PQRI 2009: You Can Still Participate

What is the PQRI? The Physician Quality Reporting Initiative is a voluntary CMS program through which participating physicians can receive an incentive bonus for reporting certain quality measures. Analysis is performed at the individual physician level, using the national provider identifier. In 2006, Congress required the establishment of such a program on a pilot basis as part of its Value Driven Health Care Initiative in Medicare. Congress made the program permanent in 2008. The parameters for the 2010 program will be determined through the rule-making process.

Why should I participate? If your practice sees a significant number of Medicare patients, and you do not participate, you may be “leaving money on the table.” In addition, with the intense focus on controlling costs in Medicare, it is likely that PQRI or something similar will become mandatory. Therefore, there is an advantage to incorporating PQRI into documentation and claims submission in terms of sooner rather than later.

How can I participate? Physicians can participate either through registries or through claims-based reporting. Because of the smaller practice sizes, most foot and ankle surgeons will report through claims-based reporting. This document focuses on claims-based reporting. There is no need to enroll or register for claims-based reporting. You participate by submitting specific additional information on the CMS-1500 form, as explained below.

Is it too late to participate in the 2009 program? No. The reporting year runs January 1 - December 31, 2009. Because the program doesn’t require registration, a physician can begin participation at any time. The challenge of starting later in the year is determining whether the practice will be able to submit the required data during the shortened time period.

What is the amount of the bonus? For the 2009 program, the successful reporting bonus is 2% of estimated “allowed charges” for all professional services covered under the Medicare provider fee schedule during the reporting period. Allowed charges are the total charges, including deductibles and copayments, for services furnished during the reporting period (Jan. 1, 2009 - Dec. 31, 2009).

What are the reporting requirements? For claims-based reporting, PQRI requires that the physician submit at least 3 PQRI “quality data codes” (QDC) for 80% of “eligible patients” (i.e., physician’s Medicare
Part B patients) during the eligibility period. The practice should select QDC measures based on an analysis (by CPT/EM) of services most frequently submitted on claims. The physician only needs to report on applicable code once per patient per period. For example, if a physician reported on all of the selected patient codes at a patient visit in May, he/she would not have to report additional information at subsequent patient visits.

Physicians who start to report mid-year will have to work closely with practice staff to make sure that “eligible patients” are identified to increase the likelihood of reaching the 80% threshold.

**What is an “eligible patient” for whom the measures is either inappropriate or the patient refuses?**

If a physician submits less than 3 quality measures on a patient claim, he or she must append a Category II CPT Code 1P, 2P, or 3P which will provide reasons for non-submission. The claim will then go through a medical applicability validation (MAV) process that will determine whether he/she should have submitted 3 measures based on services provided. If CMS determines that there were additional applicable measures, then the physician will not be entitled to the incentive payment.

**What are the reportable “quality codes”?**


Each QDC is assigned to a CPT Category II code. The following measures are the most likely to be reportable for foot and ankle surgeons for 2009, but this will vary by individual practice.

- Measure 20: Perioperative Care: Timing of Antibiotic prophylaxis-ordering physician
- Measure 21: Perioperative care: Selection of prophylactic antibiotic- first or second generation cephalosporin
- Measure 22: Perioperative care: Discontinuation of prophylactic antibiotics (non-cardiac procedures)
- Measure 114: Inquiry regarding tobacco use
- Measure 115: Advising smokers to quite
- Measure 124: HIT- adoption use of health information technology (EHR)
- Measure 126: Diabetic foot and ankle care: peripheral neuropathy: neurological evaluation
- Measure 127: Diabetic foot and ankle care: ulcer prevention: evaluation of footwear
- Measure 128: Universal weight screening and follow-up
- Measure 130: Universal documentation and verification of current medications in the medical record.
- Measure 131: Pain assessment prior to initiation of patient treatment
- Measure 138: Melanoma: coordination of care
- Measure 142: Osteoarthritis: assessment for use of anti inflammatory or analgesic over the counter medications
Measure 154: Falls: risk assessment
Measure 155: Falls: plan of care
Measure 163: Diabetes mellitus: food exam
Measure 185: Wound care: Use of compression system in patients with venous ulcers

**How do I code quality measures?**

A G Code (in the case of preventive measures) or a QCD (CPT II code) is submitted on the CMS-1500 form in the same manner as a HCPCS code. Like HCPCS, each G Code or QCD must point to an ICD-9 code on the claim. Each of the measures needs to be reported only once per patient per reporting period. A “zero” (0) must be entered in the charge amount.


**This still sounds awfully complicated. How do I figure out if it’s worth the effort for this year?**

The key is to engage you practice staff. They are the best positioned to determined whether your patient base and the type of codes you submit make it worthwhile for 2009. Even if a decision is made not to participate in 2009, you and your staff should stay on top of PQRI rules for 2010 with a goal of participation.

**Is there any right of appeal in the PQRI program?**

No.

For more information on PQRI, visit the CMS Web site at http://www.cms.hhs.gov/PQRI.

June 2009
ACFAS