Medicare’s Pay for Reporting Bonus (PQRI) – What’s in it for you?

Presented To: American Medical Association Group and Faculty Practice Educational Series

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<th>Title/Institution</th>
<th>Disclosures</th>
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<tbody>
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Who We Are

The Coker Group is a national healthcare consulting firm helping physicians, hospitals, and other providers find answers and solve problems in management and business operations.

Coker consultants and educators provide practical, effective strategies and solutions to assist the leaders of today’s health care organizations through hands-on consulting and educational forums.
“In 2007, the Centers for Medicare and Medicaid Services (CMS) launched the Physician Quality Reporting Initiative (PQRI), a voluntary reporting program to improve quality through the use of clinical performance measures. Practices who report on the designated set of quality measures can earn a bonus payment of up to 1.5% of total allowed charges for covered Medicare physician fee schedule services, based on claims submitted for services provided. This web conference will detail how to report the required data, either with or without an EHR system. This program will also help identify practices’ patients that fall within the given criteria, and determine vital information to be tracked.”
Objectives

• Identify the specifications required for PQRI quality measures, including reporting frequency and timeframes for services performed.
• Distinguish which measures apply to your specific practice.
• Manage and integrate staff successfully onboard with PQRI programs, choosing pertinent measures for each specialty.
• Determine how to construct a cost efficient method of capturing the data reliably and consistently.
• Recognize the coder’s role in the implementation process, and problems coders may experience when trying to report the measures.
To get a sense of the audience as we begin today, I would like to ask the following three questions of each of you. Please click directly on the slide, and we can found out a little bit about each other.

1. What is your role in the healthcare field?
   - Group Practice Physician
   - Solo Physician Practitioner
   - Medical Association Staff
   - Other
2. Have you participated in PQRI previously?

- Yes
- No
3. If you have participated in PQRI previously, are you continuing to do so for 2008?

- Yes
- No
Overview of Physician Quality Reporting Initiative (PQRI)
Overview of PQRI

• Established by Centers for Medicare and Medicaid Services (CMS) in July 2007
  • Enacted through Tax Relief and Health Care Act of 2006 (TRHCA), signed by President Bush on December 20, 2006
  • Continuation was allowed when the President signed the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Extension Act) on December 29, 2007
  • Built on and replaced 2006 Physician Voluntary Reporting Program (PVRP)
Overview of PQRI

- Encourages quality improvement through the use of clinical performance measures on a variety of clinical conditions

- In 2007, program was enacted for 6 months
  - July 1 – December 31, 2007

- In 2008, the program will run a full year
  - January 1 – December 31, 2008
Overview of PQRI

• In 2008, the program continues to be **completely voluntary** in nature.

• Speculation exists that the program is a precursor to Medicare’s pay-for-performance system and may become mandatory into the future, but that reality is not yet upon us.
  
  • *This program is seen by some as a way to learn how to report performance measures without penalties.*
The following providers are eligible to participate in PQRI:

Medicare physicians
- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- Doctor of Chiropractic

Practitioners
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician
- Nutrition Professional

Therapists
- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapist
Overview of PQRI

- The program is based on specific measures by which clinical performance is assessed
  - In 2008, there are 119 measures, including 2 structural measures
- The results of these measures are not published by participant nor in the aggregate
Overview of PQRI

• Measures are developed through the Physician Consortium for Performance Improvement (PCPI)

• PCPI was created in 2000 to develop performance measures for physicians, in the hopes of driving quality improvement in patient care

  • Includes representatives from more than 100 national medical specialties and state medical societies
Overview of PQRI

- Eligible providers may earn up to 1.5% of total “allowed charges” for covered services payable under the Physician Fee Schedule
  - “Allowed charges” refers to total charges, including beneficiary deductible and co-payment, not just the 80% paid by Medicare or portion covered by Medicare when they are the secondary payer
• Bonus is subject to a cap
  • May apply when a participant reports relatively few instances of quality measures
  • Cap is designed to encourage greater measure reporting
Overview of PQRI

- Cap will be calculated at the end of the reporting period by multiplying the National Average per Measure Payment Amount (National total charges associated with quality measures /National total instances of reporting) x 300% x Individual provider’s instances of reporting quality data, as long as it does not exceed 1.5% of the individual provider’s total Medicare charges for the reporting period.

