



Emergency Medicine Coding Bulletin

2008 PQRI Update

SPOTLIGHT ON THE
CMS Pay for Reporting Initiative

The Legislative Process

The Tax Relief and Health Care Act of 2006, Division B, Title 1, Section 101 mandated that physicians be paid a 1.5% bonus for meeting certain requirements relating to the reporting of CMS designated quality measures. The program is called the Physician Quality Reporting Initiative (PQRI) and allows physicians to receive a bonus if they meet a threshold of reporting 80% of the time on at least three quality measures. The design of the PQRI program for 2008 is to pay physicians for reporting whether or not they performed the quality measures. Payments do not depend on whether the quality performance clinical criteria are being met, but only that they are being reported. Of note, pay for performance will likely soon follow the pay for reporting program. The reporting period for the 2008 PQRI program comprises dates of service January 1 through December 31, 2008.

MRSI's certified ED coders are fully trained in PQRI measure reporting

CMS Vision

CMS has offered the following vision for PQRI: "to build on Medicare's comprehensive efforts to substantially improve the health and function of our beneficiaries by preventing chronic disease complications, avoiding preventable hospitalizations, and improving the quality of care delivered." Mark McClellan M.D., Ph.D., the CMS administrator, during his testimony before the House Ways and Means Subcommittee on Health stated: "CMS believes that an important component of delivering high quality healthcare is the ability to measure and evaluate quality. Accordingly, CMS is committed to the development of payment systems that will support and reward quality." CMS has now quickly rolled out the PQRI program with real money at stake for ED physicians. This is likely just the beginning of what will be a growing CMS emphasis on quality processes with more measures being developed and likely an increasing portion of physician payments at stake.

The Quality Measures

For 2008 reporting, there are 119 CMS defined quality measures that were vetted and adopted by CMS. ACEP had an active taskforce within the PCPI which developed and put forward seven ED specific measures: Aspirin at Arrival for AMI (Measure #28); Electrocardiogram Performed for Non-Traumatic Chest Pain (#54); Electrocardiogram Performed for Syncope (#55); Vital Signs for Community-Acquired Bacterial Pneumonia (#56); Assessment of Oxygen Saturation for Community-Acquired Bacterial Pneumonia (#57); Assessment of Mental Status for Community-Acquired Bacterial Pneumonia (#58); Empiric Antibiotic for Community-Acquired Bacterial Pneumonia (#59). Additional Potential ED Measures include: Stroke: Tissue Plasminogen Activator (t-PA) Considered; Stroke: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage, and Advance Care Plan (65 and older).

MRSI's proprietary ED-PACE™ coding platform assures accurate reporting of PQRI measures

CMS Processes

The ED discharge diagnosis that is submitted with the physician claim will drive the reporting process. CMS will use the discharge diagnosis to trigger the requirement for reporting quality measures. For example, patients assigned a diagnosis of acute MI will generate a reporting requirement relative to providing aspirin to the those patients.

The Coding

CMS and CPT have developed a series of CPT category 2 codes and special G codes to report these newly developed quality measures. The complete list of codes and specifications can be found at www.cms.hhs.gov/pqri/. For example, if the physician documents that a patient with an acute MI received aspirin the coder would report code 4084F.

What if the quality measure was not achieved...what if the aspirin was not given? The coder may add a modifier to further explain why the designated quality process did not take place. The following modifiers are available to further explain the various reasons why a quality measure may not have been met.

- 1P** Performance measure exclusion modifier due to **medical** reasons. *Reasons include:*
- *Not indicated (absence of organ/limb, already received/performed, other)*
 - *Contraindicated (patient allergic history, potential adverse drug interaction, other)*
 - *Other medical reasons*
- 2P** Performance measure exclusion modifier due to **patient** reasons. *Reasons include:*
- *Patient declined*
 - *Economic, social or religious reasons*
- 3P** Performance measure exclusion modifier due to **system** reasons. *Reasons include:*
- *Resources to perform the services not available (eg. equipment, supplies)*
 - *Insurance coverage or payer-related limitations*
 - *Other reasons attributable to health care delivery system*
- 8P** Modifier available if a **quality measure was not met and there is no clear documentation.**

At stake: 1.5% of all Medicare dollars including allowable, deductibles, and all co-pays.

Scenarios

65-year-old male presents with an acute MI. The physician documents giving aspirin. **REPORT 4084F**

48-year-old female presents with an acute MI. The physician documents not giving ASA due to a Hx of anaphylaxis. **REPORT 4084F, 1P** (medical reason)

25-year-old male using crack presents with an acute MI and refuses aspirin. **REPORT 4084F, 2P** (patient reason)

72-year-old male is brought in by EMS with an acute MI. No aspirin is given and nothing is documented (perhaps the aspirin was given by EMS but the chart did not indicate it). **REPORT 4084F, 8P** (reason not specified)

Reporting

It is important to contact your coding and billing professionals to make sure your group is reporting PQRI measures. Physicians will report on these measures using CPT II codes and modifiers (1P, 2P, 3P and 8P) or five digit HCPCS codes (called "G-Codes"). These codes are submitted on the actual claim along with the other ED charges. For groups filing with CMS electronically, the 2008 PQRI quality-data codes are HCPCS codes and reporting requirements follow current rules for reporting other HCPCS codes (e.g. CPT Category I codes). On the ASC X12N 837 professional health care claim transaction, HCPCS procedure codes are submitted in the SV1 "Professional Service" Segment of the 2400 "Service Line" Loop.

Payment

Physicians will be scored individually at the National Provider Identifier (NPI) level. Physicians achieving greater than 80% reporting of the quality codes on 3 or more measures will be awarded a PQRI bonus subject to a cap. Ultimately, payment of the PQRI bonus will be made to the Tax ID number or Employer Identification Number (EIN) of the group.

Questions & Answers

How will Physician Quality Reporting Initiative (PQRI) measures be structured for 2008?

The proposed 2008 PQRI quality measures have been published in the Federal Register as a part of the 2008 Physician Fee Schedule (PFS) Proposed Rule. Measure numbers for 2008 PQRI represent a continuation in numbering from the 2007 PQRI Measures 1 through 74. Gaps in measure numbering reflect those 2007 PQRI measures that are not included for implementation in 2008 PQRI. Of note, the TRHCA Tax Relief and Health Care Act further specifies that the 2008 PQRI measures must include two or more structural measures, such as the use of electronic health records (EHRs) or electronic prescribing.

What charge structure is recommended for the PQRI measure codes?

The submitted charge field cannot be left blank. The amount of \$0.00 should be entered on the claim as the charge. The billing software must allow a \$0.00 charge. If an amount greater than \$0.00 is billed on the PQRI line, the PQRI code is denied and tracked. Physicians and other eligible professionals are not allowed to collect any monies from beneficiaries for charges submitted for the PQRI codes.

Is use of an Electronic Medical Record part of the 2008 PQRI measures?

Measure #124 is defined as Adoption/Use of Health Information Technology (Electronic Health Record). The CMS is continuing to push forward advocating and supporting adoption of electronic processes that will increase patient safety and clinical efficiency. Providers will receive credit for each visit reported that utilizes an appropriate EMR. The codes reported are G8848 or G8849. To qualify, the provider must have adopted a qualified Electronic Medical Record (EMR). A qualified EMR can either be a certified through the Certification Commission for Health Care Information Technology (CCHIT) or be capable of the following:

- Generating a Medication List
- Generating a Problem List
- Entering laboratory tests as discrete searchable data elements



Expert ED Coding and Billing for Physicians and Hospitals

Medical Reimbursement Systems, Inc. · 781.937.4520 · www.mrsiinc.com