

Excellent primer for physicians

Inside ABCs of PQRI

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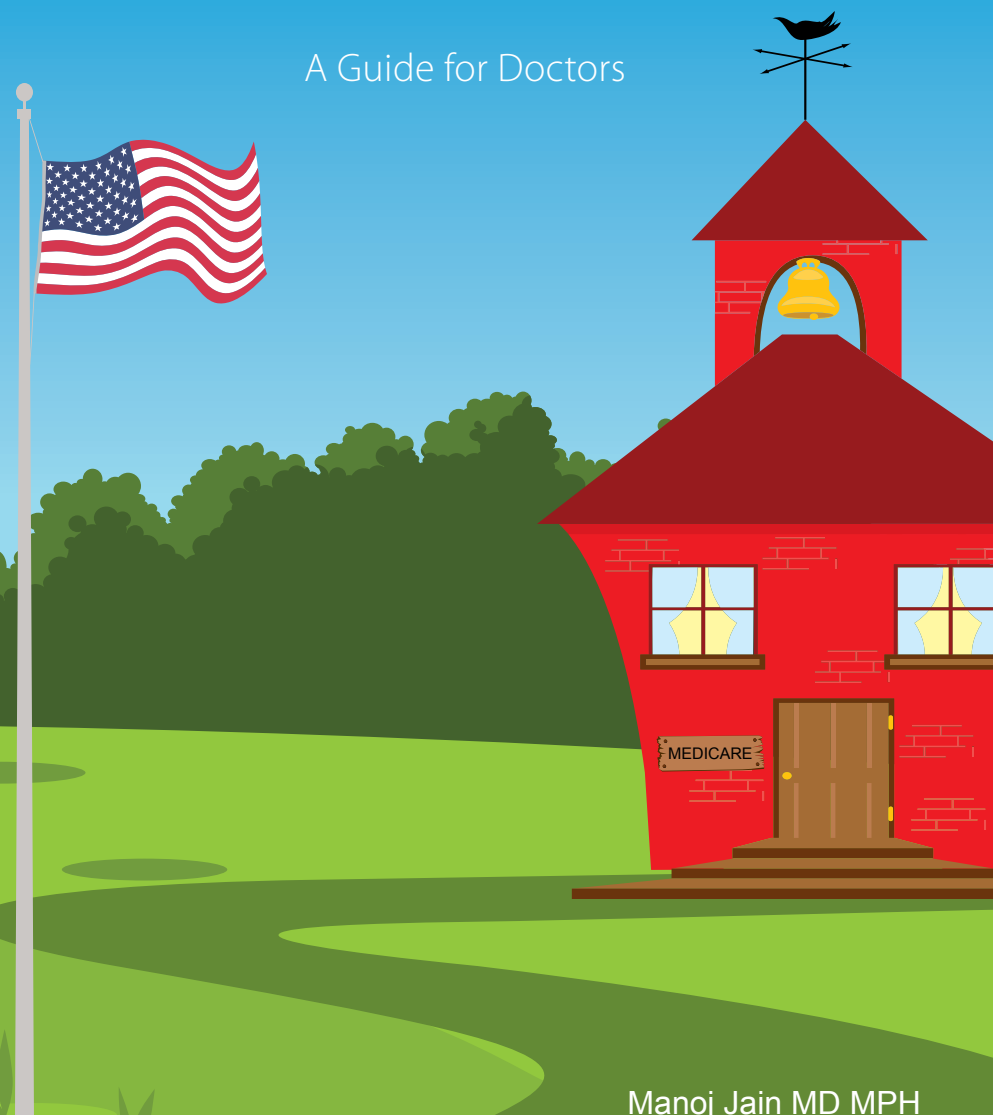
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The ABCs of PQRI