Source: http://www.aaos.org/research/committee/evidence/pqri_info.asp
The mathematical formula would be:

\[
\frac{A}{B} \times 3 \times C = \text{Bonus}
\]

Where:

A = The national total charges associated with quality measures
B = The national total instances of reporting
C = The individual provider’s instances of reporting quality data

Source: http://www.aaos.org/research/committee/evidence/pqri_info.asp
Overview of PQRI

- Financial incentives for 2008 are paid mid-2009 as a lump-sum bonus payment
  - Bonus paid to the practice at the Taxpayer Identification Number (TIN) level
Overview of PQRI

- CMS validates the reported measures using sampling or other means.
- Focus is on participants who successfully report fewer than three quality measures.
- If you report on fewer than three quality measures but could have reported on a greater number, you are ineligible for the bonus payment.
2008 PQRI Program
2008 PQRI Program

Reporting Period

• Begins on January 1, 2008, for covered services provided to Medicare beneficiaries between January 1 and December 31, 2008

• No registration is necessary to participate in the program or to begin reporting
2008 PQRI Program

- If there are no more than 3 measures that apply, each measure must be reported for at least 80% of the cases in which a measure was reportable
  - If it is determined that there were additional appropriate measures that could have been reported, the participant is ineligible for bonus
- If 4 or more measures apply, at least 3 measures must be reported for at least 80% of the cases in which the measure was reportable
2008 PQRI Program

- 119 quality measures, including 2 structural measures
  - Quality measures
    - Cover a variety of diseases/conditions
  - Structural measures
    - Have and use electronic health records
    - Have and use electronic prescribing
2008 Physician Quality Reporting Initiative (PQRI) Eligible Professional Quality Measures

3. High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus
Description: Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/80 mmHg)

18. Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months

46. Medication Reconciliation
Description: Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented
Each measure has two major components

- Numerator describes clinical action required by the measure for reporting and performance
  - Specified by CPT Category II or G-codes
- Denominator describes the eligible patient population
  - Specified by ICD-9-CM and CPT Category I codes
Each measure includes a reporting frequency:

- Report one-time only
- Report once for each procedure performed
- Report once for each acute episode
Each measure has a performance timeframe

- This timeframe is defined in each measure’s description and is unique to that measure
- Distinct from reporting frequency
- May be stated as “within 12 months” or “most recent”
For each of the measures, AMA (in collaboration with CMS, Mathematica Policy Research Inc. and National Committee for Quality Assurance) provides a participation toolkit including:

- Measure Description
- Background Information
- Data Collection
- Coding Specifications
AMA
Physicians’ Guide to Implementing Medicare’s Physician Quality Reporting Initiative:
An Insider’s View, 2007
Example: Acute Myocardial Infarction (AMI)

#28. Aspirin at arrival for acute myocardial infarction (AMI)

- Measure Description
  - Percentage of patients, regardless of age, with an emergency department discharge diagnosis of AMI who had documentation of receiving aspirin within 24 hours before emergency department arrival or during emergency department stay
  - Must be reported each time a patient is discharged from the ED with a diagnosis of AMI
Example: Acute Myocardial Infarction (cont.)

- Background Information
  - Clinical Recommendation Statements: The initial dose should be 162 mg (*Level A*) to 325 mg (*Level C*). Although some trials have used enteric-coated aspirin for initial dosing, more rapid buccal absorption occurs with non-enteric-coated aspirin formulations.
Example:

**Acute Myocardial Infarction (cont.)**

- **Data Collection**
  - Clinical use
  - Office/billing use

### Acute Myocardial Infarction

**Aspirin at Arrival for Acute Myocardial Infarction (AMI)**

<table>
<thead>
<tr>
<th>PQRI Data Collection Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Name</td>
</tr>
<tr>
<td>National Provider Identifier (NPI)</td>
</tr>
</tbody>
</table>

#### Clinical Information

**Step 1** Is patient eligible for this measure?

<table>
<thead>
<tr>
<th>Any patient regardless of age.</th>
<th>Yes</th>
<th>No</th>
<th>Code Required on Claim Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has emergency department (ED) discharge diagnosis of acute myocardial infarction.</td>
<td>☐</td>
<td>☐</td>
<td>Verify date of birth on claim form.</td>
</tr>
<tr>
<td>There is a CPT E/M Service Code for this visit.</td>
<td>☐</td>
<td>☐</td>
<td>Refer to coding specifications document for list of applicable codes.</td>
</tr>
<tr>
<td>There is a Place of Service Indicator for emergency department (23) for this visit.</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

If No is checked for any of the above, STOP. Do not report a CPT category II code.

