The new initiative from CMS can add a little to your bottom line and prepare your office for future reporting programs.

# Measuring for Medicare: THE PHYSICIAN QUALITY REPORTING INITIATIVE

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In January of 2006, the Centers for Medicare & Medicaid Services (CMS) launched the Physician Voluntary Reporting Program to collect performance measurement data in seven areas of clinical care. During the program's first year, physician participation was low because of the burden of collecting and reporting the data and the lack of financial incentives for doing so. However, with passage of the Tax Relief and Health Care Act of 2006, Congress enabled CMS to reward physicians' reporting efforts under what is now called the Physician Quality Reporting Initiative (PQRI). The remuneration, while not large, is a step in the right direction.

Reporting on just three measures 80 percent of the time for fee-for-service Medicare patients who are eligible for those measures can lead to an incentive bonus equal to 1.5 percent of all your Medicare billings for the six-month reporting period, which begins July 1, 2007. Preliminary calculations show that a family physician could receive a bonus in July 2008 that ranges from $400 to $1,400, approximately, depending on what percentage of your revenue comes from Medicare (typically between 10 percent and 35 percent). To calculate your potential bonus, divide your total Medicare practice revenue for 2006 in half (to account for the six-month reporting period) and then multiply by 1.5 percent.

This may not seem like a lot of money, but there is another inducement to participating in this voluntary pay-for-reporting initiative. More and more commercial carriers are moving toward programs that will require you to report clinical performance measures. By collecting and reporting data now, you will be prepared to respond to market-specific incentives as commercial insurers introduce them.

## How does it work?

The process of collecting and reporting data for the PQRI may seem onerous, but, like any new practice process, it should become easier with time. Here's what's involved:

**1. Select three measures.** The new initiative requires that you report only three measures to Medicare (there are 74 measures in all, 27 of which apply to family physicians' patients). A complete list of measures can be found on the CMS Web site at http://www.cms.hhs.gov/PQRI. It will be most efficient and easier to report if you choose three measures that are applicable to the same subset of patients, so select a condition that has at least three measures and is well represented in your practice. For example, if you choose to focus on diabetes, you can report the following three diabetes-related measures: A1C control, LDL control and blood pressure control.

**2. Collect your data.** A data collection sheet can remind you and your staff to collect and record the necessary data at the point of care. It also can help you identify the CPT Category II code (or "quality code") that you must submit to Medicare to indicate that you have completed the requirements for the measure. The AAFP has created two sheets, one for physicians and one for coders, that you can download in an Excel file from the online version of this article at http://www.aafp.org/fpm/20070600/37meas.html. Both contain the 27 reporting

measures, corresponding codes and modifiers. They also provide a description of each measure's requirements, including how often the measure must be reported. You can modify the templates to include only those measures you wish to use (see the diabetes example on the opposite page, which is also available in the aforementioned Excel file). If you already use an electronic health record (EHR) system, the sample data collection sheet will help you develop or modify templates to match the PQRI measures and ensure that your coding is correct.

The new PQRI program rewards physicians for collecting and reporting data.

Depending on your practice's workflow and staffing, you may choose to use one or both of the data collection sheets to help you report the appropriate measures and select the correct codes. The coder's sheet is designed to align with the physician's sheet, allowing coding staff to match the measure indicated on the physician's sheet to the appropriate Category II code. It is also useful for verifying documentation of the measure reported.

To earn the incentive bonus, family physicians must report at least three measures for 80 percent of eligible patients.

**3. Report your data.** The data reporting process for the PQRI is integrated with your billing process. When you report a Category II code for the first time, it notifies your carrier to track your reporting of that measure.

Choosing three measures that apply to the same subset of patients will make the reporting process easier.

To report a measure, enter the appropriate ICD-9 code and CPT Category I code on your 1500 claim form or electronic 837P claim, as usual. On the next line, enter the CPT Category II code with the appropriate ICD-9 code and report a $0.00 charge. (If your billing software does not allow a $0.00 charge, you can use a small amount such as $0.01, which you will have to write off later.) The quality code must be submitted to Medicare on the *same claim form* as your charges for services. CMS will not recognize claims that are resubmitted to add quality codes previously omitted.