Physician Quality Reporting Initiative

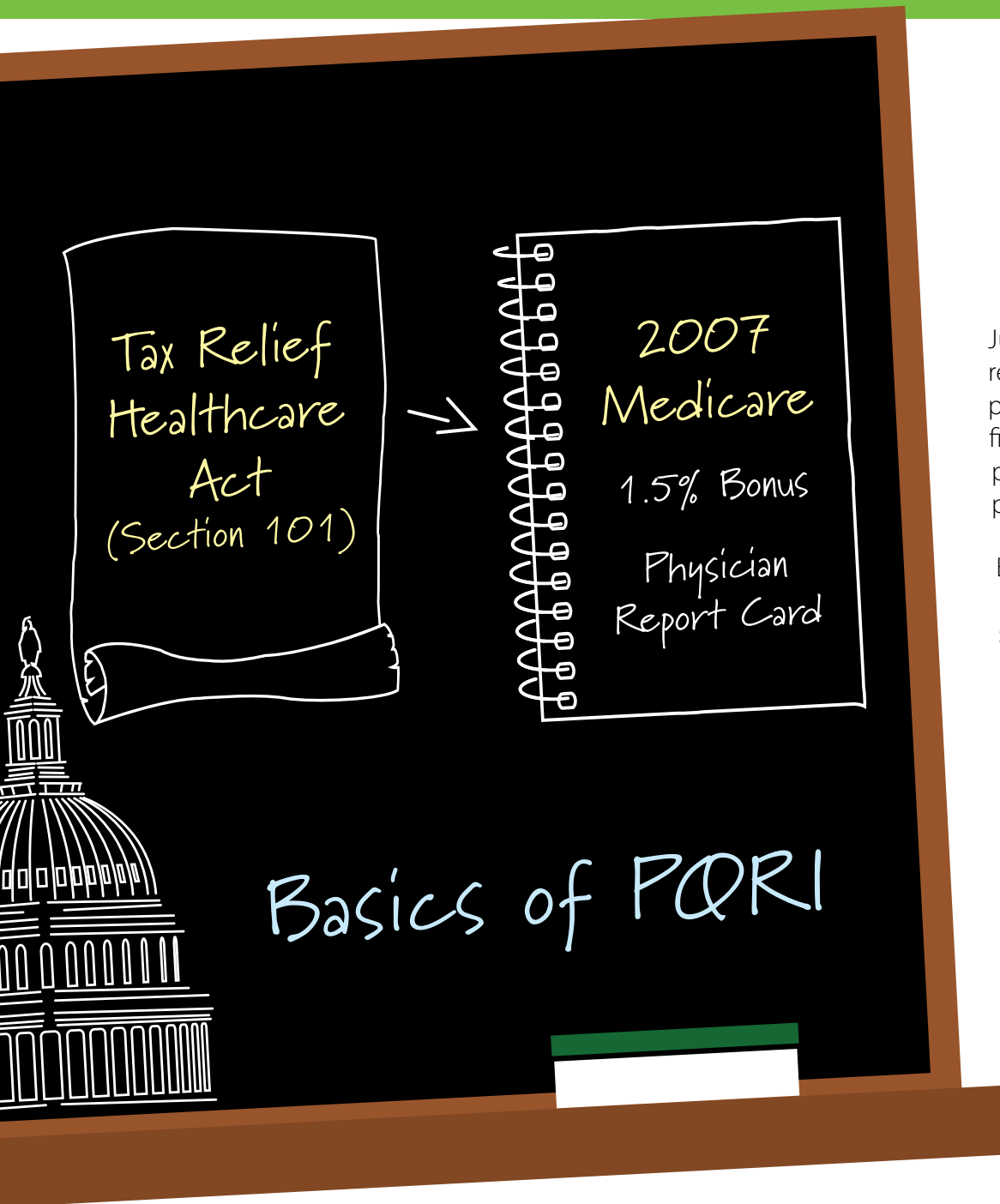
A Guide for Doctors



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Learning the Basics of PQRI

Just as medical knowledge changes over time, so do the rules and regulations related to Medicare's quality initiatives and payments to physicians. Though many of us physicians stay current with changes in our fields, often it is difficult for us to keep up with the changes in Medicare's policies. Yet in the long run, keeping track of these policies helps in providing better care to our patients and makes financial sense too.

