THE ALLIANCE FOR PATIENT ACCESS

Medicare Physician Quality Reporting Initiative Fact Sheet

Under Medicare's 2007 Physician Quality Reporting Initiative (PQRI), eligible professionals who successfully report a designated set of quality measures on claims for dates of service from July 1 to December 31, 2007 may earn a bonus payment, subject to a cap, of 1.5% of total allowed charges for covered Medicare Physician Fee Schedule Services. The program is mandated by the Tax Relief & Health Act of 2006.

2007 PQRI reporting is based on 74 quality measures covering a broad range of patients, conditions, and specialties, including eight neurology/physical medicine-related measures (stroke and stroke rehabilitation):

1. #10. Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports
2. #11. Carotid Imaging Reports
3. #31. Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage
4. #32. Discharged on Antiplatelet Therapy
5. #33. Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge
6. #34. Tissue Plasminogen Activator (t-PA) Considered
7. #35. Screening for Dysphagia
8. #36. Consideration of Rehabilitation Services

Reporting Quality Measures

There are specific PQRI quality-data codes associated with each of the 2007 PQRI measures that must be reported on claim forms. PQRI quality data codes include CPT Category II codes (alpha-numeric ending in "F") and temporary HCPCS "G" codes (where relevant CPT II codes have not yet been developed). Reporting may indicate:

- Measure met
- Measure not met due to documented, allowable reasons
- Measure not met without documentation as to why

Note: Incentive payment is based upon reporting—not performance. Professionals are eligible for incentive even if reporting indicates measure was not met without documentation why.

Measures must be reported on claim lines (paper or electronic) separate from payable services and include:

- Date of service
- Place of service
- PQRI quality data code (CPT II or HCPCS "G" code)
- Diagnosis pointer (to ICD-9-CM diagnosis code)
- Submitted charge ($0.00 or $0.01—if system does not handle $0)
- Performing provider number

Specifications

CMS has developed specifications for each measure that include:

- Description of the measure
- Instructions as to when and how the measure should be reported
- Numerator/Denominator—to determine reporting frequency (must meet 80% threshold to count toward eligibility for incentive payment)
- Rationale supporting the measure
- Clinical recommendation statements—evidence-based recommendation for management

Calculating the Incentive Payment

The 1.5% bonus payment is calculated using total allowed charges under the Physician Fee Schedule furnished 7/1/07-12/31/07 and submitted by 2/29/08 and paid under the Physician Fee Schedule.

Payment is subject to a cap for professionals with relatively few instances of reporting quality measures. The cap is based on:

- Total instances of reporting quality data for all measures (not limited only to measures meeting the 80% threshold) multiplied by:
  - 300%
  - The national average per measure payment amount (will be calculated at the end of the reporting period)

Getting Started

As long as you're enrolled in the Medicare program, there's no need to register. Just take the following steps:

1. Review the list of 74 measures and identify those relevant to your practice
2. Report measures on claim forms during 7/1/07-12/31/07 reporting period
   - CMS will determine (using algorithms) whether reporting has met the 80% threshold for at least three measures (if four or more are applicable) or all applicable measures (if fewer are applicable)
3. Submit claims for all Medicare Physician Fee Schedule services provided through 12/31/07 by 2/29/08
   - CMS will make 1.5% incentive payment and provide report of performance in mid-2008

For more information, CMS has released excellent educational materials about the 2007 PQRI, which are available at *http://www.cms.hhs.gov/PQRI*.