Once you report a quality code with a diagnosis code, that diagnosis code must be accompanied by the appropriate quality code(s) 80 percent of the time for you to qualify for the bonus payment. Even if you did not perform the test or service in question at the patient's visit, you should report the code with the appropriate exclusion modifier, as indicated on the data collection sheet. For more details on the reporting process, visit the CMS site at http://www.cms.hhs.gov/PQRI/.

Because the data reporting function is integrated with your billing data, you can complete your reporting efficiently at the time of service. Having the data collection sheet stapled to your superbill is a good reminder. EHR users can create an alternative reminder system with staff to make sure the quality codes are submitted to Medicare.

**4. Analyze your data.** It is important to examine your data to see where you can improve. CMS will send you reports comparing your PQRI data to that of your peers nationwide, but the first one will not be available until the middle of 2008, when you will be six months into the next reporting period. To have a strong performance in January 2008, you must respond to your own data in a timely way during 2007. Though the PQRI program is based only on data reporting this year, you may be expected to hit certain quality levels in the future.

Most practice management systems can create a report of all patients who had charges posted with particular ICD-9 codes. The

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## SAMPLE REPORTING FOR DIABETES MEASURES

The example below shows how to report Category II codes for three measures: A1C, LDL and blood pressure. The codes are specific to the patient's results for each measure, which are listed beneath the codes. Note that there are four quality codes in this example because two codes are required for reporting blood pressure control.

| ICD-9 code | CPT code | CPT II code for A1C | CPT II code for LDL | CPT II code for systolic BP | CPT II code for diastolic BP |
|---|---|---|---|---|---|
| 250.xx | 99214 | 3044F | 3048F | 3074F | 3078F |
| Diabetes | Level-IV Service | A1C <7.0 | LDL <100 | Systolic BP <130 | Diastolic BP <80 |

## AAFP PHYSICIAN'S PQRI DATA COLLECTION SHEET – DIABETES

The AAFP has developed data collection sheets to help you report measures and select quality codes at the time of service. To download the Excel templates of the physician's diabetes data collection sheet (shown below), the coder's diabetes data collection sheet or the complete set of 27 applicable measures for family medicine, visit http://www.aafp.org/practicemgt/pqri.

| PHYSICIAN | DATE | MR# | NO. OF YEARS IN PHYSICIAN'S CARE |
|---|---|---|---|
| PATIENT NAME | | DOB | DATE LAST SEEN |

*Initial to indicate measures to be reported*

| Initial | Measure & result | Code (See below for modifier indications) |
|---|---|---|
| **A1C –** Patients aged 18-75. Report with 99201-99215, 99341-99350, 99304-99310, 99324-99337, 97802-97804, G0270, G0271. Report at least once per reporting period. | | |
| | Most recent A1C level within 12 months <7.0% | 3044F |
| | Most recent A1C level within 12 months 7.0% to 9.0% | 3045F |
| | Most recent A1C level within 12 months >9% | 3046F |
| | A1C not performed within 12 months, reason not otherwise specified | 3046F-8P |
| **Lipid management –** Patients aged 18-75. Report with 99201-99215, 99341-99350, 99304-99310, 99324-99337, 97802-97804, G0270, G0271. Report at least once per reporting period. | | |
| | Most recent LDL-C level within 12 months <100 mg/dL | 3048F |
| | Most recent LDL-C level within 12 months 100-129 mg/dL | 3049F |
| | Most recent LDL-C level within 12 months ≥130 mg/dL | 3050F |
| | Not performed within 12 months, reason not otherwise specified | 3048F-8P |
| **Blood pressure –** Patients aged 18-75. Report with 99201-99215, 99341-99350, 99304-99310, 99324-99337, 97802-97804, G0270, G0271. Report at least once per reporting period. Report both systolic and diastolic. | | |
| | Most recent systolic blood pressure within 12 months <130 mm Hg | 3074F |
| | Most recent systolic blood pressure within 12 months 130-139 mm Hg | 3075F |
| | Most recent systolic blood pressure within 12 months ≥140 mm Hg | 3077F |
| | Most recent diastolic blood pressure within 12 months <80 mm Hg | 3078F |
| | Most recent diastolic blood pressure within 12 months 80-89 mm Hg | 3079F |
| | Most recent diastolic blood pressure within 12 months ≥90 mm Hg | 3080F |
| | BP not performed within 12 months, reason not otherwise specified | 2000F-8P* |
| **Performance Measure Modifier Indications**<br>8P – Performance measure exclusion due to action not performed, reason not otherwise specified. | | |