By the 2006 Tax Relief and Healthcare Act Section 101, Congress has authorized the establishment of a physician quality reporting system by Medicare. The program has been titled Physician Quality Reporting Initiative (PQRI).

Under the PQRI program, Medicare is offering a 1.5% of Medicare allowable (total collections from Medicare for a physician) as a bonus if physicians report their performance on selected measures from July 2007 to December 2007. An average physician may earn a bonus of \$1,000 to \$3,000 over 6 months.

Along with the bonus payments, PQRI will provide physicians with their confidential quality performance reports on selected measures in June 2008.

PQRI is just the beginning of the road – starting with payment for reporting, then with public reporting and payment for performance with potentially much larger bonuses. Participating in PQRI in 2007 is a good investment that will pay off for years on many fronts: professionally, financially as well as in improving quality performance and patient care.



The Big Picture: Value Based Purchasing

PQRI is the first Medicare program which will have a direct financial impact on physicians under the value-based purchasing (VBP) strategy. Value-based purchasing is a key mechanism for Medicare to transform itself from being a passive payer to an active purchaser of healthcare by linking payment more directly to performance.

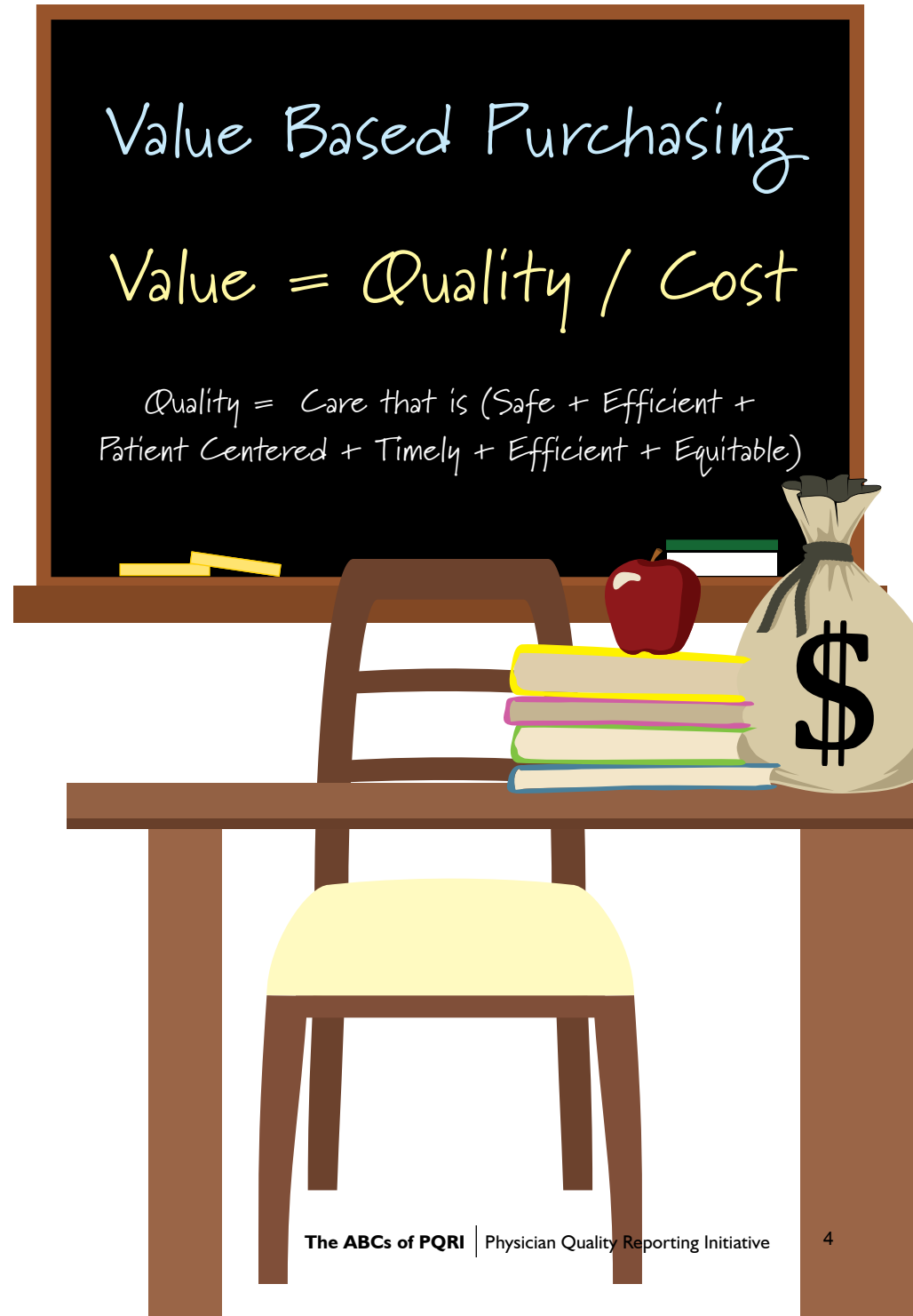
Currently, Medicare Physician Fee Schedule is based on quantity and resources, a **volume-based payment system**. Soon, this will no longer be the case. Over the next several years, fees will be based on quality and value, a **value-based system** where value is defined as:

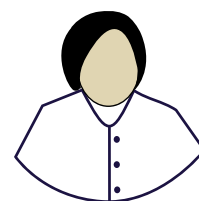
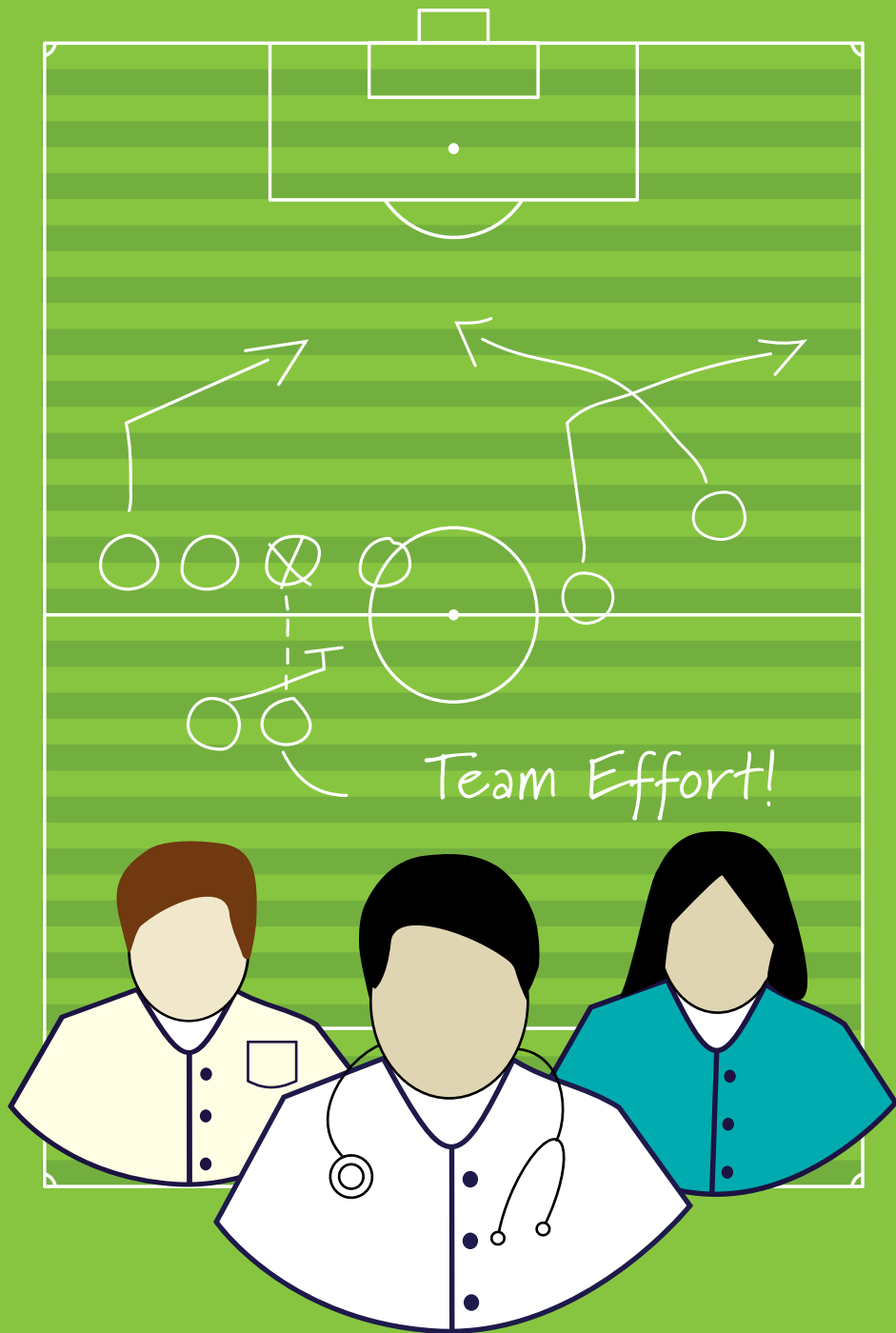
$$\text{Value} = \text{Quality} / \text{Cost}$$

