin participating in PQRI today by submitting the required data.

What is the reporting period for PQRI?
Either 6 months (July 1-December 31) or the full calendar year, depending on the reporting option you select for submitting data.

How many measures are there?
For 2010, CMS offers 179 measures to choose from. In most cases, physicians must submit data for 80% of applicable patients on at least 3 of these measures.

Where did the PQRI measures come from?
Most of the measures were developed by the American Medical Association (AMA)-convened Physician Consortium for Performance Improvement (AMA-PCPI), the National Committee for Quality Assurance (NCQA), and/or individual specialty societies. The National Quality Forum, representing a broad range of healthcare stakeholders, vetted the measures for validity.

The AMA-PCPI includes representatives from more than 100 specialty and state medical societies, as well as the Council of Medical Specialty Societies, the American Board of Medical Specialties and its member boards, experts in methodology and data collection, the Agency for Healthcare Research and Quality, and CMS.
The NCQA is a private nonprofit organization dedicated to improving the quality of healthcare. It has created measures to assess the performance of health plans and physician groups, and it also certifies practices as patient-centered medical homes.

**What does a PQRI measure look like?**
Each measure includes a denominator and a numerator. In the aggregate, the denominator is the number of eligible cases and the numerator refers to the number of specified interventions that took place. The supplied data allow CMS to calculate the percentage of a defined patient population that received a particular process of care or achieved a particular outcome, depending on the measure.

Diagnosis and procedure codes and patient demographics are used to report the denominator. For example, if you have a patient with diabetes, and you submitted a claim for that patient in the reporting period with a diabetes diagnosis code (eg, 250.00), then that individual patient would be eligible for the diabetes measure.

The numerator for individual measures tracks the care you delivered. For example, if the measure has to do with smoking cessation, it would show whether you counseled patients who smoke during each encounter in the reporting period. Some measures that apply to single episodes of care, such as surgery, would only cover the patient during that episode.

**How do I select the measures to report on?**
Review the 2010 PQRI measures list and decide which make the most sense for your practice. Each measure specification lists the characteristics that place a patient in the denominator, as well as the clinical actions required to meet the goals of the measure.

Among the selection criteria you might use are these:
- Clinical conditions usually treated
- Types of care typically provided (eg, preventive, chronic, acute)
- Settings where care is usually delivered (eg, office, emergency department, surgical suite)
- Quality improvement goals for the year

**What are measures groups?**
A measures group is a collection of measures corresponding to a patient condition, an episode of care, or overall patient care. As an alternative to reporting on 3 individual measures, an EP may choose to report on a measures group if all of the measures within the group are applicable to services that EP provides to Medicare patients. The measures included in measures groups are drawn from the overall list of PQRI measures.

For 2010, EPs can submit data for any of the following measures groups:

- Diabetes mellitus
- Chronic kidney disease (CKD)
- Preventive care
- Rheumatoid arthritis (RA)
- Perioperative care
- Back pain
- Hepatitis C
- Ischemic vascular disease (IVD)
- Community-acquired pneumonia (CAP)
- Coronary artery bypass graft (CABG)
- Heart failure (HF)
- Coronary artery disease (CAD)
- HIV/AIDS

**Who reports the PQRI data and who receives the rewards?**
Until this year, only individual EPs could report data and receive the CMS bonuses if they qualified. Starting in 2010, group practices may report data for the entire group and receive the incentive payment if they meet reporting criteria. Like EPs, group practices are eligible for bonuses of 2% of their total Medicare allowed charges.

**How do I report PQRI data?**
There are 3 pathways for reporting PQRI data to CMS: claims-based, registry, and electronic health record (EHR). All methods use diagnostic codes and special procedure codes known as CPT II codes (or temporary G codes) to describe care processes. The claims-based method submits these codes on the regular claim form. Practices submit claims to the same Medicare intermediaries as part of the normal claims process.
The registry method involves reporting through an electronic registry that may be set up and maintained by an academic institution, a commercial vendor, a medical society, or some other party. Only registries that have been approved by CMS can be used to submit PQRI data. A practice may capture data automatically from its billing system or its EHR for entry into a registry. In some cases, clinicians may have to enter certain kinds of information manually.

CMS has also begun accepting data from particular EHR vendors. The EHR method encompasses only a handful of PQRI measures (10 as of 2010). The list will expand to include 22 measures in 2011. For a list of approved EHR vendors and registries, go to: http://www.cms.gov/PQRI/20_AlternativeReportingMechanisms.asp#TopOfPage.

How do the reporting requirements differ by pathway?
As mentioned earlier, EPs participating via claims-based submission are normally required to report on at least 3 measures for 80% of their applicable patients under the claims-based method. But if fewer than 3 PQRI measures apply to the EP’s practice or specialty, the EP can report on less than 3 applicable measures and receive the bonus payment.

The registry pathway has the same requirements as the claims-based pathway, with 1 significant difference: An EP can choose to forego reporting for 80% of applicable patients. Instead, an EP can submit data for 15 consecutive patients (6 months reporting) or 30 consecutive patients (12 months reporting). Of these consecutive patients, only 2 must be Medicare patients.

When submitting data via the EHR pathway, an EP must submit data for measures that are in the approved list of EHR measures. If you have deployed an EHR that has been approved by CMS for PQRI reporting, you should contact your vendor to confirm the current list of measures/reporting pathways that they support.

What are CPT II codes?
These new codes were created to reflect the quality of care you deliver and/or the outcomes of care for your patient. These should not be confused with G codes, which are temporary designations that were used until the CPT II equivalents were developed. Directly tied to the measures selected by CMS, these new codes track evidence-based quality standards and also have modifiers that allow EPs to explain why certain actions were not performed.

For example, 1 PQRI measure addresses screening colonoscopy in a particular age group. You would use 1 CPT II code to indicate that the patient had undergone the test and another to show that he or she did not. There are also modifiers that show the reason: The patient refused to be screened, there was a medical reason not to receive the test, or there were system limitations, such as the absence of a physician trained to do colonoscopies. CMS takes these modifiers into account when it analyzes the performance of EPs.

Will I be audited?
If you participate in PQRI via the claims-submission process, you are submitting your CPT-II codes with each claim. An integral part of each and every claim you submit for reimbursement is your attestation that all the information contained on the claim is accurate. When you submit PQRI data via a registry or an EHR, you must sign a standalone attestation that declares the same. However, there is no indication that CMS plans to audit practices in this area.

The purpose of the PQRI program is to understand the quality of care delivered to Medicare patients and to help EPs improve their performance. In that sense, the data that CMS delivers back to EPs are only as good as the data it receives.

Will CMS tell me how I did?
You will receive the feedback report even if you did not qualify for the incentive payment as long as you reported on at least 1 valid PQRI measure at least once during the reporting period. The report is confidential and available only to you. It will not be shared with any other entity or individual and it will not be published by CMS on its Website.

What’s next?
Quality reporting is here to stay. The new reform law extended the life of the PQRI program, and private payers are interested in seeing quality data as well. Although PQRI participation is voluntary and the incentives are not performance-based at this point, it seems clear that future reimbursement will depend on the quality of care a physician delivers. PQRI reporting can help you prepare for the next step in healthcare reform.