Physician Quality Reporting Initiative Begins July 1, 2007

Beginning July 1, 2007, physicians and other healthcare practitioners can participate in the Physician Quality Reporting Initiative (“PQRI”), which is a quality reporting program through the Centers for Medicare and Medicaid Service (“CMS”). Under PQRI, eligible professionals who successfully report certain quality measures on claims for dates of services from July 1 to December 31, 2007 may earn a bonus payment of 1.5 percent of the total allowed charges for covered Medicare Physician Fee Schedule services during that same period, subject to a cap.

Eligible Professionals

Professionals who are eligible to participate in PQRI are (1) physicians, including doctors of medicine, doctors of osteopathy, doctors of podiatric medicine, doctors of optometry, doctors of oral surgery, doctors of dental medicine, and chiropractors; (2) practitioners, including physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, clinical psychologists, registered dieticians, and nutrition professionals; and (3) therapists, including physical therapists, occupational therapists, and qualified speech-language pathologists. These eligible professionals may participate in PQRI as long as they have enrolled in Medicare, even if they have not signed a Medicare participation agreement. No registration is required to participate in PQRI.

Quality Measures

PQRI reporting is based on 74 quality measures, which can be found on CMS’s website at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage. These measures are designed to encourage quality improvement and avoid unnecessary costs and include aspects of patient care such as prevention, management of chronic care conditions, management of acute episodes of care, resource utilization, and care coordination.

Specific PQRI quality-data codes are associated with each of the 74 measures. These quality-data codes, which are primarily CPT II codes, should be reported on paper-based CMS 1500 forms or electronic 837-P forms as a $0.00 charge. Each measure also has reporting frequency requirements, and some measures have specific performance time frames. Certain “exclusion” modifiers may be used with the CPT II codes to explain why a measure was not provided in a certain case, such as, when a given measure is contraindicated.

Successful Reporting

The determination of successful reporting depends on how many quality measures apply to the services furnished by a particular eligible professional during the July 1 to December 31, 2007 reporting period. Eligible professionals must select which of the 74 quality measures best fit their practice and report those measures in a certain percentage of the applicable cases. If no more than three quality measures apply to the services provided by the eligible professional, then each measure must be reported for at least 80 percent of the cases in which the measure was reportable. If four or more quality measures apply to the services provided by the eligible professional, then at least three of those measures must be reported for at least 80 percent of the cases in which the particular measure was reportable.

Payments

Participating eligible professionals, who successfully report as described above, may earn a 1.5 percent bonus payment, subject to a cap. The 1.5 percent bonus payment is based on the allowed charges for all covered services (not just those charges associated with reported quality measures) furnished during the July 1 to December 31, 2007 reporting period and paid under the Medicare Physician Fee Schedule. “Allowed charges” refer to the total
charges for covered services, including beneficiary deductibles and copayments. Bonus payments will be made as a lump sum in mid-2008.

A payment cap that reduces the potential bonus below 1.5 percent may apply in situations in which an eligible professional reports relatively few instances of quality measure data. In other words, the cap is meant to encourage more instances of measure reporting. The cap is calculated by using an established formula that accounts for the total instances of reporting for all measures by a particular eligible professional compared to a related national average reporting figure. Because the cap calculation depends on how much all eligible professionals participate in PQRI during the reporting period, the cap cannot be determined until after PQRI ends.

**Strategies for Successful Reporting**

PQRI is a “payment for reporting” program. Therefore, the best strategy for success is to report early and report often. Eligible professionals should also report as many measures as possible to increase the likelihood of reaching the 80 percent requirement for the requisite number of measures and decrease the likelihood of being subject to the cap. Additionally, eligible professionals who report only one or two measures may have to go through a validation process in which CMS will determine whether other measures should have been reported.

Eligible professionals should select the quality measures that apply to them now and establish internal systems for identifying reporting opportunities, documenting the measures, and reporting the measures to Medicare. Refer to the chart below for an outline of the steps that are included in the PQRI process. CMS recommends that eligible professionals begin testing the reporting procedures as soon as possible and has established a mechanism for doing so on its website. CMS, in conjunction with the American Medical Association (“AMA”), is also developing worksheets to help eligible professionals navigate the PQRI process, and these worksheets should be available on the CMS and AMA websites soon.

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### Steps to Successful Reporting

1. **Select the measures that apply**
2. **Identify reportable opportunities**
3. **Document the measure**
4. **Use the appropriate CPT II or G Code**
5. **If measure not performed, use exclusion modifier**
6. **Submit the claim to Medicare**

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This Health Care Law Alert is intended to provide general information for clients or interested individuals and should not be relied upon as legal advice. Please consult your attorney for specific advice regarding your particular situation. If you do not have an attorney and require assistance please consult with the following:

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