Value-based purchasing is being implemented in all settings including hospitals, nursing home and physicians' offices. VBP has widespread support from the President's budget office, Congress, Med PAC, Institute of Medicine, private health plans and employer coalitions.

Under VBP, PQRI will impact physicians of all specialties. Participating in the program does not require any registration but only requires filling additional codes in the Medicare billing CMS 1500 HCFA form. Not participating in PQRI does not have a penalty; however, for many physicians it would amount to "leaving money on the table."

If providers wish to participate in PQRI here are 4 simple lessons.



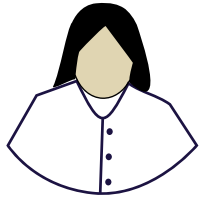


Lesson 1: Engaging the Team

In order to reach the goal of PQRI successfully, a team effort will be required. We need to engage several members:

- Physicians within our practices need to be aware of PQRI so they can also collaborate on this initiative.
- The office clinical staff, which includes our nurse and nursing assistant, is essential to the process, because they need to be aware of the quality measures and how to abstract clinical data from the patient chart (such as an hemoglobin A1c value) if necessary.
- The hospital quality improvement coordinator is important if our measures relate to in-patients for chart abstracted data (such as timing of preoperative antibiotic in peri-operative care).
- The billing administrator is critical because he or she will place the codes necessary for receiving credit for evaluation of the measure.

All team members are essential in gathering and transferring quality measures information for successful data reporting for PQRI.



Lesson 2: Selecting Quality Measures

Some 74 evidence-based measures developed by professional specialty societies and endorsed by Medicare are available for providers to choose. These indicators cut across all settings (in-patient, out-patient, emergency room) as well as across all specialties.

We need to select three or more quality measures which are relevant to our practice from those conditions that we treat most frequently. Of the indicators we choose, we need to report on 80% or more of the total encounters. Failure to reach 80% reporting on three measures would make us ineligible for the bonus.

2007 Physician Quality Reporting Initiative (PQRI) Physician Quality Measure

Family Practice and Internal Medicine Measures

- Hemoglobin A1c Poor Control in Type 1 or 2 Diabetes Mellitus
- Low Density Lipoprotein Control in Type 1 or 2 Diabetes Mellitus
- High Blood Pressure Control in Type 1 or 2 Diabetes Mellitus
- Screening for Future Fall Risk
- Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)

