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ARE YOU READY?

VOLUNTARY PQRI WILL SET THE STANDARD

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Pay for performance—or P4P, as many have come to call it—is the next sweeping change to hit the health care community, now that the national provider identifier (NPI) is old hat. The theory behind pay for performance is multi-fold. It serves as a means toward achieving a) transparency in the provision of health care and the pricing of health care services in society, b) "consumer driven health care," and c) "outcomes-based/value-driven health care and payment." Ultimately, the goal of the pay-for-performance initiative is to compensate providers who are delivering a higher quality of health care—as measured through better outcomes for their patients—at an increased rate.

PQRI: AN IDEA IS BORN

Pay for performance is not in its first incarnation. In 2006 the federal government attempted to motivate the medical community in the direction of pay for performance via a voluntary reporting initiative, but to little avail. Because of the paltry rate of participation, the government revamped the system so as to provide a monetary incentive for voluntary reporting. The new system was signed into law on December 20, 2006, in the Tax Relief & Health Care Act of 2006 (TRHCA). Currently, this is where the medical community stands: as of July 1, 2007, voluntary reporting spurred by a financial incentive, known officially as the Physician Quality Reporting Initiative (PQRI), will begin.

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Who can participate? Any provider designated as an "eligible professional" by the TRHCA is free to participate in the PQRI. Eligible professionals include the following: medical physicians as defined by the Social Security Act §1861(r)—doctors of medicine, osteopathy, podiatric medicine, optometry, oral surgery, dental medicine, and chiropractors; practitioners, as defined by the Social Security Act §1842(b)(18)(C)—physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwifes, clinical social workers, clinical psychologists, registered dieticians and nutritional professionals; and physical, occupational, and qualified speech-language therapists.

There are some statutory limitations, however, as to who can participate. With some exceptions, *any* Medicare-enrolled eligible professional may participate in the PQRI, regardless of whether he or she has signed a Medicare participation agreement to accept assignment *(continued on page 20)*

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on all claims. However, otherwise eligible providers *not* enrolled in the Medicare program will not be able to participate.

Similarly, because the TCHRA defines the PQRI as pertaining to covered services paid under the Physician's Fee Schedule, providers working in Rural Health Clinics (RHC) or Federally Qualified Health Centers (FQHC) are not able to participate. Other Part B services that are paid via other reimbursement systems (such as RHCs, labs, and FQHCs) are not contemplated by the statute, and thus are not eligible for inclusion in the PQRI.

Finally, providers who have not yet obtained an NPI are ineligible for participation. Although the bonus payments will be made to the holder of the Taxpayer Identification Number (TIN) and then must be distributed to the individual participating providers, the individual analyses of the reported data for success and bonus calculation will be done at the individual provider lever via the NPI.

The only other potential roadblock to participation is that the medical college associated with a provider's specialty must have developed, vetted, and submitted to CMS reporting measures relating to that specialty practice. If this has not been done, then there really is no way for providers to report their performance because measures specific to their practices will not have been approved for or included in the PQRI. Rather, such providers should appeal to their medical college to develop such measures.

This should only be an issue for a small segment for the medical community because most areas of specialty have, in fact, already developed these measures. However, if your client's specialty has not been represented in the current 2007 PQRI measures, then be sure to raise the issue sooner rather than later because the proposed 2008 measures will be published in the Federal Register by August 15, 2007.

How does one participate? Easily—just start coding your providers' selected quality measures as of July 1, 2007. Nothing is that easy, though, right?

Selecting Measures. To prepare for the onset of the PQRI, providers must review the final 2007 PQRI Quality Measure Specifications and select the measures which best apply to their patient panels. After July 1st rolls around, providers need only to report on the selected measures by submitting on their regular claim forms the quality-data codes (CPT Category II codes and temporary G-codes) specifically established for the PQRI. There is no registration requirement prior to submission of these codes. Simply begin coding your chosen quality measures as of July 1, 2007.

When selecting applicable quality measures, providers must, if possible, select a minimum of three measures on which they will report.

That being said, there is still quite a bit of procedural work to be done prior to the July 1st start date. As billing partners, HBMA companies should communicate with their providers sooner rather than later in order to ascertain client interest in participation in the PQRI and to arrive at documentation procedures necessary to capture the reporting information.