*To be confirmed by CMS no later than July 1, 2007. Visit http://www.cms.hhs.gov/PQRI for coding updates.

## 6 THINGS TO KNOW ABOUT THE PQRI

1. You must bill with your national provider identifier (NPI) to participate in the program. The data reporting will be analyzed by an individual's NPI, although the bonus payment will be made to the holder of the taxpayer identification number (TIN).

2. You must choose at least three applicable measures to report. Measures are reported using CPT Category II codes, which link to the patient's diagnosis.

3. Once you pair a CPT Category II code with an ICD-9 code, the number of times you report that ICD-9 code for any eligible patient during the reporting period will determine the denominator for the measure (i.e., the number of opportunities you had to perform and report the measure). For example, submitting a CPT Category II code for diabetes for any patient causes all patients with a diagnosis of diabetes to be included in the denominator. Once reported, the CPT Category II code must be included with the diagnosis 80 percent of the time to be eligible for the bonus payment.

4. At this time, the only criterion for bonus payment is the presence or absence of a quality code. There is no intention to set or evaluate performance levels in the first year of the program.

5. The initial reporting period begins July 1, 2007, and ends Dec. 31, 2007. CMS must receive claims by Feb. 29, 2008, for them to be included in the 2007 reporting period.

6. Your total Medicare billings for the second half of 2007 will be used to determine the amount of the bonus, not just billings that included the selected measures. A cap may be applied to the bonus amount in certain situations.

A data collection sheet can remind you to collect the appropriate data for each measure and help you select the corresponding CPT Category II code.

Physicians must submit the quality codes on the same claim as the charges for the service.

Keep track of your data collection rate, and, if necessary, implement changes to ensure that patients receive recommended tests and services.

reports can also provide the CPT codes that were reported on the claims. If your system is capable of interfacing with Excel or Access, you can track and even graph results in a short time.

If your analysis reveals that the percentage of your patients who are receiving the indicated care for a particular measure is low, it's time to make systematic changes to improve performance. Consider developing a patient registry to track the progress of your delivery of recommended services. (For more information on patient registries and to download a sample diabetes registry, see "Using a Simple Patient Registry to Improve Your Chronic Disease Care," *FPM*, April 2006, http://www.aafp.org/fpm/20060400/47usin.html.) Your EHR might also have a registry function available.

### Reaping the rewards

Now that CMS has created a program with incentives for collecting and reporting data, it is time to take advantage of it. Once your systems are in place to participate in the PQRI, you can investigate the availability of other employer or health plan programs in your local market, such as Bridges to Excellence (http://www.bridgestoexcellence.org/), that provide cash rewards for data reporting and quality improvement. The rewards you'll receive are not only monetary: Patients will receive more consistent care, and staff will be more actively involved in quality improvement efforts. If these incentives don't persuade you to take part in the PQRI, remember that it will prepare your practice for other quality and pay-for-performance incentives as they emerge in your market. FPM

Send comments to **fpmedit@aafp.org.**

## OTHER PQRI AND PAY-FOR-PERFORMANCE RESOURCES

AAFP PQRI Web site: http://www.aafp.org/practicemgt/PQRI

CMS PQRI Web site: http://www.cms.hhs.gov/PQRI

List of all 74 PQRI measures: http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp

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