**Step 2** Does patient meet or have an acceptable reason for not meeting the measure?

**Aspirin within 24 hours before ED Arrival or during ED stay**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Code to be Reported on Line 24D of Paper Claim Form, if Yes (or Service Line 24 of Electronic Claim Form)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Received</td>
<td>☐</td>
<td>4084F</td>
</tr>
<tr>
<td>Not received for one of the following reasons:</td>
<td>☐</td>
<td>4084F-1P</td>
</tr>
<tr>
<td>* Medical (eg, not indicated, contraindicated, other medical reason)</td>
<td>☐</td>
<td>4084F-2P</td>
</tr>
<tr>
<td>* Patient (eg, patient declined, economic, social, religious, other patient reason)</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

Document reason here and in medical chart.

If No is checked for all of the above, report 4084F-8P (Aspirin was not received within 24 hours before emergency department arrival or during emergency department stay, reason not otherwise specified.)
Example: Acute Myocardial Infarction (cont.)

- Coding Specifications

  - An ICD-9 diagnosis code for acute myocardial infarction and a CPT E/M service code and a place of service indicator for emergency department are required to identify patients to be included in this measure
Example: Acute Myocardial Infarction (cont.)

- Acute myocardial infarction ICD-9 diagnosis codes:
  410.01, 410.11, 410.21, 410.31, 410.41, 410.51, 410.61, 410.71, 410.81, 410.91

  **AND**

- CPT E/M service codes:
  99281, 99282, 99283, 99284, 99285 (emergency department visit); 99291 (critical care)

  **AND**

- Place of Service Indicator: 23 (emergency department)
Implementation and Utilization of PQRI Program
Implementing PQRI

Step 1: Determine the measures that apply to your practice

- It is important that all applicable measures are identified for your practice so that reporting can be completed with maximum efficiency
  - Remember that any 3 of the measures that relate to your practice must be reported
- Currently, the measures are not broken down by specialty
Implementing PQRI

Professional organizations may be an asset in isolating applicable measures

• For example, the American College of Cardiology has posted a work sheet on their website (www.acc.org)

• The worksheet isolates each of the measures the ACC views as applicable to this line of service
<table>
<thead>
<tr>
<th>Measure 6: CAD</th>
<th>Measure 7: CAD with Prior MI</th>
<th>Measure 5: HF with LVSD</th>
<th>Measure 118 (option2): CAD with LVSD</th>
<th>Measure 8: HF with LVSD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary artery disease: 414.00-414.07, 414.8, 414.9</td>
<td>Acute myocardial infarction: 410.00-410.92</td>
<td>Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91</td>
<td>Acute myocardial infarction: 410.00-410.92</td>
<td>Hypertensive heart disease with Heart failure: 402.01, 402.11, 402.91</td>
</tr>
<tr>
<td>Acute myocardial infarction: 410.00-410.92</td>
<td>Old MI: 412</td>
<td>Hypertensive heart and renal disease with Heart failure: 404.01, 404.03, 404.11, 404.13, 404.91, 404.93</td>
<td>Other acute and subacute forms of ischemic heart disease: 411.0, 411.1, 411.81, 411.89</td>
<td>Other acute and subacute forms of ischemic heart disease: 411.0, 411.1, 411.81, 411.89</td>
</tr>
<tr>
<td>Other acute and subacute forms of ischemic heart disease: 411.0, 411.1, 411.81, 411.89</td>
<td>Angina: 413.0, 413.1, 413.9</td>
<td>Heart Failure: 428.0, 428.1, 428.20-428.23, 428.30-428.33, 428.40-428.43, 428.9</td>
<td>Coronary artery disease: 414.00-414.07, 414.8, 414.9</td>
<td>Coronary artery bypass status: V45.81</td>
</tr>
<tr>
<td>Angina: 413.0, 413.1, 413.9</td>
<td>Aortocoronary bypass status: V45.81</td>
<td>PTCA status: V45.82</td>
<td>Aortocoronary bypass status: V45.81</td>
<td>PTCA status: V45.82</td>
</tr>
<tr>
<td>PTCA status: V45.82</td>
<td><strong>Antiplatet therapy prescribed</strong></td>
<td><strong>Beta-blocker therapy prescribed</strong></td>
<td><strong>ACE-I or ARB therapy prescribed</strong></td>
<td><strong>Beta-blocker therapy prescribed</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>No, due to exception</td>
<td>No, due to exception</td>
<td>No, due to exception</td>
<td>No, due to exception</td>
<td>No, for reason documented</td>
</tr>
<tr>
<td>4011F + P modifier below</td>
<td>4011F + P modifier below</td>
<td>4006F + P modifier below</td>
<td>4009F + 3021F + P modifier below</td>
<td>G8468 + G8469</td>
</tr>
<tr>
<td><strong>G8450</strong></td>
<td><strong>G8451</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The selected P modifiers require documentation of reason in medical record.