The CMS website provides the listing of 2007's final seventy-four measures. Providers should select those on which they will report (accessible as downloads from the main page addressing PQRI Measures/Codes: www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage). This listing provides a brief description of the various quality measures, allowing providers to determine which best apply to their practices and patient panels.

Once the reporting measures have been selected, providers should be sure to reference the measure specifications (again, found as a download from the PQRI Measures/Codes page). This lengthy document provides details and instructions for each measure, such as the reporting frequency and timeframe, the CPT & ICD-9 codes that trigger a measure's reportable action (which will contribute to the denominator figure when analyzing a provider's PQRI success), the actual CPT-II or G-codes (i.e., the quality-data codes) to be used to report the PQRI measure (which will contribute to the numerator figure when analyzing a provider's PQRI success), the modifiers allowed for the measure (these vary measure-by-measure), etc.

It is beyond critical for billing companies and providers to carefully review this document so as to accurately and successfully conduct the PQRI coding.

When selecting applicable quality measures, providers must, if possible, select a minimum of three measures on which they will report. Then, in order to satisfactorily meet the reporting requirements of the PQRI and ensure eligibility for the compensation element of the program, providers must meet certain reporting thresholds:

1. When no more than three quality measures are reported on, each measure must be reported to CMS in *at least 80%*

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of cases in which the measure is reportable.

2. When four or more measures are applicable, then the 80% threshold must be met on at least three of the measures reported.

In the event that a provider's practice does not relate to three reportable measures, but only to one or two, or if providers try to game the system by selecting measures with limited application to their practice so as to reduce their reporting burden, then the bonus cap (see discussion below) will inevitably impact that practice's bonus payment. The goal is to report as much as possible.

Capturing and Reporting PQRI Data. OK, now that your providers have selected their measures, it is up to the billing company—with the help of the providers' offices—to code and file claims that report the provider's performance. Here billing companies will find themselves at another critical juncture: figuring out how to capture and report the PQRI data.

Successfully capturing the relevant PQRI data will require some cooperative effort on behalf of billing companies and provider practices. Mechanisms must be established and in place by July 1, 2007 (or as soon thereafter as possible to ensure the highest percentage of PQRI data capture and reporting, for PQRI data must be filed with the *initial* claim form; it cannot follow on a separate claim!).

Such mechanisms might include running a report on all patients with a particular diagnosis code which will trigger a measure. That report would tell your provider the universe of patients to whom the PQRI measure would apply. Another mechanism that might be helpful is to build ticklers into your provider's EMR system. The tickler could pop up as certain ICD-9 or CPT codes are used, alerting the provider that PQRI measure action and coding (including, possibly, modifier coding for non-performance of the measure) is required. This crucial step of implementing processes takes time, however, and thus must be addressed immediately.

As far as documenting the data is concerned, CMS is in the process of developing measure-specific worksheets for use by providers in capturing the relevant PQRI data. When available, they will be found at the CMS PQRI website, http://cms.hhs.gov/pqri. These worksheets should provide a quick and easy PQRI addendum to the practice's regular encounter form (although the office will still need to identify the patients with whom these worksheets are to be used). Alternatively, billing partners and providers can work to develop their own worksheets to capture and document PQRI data for reporting purposes.

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Reporting PQRI Data. Once PQRI measure data has been captured and documented, it must be reported for successful participation in the PQRI (remember, a minimum rate of 80% for three measures). This is easily accomplished by using the standard CMS-1500 form, placing the quality data code in field 24D. Filing is equally simple with the electronic 837-P claim in which you and submit the quality data codes in the SV101-2 "Products/Services ID" Data Element on the SV1 "Professional Service" segment of the 2400 "Service Line" loop. It's also necessary to identify in this segment that a quality data code is being supplied by submitting the HC in data element SC101-1 within the SV1 "Professional Service" segment.

Regardless of whether you file the claim on paper or electronically, you must be sure to enter a dollar amount—preferably $0.00, but if you are unable to submit or process zero-dollar charges, then use $0.01. That's all there is to it.

