# My Notes on the March 22, 2011 CMS Open Door Forum on Physician Quality Reporting System (PQRI) for the Beginner

Today's CMS Open Door Forum was a good one. The slides (**pdf here**), although reviewed quickly during the call, are a comprehensive resource for anyone needing in-depth information on qualifying for incentives through PQRI. The information is complex, but anyone can start the process tomorrow and successfully get their check (next year.)

## PQRI has been renamed PQRS.

These are the key points of the information presented:

1. You can tell if you are **eligible** for the incentive program by checking the main PQRS site **here**. Scroll down to Downloads and click on "List of Eligible Professionals."
2. There is **no registration** required to report quality data.
3. PQRS should not be confused with incentives offered for ePrescribing or meaningful use of a certified Electronic Health Record – these are three distinct systems.
4. There are new Physician Quality Reporting Measure Specifications every year – use the correct year.
5. Reporting can be done as **individual eligible providers or as groups,** however groups needed to be self-nominated

by January 31, 2011, so that door is closed for this year.

6. Eligible providers can choose to report for 12 months: January 1”“December 31, 2011 or for 6 months: July 1-December 31, 2011 (claims and registry-based reporting only.)
7. There are **two reporting methods for submission of measures groups** that involve a patient sample selection: 30-patient sample method and 50% patient sample method. An “intent G-code” must be submitted for either method to initiate intent to report measures groups via claims. If a patient selected for inclusion in the 30-patient sample did not receive all the quality actions and that patient returns at a subsequent encounter, QDC(s) may be added (where applicable) to the subsequent claim to indicate that the quality action was performed during the reporting period.
   Physician Quality Reporting analysis will consider all QDCs submitted across multiple claims for patients included in the 30-patient samples.
8. Eligible professionals who have contracted with Medicare Advantage (MA) health plans should not include their MA patients in claims-based reporting of measures groups using the 30 unique patient sample method. **Only Medicare Part B FFS patients** (primary and secondary coverage including Railroad Medicare) should be included in claims-based reporting of measures groups.
9. **Choose which group measures** OR individual measures (3 minimum) you want to report on based on your method of reporting. Review your choices **here.**
10. If you plan to report using a registry or EHR, make sure the systems are qualified by checking **here.**
11. Here is the **schedule** for PQRS incentives and “payment adjustments” (financial dings.)

    - Incentives (based on the eligible professional’s or group’s estimated total Medicare Part B PFS allowed

charges)
    - 2007 ”“1.5% subject to a cap
    - 2008 ”“1.5%
    - 2009, 2010 ”“2.0%
    - 2011 ”“1%
    - 2012, 2013, 2014 ”“0.5%
- Payment Adjustments (you lose money)
    - 2015 ”“98.5%
    - 2016 and subsequent years ”“98.0%

## What follows are the Questions and Answers from the listeners.

***Q: Do PQRS measures need to be reported once per encounter or once per episode?***

A: It depends on the measure. Check the list to see what each measure requires.

***Q: Is there a code to submit if we cannot qualify due to low numbers of Medicare patients?***

A: No, CMS will calculate this and will know you cannot qualify and you will be exempt from the payment adjustment.

***Q: Can both admitting physicians and consulting physicians submit the same quality codes?***

A: Yes, all eligible providers working with a patient can report the same code if appropriate.

***Q: How do we know if we qualified for the eRx incentive for 2010?***

A: Payments will come early fall and feedback reports will be available that break down each provider’s incentive.

***Q: For the eRx incentive, is it 10 eRxs before June 30, 2011 and 25 before January 31, 2011 for each PROVIDER or each***

***PRACTICE?***

A: Each provider.

***Q: What is the difference between the numerator and the denominator in PQRS?***

A: The numerator is the clinical quality action (for instance, putting a patient on a beta blocker) and the denominator is the group of patients for whom the quality action applies (which patients with appropriate diagnoses are eligible for beta blocker therapy.)

***Q: Do all the preventive measures in this group have to be utilized?***

A: Not all measures will apply to all patients, for instance mammograms for females only.

***Q: Is there a code to be placed on the claim that says a measure is not applicable for this patient?***

A: No.

***Q: How do you know if a measure code on a claim has been accepted?***

A: You will receive a rejection code on your EOB that indicates the code was submitted for information purposes only. Remittance Advice (RA) with denial code N365 is your indication that Physician Quality Reporting codes were passed into the National Claims History (NCH) file for use in calculating incentive eligibility.

***Q: How can a new provider get started with quality reporting?***

A: Any provider can start any time by reporting through claims, a registry or an EHR.

***Q: Should providers bill for PQRI under their individual number or under their group number?***

A: Under their individual number.

***Q: Can a physician delegate the eRx process to a staff member, just as they might have a nurse write a prescription for them?***

A: Yes.

***Q: Can you clarify the three incentive programs and which a practice can participate in at the same time?***

A: The Physician Quality Reporting System, eRx Incentive Program, and EHR Incentive Program are three distinctly separate CMS programs.

The Physician Quality Reporting System incentive can be received regardless of an eligible professional's participation in the other programs.

There are three ways to participate in the EHR Incentive Program: through Medicare, Medicare Advantage, or Medicaid.

If participating in the EHR Incentive Program through the Medicaid option, eligible professionals are able to also receive the eRx incentive.

If participating in the Medicare or Medicare Advantage options for the EHR Incentive Program, eligible professionals can still report the eRx measure but are only eligible to receive one incentive payment. Eligible professionals successfully participating in both programs will receive the EHR incentive.

Eligible professionals should continue to report the eRx measure in 2011 even if their practice is also participating in the Medicare or Medicare Advantage EHR Incentive Program because claims data for the first six months of 2011 will be analyzed to determine if a 2012 eRx Payment Adjustment will apply to the eligible professional.

If an eligible professional successfully generates and reports electronically prescribing 25 times (at least 10 of which are

in the first 6 months of 2011 and submitted via claims to CMS) for eRx measure denominator eligible services, (s)he would also be exempt from the 2013 eRx payment adjustment.

The transcript and a recording of today’s call will be posted on the CMS website within a few weeks.

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