- Oral Antiplatelet Therapy Prescribed for Patients with Coronary Artery Disease
- Beta-blocker Therapy for Coronary Artery Disease Patients with Prior Myocardial Infarction (MI)
- Heart Failure: Beta-blocker Therapy for Left Ventricular Systolic Dysfunction
- Antidepressant Medication During Acute Phase for Patients with New Episode of Major Depression
- Stroke And Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports
- Stroke and Stroke Rehabilitation: Carotid Imaging Reports
- Primary Open Angle Glaucoma: Optic Nerve Evaluation
- Age-Related Macular Degeneration: Age-Related Eye Disease study (AREDS) Prescribed/ Recommended
- Age-Related Macular Degeneration: Dilated Macular Examination
- Cataracts: Assessment of Visual Functional Status
- Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
- Osteoporosis: Communication with the Physician Managing Ongoing Care Post Fracture
- Aspirin at Arrival for Acute Myocardial Infarction (AMI)
- Beta-Blocker at Time of Arrival for Acute Myocardial Infarction (AMI)
- Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage
- Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy
- Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge
- Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator (t-PA) Considered
- Stroke and Stroke Rehabilitation: Screening for Dysphagia
- Stroke and Stroke Rehabilitation: Consideration of Rehabilitation Services
- Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older
- Osteoporosis: Management Following Fracture
- Osteoporosis: Pharmacologic Therapy
- Osteoporosis: Counseling for Vitamin D, Calcium Intake, and Exercise
- Medication Reconciliation

- Advance Care Plan
- Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
- Characterization of Urinary Incontinence in Women Aged 65 Years and Older
- Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older
- Asthma: Pharmacologic Therapy
- Electrocardiogram Performed for Non-Traumatic Chest Pain
- Electrocardiogram Performed for Syncope
- Vital Signs for Community-Acquired Bacterial Pneumonia
- Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia
- Assessment of Mental Status for Community-Acquired Bacterial Pneumonia
- Empiric Antibiotic for Community-Acquired Bacterial Pneumonia
- Gastroesophageal Reflux Disease (GERD): Assessment for Alarm Symptoms
- Gastroesophageal Reflux Disease (GERD): Upper Endoscopy for Patients with Alarm Symptoms
- Asthma Assessment
- Appropriate Treatment for Children with Upper Respiratory Infection(URI)
- Appropriate Testing for Children with Pharyngitis

Surgical Measures

- Perioperative Care: Timing of Antibiotic Prophylaxis - Ordering Physician
- Perioperative Care: Selection of Prophylactic Antibiotic - First or Second Generation Cephalosporin
- Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures)
- Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
- Perioperative Care: Timing of Prophylactic Antibiotic - Administering Physician

- Use of Internal Mammary Artery (IMA) in Coronary Artery Bypass Graft (CABG) Surgery
- Pre-Operative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery
- Perioperative Care: Discontinuation of Prophylactic Antibiotics (Cardiac Procedures)

Specialty Measures

- Cataracts: Documentation of Pre-Surgical Axial Length, Corneal Power Measurement and Method of Intraocular Lens Power Calculation
- Cataracts: Pre-Surgical Dilated Fundus Evaluation
- Melanoma: Patient Medical History
- Melanoma: Complete Physical Skin Examination
- Melanoma: Counseling on Self-Examination
- Dialysis Dose in End Stage Renal Disease (ESRD) Patients
- Hematocrit Level in End Stage Renal Disease (ESRD) Patients
- Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation
- Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy
- Gastroesophageal Reflux Disease (GERD): Biopsy for Barrett's Esophagus
- Gastroesophageal Reflux Disease (GERD): Barium Swallow-Inappropriate Use
- Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
- Myelodysplastic Syndrome(MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
- Multiple Myeloma: Treatment With Bisphosphonates
- Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry
- Hormonal Therapy for Stage IC-III, ER/PR Positive Breast Cancer
- Chemotherapy for Stage III Colon Cancer Patients
- Plan for Chemotherapy Documented Before Chemotherapy Administered
- Radiation Therapy Recommended for Invasive Breast Cancer Patients Who Have
- Undergone Breast Conserving Surgery

Performance Report

June 2008

Inpatient Measures

CPT II Aspirin for AMI	*****
CPT II Beta Blocker for AMI	***
CPT II Empiric antibiotics for CAP	****

Outpatient Measures

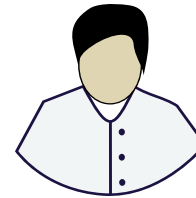
CPT II Hemoglobin A1c in DM	****
CPT II Blood Pressure Control in DM	****