1P: medical reason documented 2P: patient reason documented 3P: system reason documented

Reason for not prescribing must be documented in medical record.

**E/M service codes:**
- **Ambulatory:** 99201-99205, 99212-99215, 941-99245
- **Hospital Discharge:** 99238, 99239
Implementing PQRI

If all else fails, determine the measures that apply to your practice by looking through each of the 119 measures and isolating those that pertain to you.
Implementing PQRI

Step 2: Give serious thought to data collection

- Data collection for this program can be timely and costly unless given copious thought
- Data may be collected using electronic, paper or administrative methods
- Electronic methods, if available, may prove to be the most cost and time efficient
Implementing PQRI

Data collection

- Electronic health record system (EHRS)
  - Some data may be entered by physician or other clinician during a patient visit
  - Other data may be entered from laboratory reports, radiology reports, or other reports from healthcare institutions were patients receive care
  - Use of standardized codes can make querying in an EHRS possible
    - If standardized codes are not yet available, work with EHRS vendors to allow this capability
Data collection (cont.)

- Paper medical records
  - Abstract data from existing records
    - PCPI provides definitions to help the abstractor find required data elements in a medical record
  - Use a flowsheet to prospectively gather data
    - PCPI provides an algorithm to construct each component of the measure
Implementing PQRI

Data collection (cont.)

• Administrative data (paper or electronic)
  • All required data can be obtained from billing data by using CPT Category II codes and/or G codes \textit{in conjunction} with CPT Category I and/or ICD-9 codes
Data collection (cont.)

- CPT Category II codes are non-reimbursable and do not have relative values associated with them
- CPT Category II codes are optional and do not serve as a substitute for Category I codes
Implementing PQRI

Data collection (cont.)

• G codes
  • Healthcare Common Procedure Coding System (HCPCS) codes for reporting quality data
  • Used where Category II codes are not yet available
  • Maintained by CMS
Implementing PQRI

Data collection (cont.)

• Reporting for PQRI can be made easier by working with EHRS vendors
  • Vendors can modify and individualize existing system to meet your practices’ needs
• Practice management needs to be involved if utilization of EHRS is not an option
• Third party vendors may be required if your practice is unable to complete reporting using any other method
Step 3: Know how to report

- Reporting is claims-based
  - Paper-based CMS 1500 Claim form
  - Electronic transaction claim 837-P
- CPT Category II (or G-code) must be reported on the same claim as patient diagnosis and services to which the quality-data code applies
Implementing PQRI

• Providers should append the appropriate CPT Level II or G-codes to the CMS 1500 or 837-P form used to report the service for which the measures are appropriate
  • A physician does not have to be a Medicare participating physician, but the only way to report the measures is on the CMS 1500 or 837-P form

Source: http://www.aaos.org/research/committee/evidence/pqri_info.asp
Implementing PQRI

- Ensure that your computerized practice management system can accept CPT Level II or G-codes
  - These codes are alpha-numeric and some systems will not accept them

Source: http://www.aaos.org/research/committee/evidence/pqri_info.asp
Implementing PQRI

• If you are using a clearing house or scrubbing service to submit your bills, you must be sure that the service can accept CPT Level II or G-codes, as some cannot.

• Another potential computer problem is that some systems will not accept a 0 dollar amount in the field following a CPT code.
  • If that is the case in your system, it is easily solved by inserting a small dollar amount, like $1.

Source: http://www.aaos.org/research/committee/evidence/pqri_info.asp
Implementing PQRI

- If quality-data is not submitted on the same claim as the applicable patient diagnosis, service and procedure codes will **not** count toward successful reporting or for calculation of a potential bonus payment.
  - It is not possible to re-submit claims, so if a claim is submitted incorrectly, it is impossible to go back and correct it.
    - Reporting correctly the first time becomes extremely important.
Step 4: Invest providers in the program

- Providers must be made aware of the importance of this program and their responsibilities as a part of it.
- Financial incentives for participation may be utilized vis-a-vis the potential 1.5% “bonus” provided by Medicare.
- Documentation is the driving force behind the success of this program.
  - This documentation needs to be completed by the providers and in the patient’s charts.
Step 5: Recognize the importance of coders