Remember, however, if the provider did not perform the measure's action, use an allowed modifier as identified in the measure specifications to indicate a reason for non-performance. Modifiers are: 1P – not performed for medical reasons; 2P – client refused action; 3P – systems reason for inaction; or 8P – not performed, but reason not specified. These modifiers are critical because the actions to which the measures apply are the identified standards of care in the industry. In situations in which a provider has not complied with the standard of care, a reason must be provided to clarify why not. Remember, at some future point, the results of such reporting will be made available to the general public (and thus, providers' patients) and will determine the rate at which providers will receive compensation. The more accurate and fulsome the information that is provided as to why providers did or did not comply with measures, the better off they will be!

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WHAT'S IN IT FOR PROVIDERS?

Professional Growth. Providers deciding to participate in the PQRI will have access to the CMS data analysis of their reporting via confidential feedback reports which will be provided in mid-2008, around the time of the bonus payment distribution. This analysis will educate providers as to the level of care that they are providing as compared to other initiative participants. While the 2007 individual provider quality data will not be made available to the public, it is the intention of CMS eventually to publish all reporting data so as to encourage consumer-driven healthcare.

Financial Incentive. There is also a financial incentive. Providers who successfully participate (i.e., meet the 80% reporting threshold) from July 1 through December 31, 2007, will receive a lump-sum bonus payment in mid-2008. This bonus will equate to up to 1.5% of the providers' *total allowed charges* for covered services from July 1 through December 31, 2007, not just those that were reported via PQRI! Moreover, the total allowed charges will apply to all Medicare charges, regardless of whether Medicare was the primary or secondary payer.

This seems great—money for nothing (other than the aforementioned implementation of some processing mechanisms). However, there are some caveats regarding the bonus—most notably, "The Cap." Per CMS, the purpose of the cap is twofold: first, it encourages more instances of reporting measures—the more measures that are selected and reported, the more likely the cap will not affect the bonus payment. Secondly, the cap attempts to draw a rough equity between providers who are reporting on measures requiring disparate reporting burdens.

For example, take two eligible professionals who have same type of practice. One reports on measures which affect relatively few patients, the other selects measures that need to be reported on virtually every patient. The cap is designed to limit the bonus of the providers who have to do less work because theychose measures which required infrequent reporting. The bottom line is: the more measures that are selected and reported, the more likely the cap will not affect the bonus payment.

Calculating the Cap. The cap is calculated by multiplying (1) the total instances of reporting quality data for all measures submitted by a provider by (2) a constant of 300%. That total is then multiplied by (3) the national average per measure payment amount (NAPMPA). NAPMPA, the calculation of national total amount of allowed charges associated with quality measures divided by national total instances of reporting, cannot be ascertained until after the reporting period is over and all national data has been collected.

> ***Example:*** Assume the individual reports 10 times on one measure with limited application to the practice. This is multiplied by 300% to get $30. If the NAPMPA is $100, then multiply 30 by 100. The cap would be $3000. This may be below the full 1.5% that a provider is eligible to receive. Each instance of reporting a quality measure increases the value of the cap, until the cap supersedes the 1.5% calculation of all Medicare charges. At that point, providers get the full 1.5% bonus.

To further ensure that providers maximize their bonus potential, they must be sure to expeditiously submit all claim information to their billing partners for processing. All claims eligible for consideration for this bonus must be submitted to the Medicare Part B Carrier by February 29, 2008.

WHAT'S NEXT?

Right now, the pay-for-performance initiative is voluntary, and the payoff for the additional work is questionable, if not negligible. But what lies ahead is the real issue! Hospitals are now in their second year of reporting, and their bonus has increased to 2%, thus providing empirical evidence that the provider "bonus" is likely to increase over time as well.

Further, the TRHCA mandates that any raises *or avoidance of cuts* in the Medicare Physician Fee Schedule (remember there is currently a law on the books authorizing a 10% cut in Medicare fees!) shall be directly tied to reporting measures! So, this "voluntary" program will quickly morph into a mandatory one—in practice, if not literally so.

As the bonus increases continue and fee schedule cuts are applied, the disparity between payments to reporting providers versus non-reporting providers will be vast. Essentially this will create a mandatory reporting system. Further, as consumers become more savvy in their selection of health care services, they will select those providers who have performance data available for review, thereby allowing for the very transparency in health care that the PQRI was designed to achieve. ▲

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