Extra Credit

BONUS: 1.5 % of Medicare Allowable

Physician: _____

Specialty: _____ Year: _____



Lesson 4: Collecting Payment and Performance Report June 2008

Physicians will receive a maximum of 1.5% of Medicare allowable for all diagnoses they bill for. If relatively few individual instances of reporting quality data are done, then a lower payment will be made based on a formula (Reference: www.cms.hhs.gov/PQRI Analysis and Payment on the sidebar menu). Also in June 2008 a performance report will be provided to physicians based on their reported data. Though this report card is presently confidential, soon it is likely to be publicly reported and related to pay for performance.

All coding and payment are based on a unique individual NPI, National Provider Identifier, and it is essential that our billing administrators obtain an NPI number for us. Validation will be performed on a sample of measures to ascertain that data is being reported accurately. More details on this strategy are on the PQRI website.



Practise Exercise: Sample Case

Dr. Jones, an internist, wishes to participate in PQRI:

First:

She engages her partners, office manager, clinical staff, billing staff and hospital QI coordinator and learns about the details of PQRI through Medicare's website www.cms.hhs.gov/PQRI

Second:

Dr. Jones selects 3 or more measure. In this case she selects 5 measures for reporting, and learns about the inclusion and exclusion criteria from the website www.cms.hhs.gov/PQRI and selecting Measures and Codes.

In-patient measures

CPT II Aspirin at arrival for AMI

CPT II Beta Blocker at time of arrival for AMI

CPT II Empiric antibiotics for community acquired pneumonia

Outpatient measures

CPT II Hemoglobin A1c poor control in Type 1 or 2 Diabetes Mellitus

CPT II High Blood Pressure Control In Type 1 or 2 Diabetes Mellitus

Third:

Dr. Jones develops systems in collaboration with office nurse and hospital QI coordinator for selected measures to obtain performance data. For example, in the office Dr. Jones has her

nurse review the Hemoglobin A1c and blood pressure for each diabetic and flag those with an A1c above 9.0% or blood pressure more than 140/80 mm Hg.

Dr. Jones contacts the hospital QI coordinator and requests the performance indicators on her patients in the hospital with AMI and pneumonia. The hospital QI coordinator does a concurrent review of the data so that he can provide Dr. Jones with the performance measure and also so that the hospital can improve its performance on core measures.

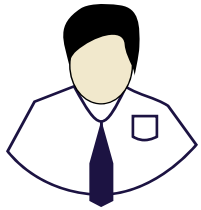
Dr. Jones then places a CPT II code for the performance measure with no modifier if the measure was performed. If there is a contraindication, Dr. Jones places a 1P modifier, and if the quality measure was not addressed or not documented then the doctor places the 8P modifier. The billing administrators submit the CPT II at the same time as the CPT I code for payments.

Fourth:

Dr. Jones and the billing staff makes sure that they code for at least 80% of the cases on at least three of the five indicators she has selected. Reporting on greater number of cases assures that the maximum cap of 1.5% bonus payment will be made.

Fifth:

In June 2008 Medicare gives Dr. Jones a bonus and sends a confidential quality performance report card for the July-December 2007 time period. Her bonus payment was based on a 6 month Medicare allowable payment. Unfortunately, Dr. Jones will not know if she reached the 80% in three indicators until June 2008.



Next Steps by Physicians

PQRI is part of a strategy to use value-based purchasing to deliver care based on the Institute of Medicine's STEEEP principles: safe, timely, effective, efficient, equitable, and patient-centered.

The 2007 PQRI reports will be confidential, and the payments will be based on reporting (not performance) of quality measures. However, future reports will likely be publicly reported and will have bonus payments aligned with performance. Similar strategy is in place for hospitals. Over the next several years, electronic based and registry-based reporting will facilitate concurrent reporting for PQRI.

PQRI may seem cumbersome and time consuming, however it lays a foundation for physician-based measurement, evaluation and quality improvement for years to come.

References: www.cms.hhs.gov/PQRI

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