- Coders continue to be an essential component of the process
- Coders can be used to train providers on the specifics of this system
- Coders can pull the “numerator” and “denominator” from patient records
As mentioned previously, each measure has two major components

- Numerator describes clinical action required by the measure for reporting and performance
  - Specified by CPT Category II or G-codes
- Denominator describes the eligible patient population
  - Specified by ICD-9-CM and CPT Category I codes
Modifiers may be used with Category II codes

- Modifiers are used to substantiate documentation
- Used to indicate that a service specified in the performance measure was considered, but not provided
- May be due to medical, patient, or system circumstances
- Modifiers serve as denominator exclusions
  - Not all performance measures have exclusions, however, so be cautious about compliance
<table>
<thead>
<tr>
<th>Performance Measure Exclusion Modifier</th>
<th>Possible Reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>1P Performance measure exclusion modifier due to medical reasons</td>
<td>Not indicated (absence of organ/limb, already received/performed, other) Contraindicated (patient allergic history, potential adverse drug interaction, other) Other Medical Reasons</td>
</tr>
<tr>
<td>2P Performance measure modifier due to patient reasons</td>
<td>Patient Declined Economic, social or religious reasons Other patient reasons</td>
</tr>
<tr>
<td>3P Performance measure modifier due to system reasons</td>
<td>Resources to perform the services not available (equipment, supplies) Insurance coverage or payer-related limitations Other reasons attributable to health care delivery system</td>
</tr>
<tr>
<td>8P Performance measure reporting modifier – action not performed, reason not otherwise specified</td>
<td>Action not performed - not otherwise specified</td>
</tr>
</tbody>
</table>

We did the PQRI last year. From our standpoint, the reporting went well…. however, we won't know if our reporting was up to their standards until June of this year - that's when we are suppose to get our PQRI "bonus" from Medicare. We did not continue it for the 2008 year because unless you have "willing" providers, the coders have to go back and read the progress and hospital notes in order to extract the correct data and it can be time-consuming.”

-Coker communication with previous PQRI participant
Conclusions
Implementing PQRI

Reasons not to participate:

• If your practice management billing system or your clearing house will not accept CPT Level II or G-codes, it may cost more to modify your system than you may recover in the bonus payment

• If you have to collect data by abstracting medical charts, the costs may outweigh the bonus

Source: http://www.aaos.org/research/committee/evidence/pqri_info.asp
Implementing PQRI

For additional assistance navigating the PQRI program:


• Consult the AMA website

• Contact your professional organization

• Use the tool kit provided on the CMS website
Tips for Successful Participation

Successful participation in PQRI is dependent on accurate submission of all information required for selected PQRI measures on Medicare claims for services provided to Medicare Fee-for-Service beneficiaries. The following tips are offered to assist eligible professionals’ accuracy of reporting:

1. For measures that you have selected, review all ICD-9-CM and Evaluation and Management (E/M) codes that will qualify claims for inclusion in calculations and be sure that each claim includes an appropriate Quality Data Code (QDC) or QDC with allowable modifier and correct National Provider Identifier (NPI).

2. For measures that require that clinical values be captured for coding, make sure that these clinical values are available to those who are doing your coding.

3. For measures that only require reporting once per patient per reporting period, report early to ensure that the claim counts toward successful reporting.

4. For measures that involve time frames, ensure that all members of the team understand and capture this information in the clinical record to facilitate coding.

5. For measures that require more than one CPT II or G-code, please ensure that all codes are captured on the claim.

6. When submitting codes for Measure #3 - High Blood Pressure Control in Type I and Type II Diabetes Mellitus, be sure to include codes for both the systolic and diastolic blood pressure.

7. When applicable, utilize the 8P modifier when the action required is not performed or reason not otherwise specified, so that the claim will count toward successful reporting.

8. Pay attention to demographics. Remember that some measures specify an age or sex requirement for successful reporting.

9. Some measures apply broadly to all Medicare patients and do not specify an ICD-9-CM diagnosis code in the denominator. Eligible cases for reporting Measure #4 - Screening for Future Fall Risk, #46 - Medication Reconciliation, or #47 - Advance Care Plan are pulled into the denominator through the CPT E/M office visit codes for one time submission per reporting period.

10. Perioperative care measures specify reporting for ordering a prophylactic antibiotic (Measure #20), which is different from administering the antibiotic (Measure #30).

For additional educational resources or information on the Physician Quality Reporting Initiative, the PQRI web page contains all publicly available information at http://www.cms.hhs.gov/PQRI on the CMS website.
Questions/Comments?

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