PQRI for Glaucoma Specialists

Can you benefit by participating?

BY RENEE HATFIELD, BA

By now, we have all heard that the initial reporting period for the Centers for Medicare & Medicaid Services' (CMS) Physician Quality Reporting Initiative (PQRI) started on July 1, 2007. The CMS has initiated this reporting system to focus on specific clinical conditions and scenarios utilizing (1) new Category II Codes to report each measure, (2) precise ways to bill the CPT, ICD-9-CM, and Category II codes involved, and (3) a formula to calculate each measure to be monitored.

Navigating the PQRI process can be confusing, and I applaud any physician who has taken on the challenge. Is the effort worth the payoff, however? This article breaks down the CMS' reporting contingencies and discusses their effect on glaucoma practices.

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PQRI BASICS

Measure 12

Although the CMS promotes reporting for all measures applicable to patient care—including general measures—the CMS has identified only one for glaucoma patients. Table 1 lists the specifics for Measure 12

TABLE 1. SPECIFICS OF MEASURE 12 (POAG, OPTIC NERVE HEAD EVALUATION)*

CPT	ICD-9	Successful Reporting	CPT II Codes
92002-92014 99201-99205 99212-99215 99241-99245	365.01 365.10 365.11 365.12 365.15	Optic nerve head evaluation performed within 12 months	2027F
		Optic nerve head evaluation *not* performed in last 12 months, for medical reasons	2027F-1P
		Optic nerve head evaluation *not* performed in last 12 months, reason not specified	2027F-8P

**Applies to patients ≥18 years old diagnosed with POAG, and physicians billing for optic nerve head evaluation with an E/M code.*

Courtesy of the CMS.

(primary open-angle glaucoma [POAG]-diagnosed patients receiving an optic nerve head evaluation).

To receive credit for their services through PQRI, physicians must report on 80% of patients who qualified for a specific measure between July 1 and December 31, 2007. Based on the current guidelines, physicians can submit claims on paper (CMS 1500) or electronically (transaction claim 837-P) without incurring any additional costs. (See *Does PQRI Have Hidden Costs?*)

Eligible physicians can report the same measure for subsequent visits, but the CMS will calculate their bonus for that measure based on the visit that showed their highest performance.[1] In most instances, the CMS uses the first visit.

Validation Process

The CMS has created a measure-applicability validation process for physicians who submit fewer than three quality measures for 80% of their eligible patients or encounters. Because the CMS has identified only one quality measure for glaucoma, the validation criteria apply to glaucoma specialists.

During the two-part validation process, the CMS evaluates providers' claims (based on their National Provider Identifier numbers) with the clinical relation test to determine if they could have submitted quality codes for additional measures in designated clinical areas.[2]

The second step in the process is the minimum threshold test. This stage applies to providers for whom the clinical relation test identified additional measures they could have submitted.

The CMS has defined three clinical areas for ophthalmology: cataracts; diabetic retinopathy; and glaucoma. Because only Measure 12 is identified for glaucoma, the other clinical areas do not need to be reported, unless they are applicable. Additionally, the validation process excludes many general measures (eg, high blood pressure control in type 1 or 2 diabetes, screening for future fall risk, and medication reconciliation).

At first glance, the validation process appears to be straightforward for glaucoma specialists. Because they are not obligated to submit extraneous reports for the CMS' review, they have a high potential for receiving the 1.5% bonus in 2008. A closer look, however, suggests otherwise.

CAPPING THE PQRI BONUS

According to the American Academy of Ophthalmology: "Ophthalmologists can report on any measure they believe applies to them, including those from other specialties. The bonus is contingent upon (1) achieving 80% success for patients that have a disease/diagnosis [that matches the quality measure the physician is reporting] (eg, examining the optic nerve for a glaucoma patient) and (2) achieving that success rate for three quality measures (or fewer measures if less apply)."[3]

To ensure that physicians who only report a few cases do not receive the same size bonus as those who report quality measures more frequently, Congress imposed a cap based on the following formula:

PQRI bonus cap = individual's instances of reporting quality data X 300% X amount of national average payment per measure.

Where the:

Amount of national average payment per measure = national charges associated with quality measures/ national instances of reporting.

The cap serves a dual purpose, said Tom Valuck, Director of the CMS' Special Program Office for Value-Based Purchasing, which has the responsibility for implementing the PQRI. First, it encourages providers to report multiple quality measures. Second, it attempts to equalize bonus payments for providers who report at different levels. "The primary driver of the calculation is the amount of reporting that the individual participating professional has done," said Mr. Valuck.[4]

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The CMS' capitation calculation formula puts glaucoma specialists at a disadvantage compared with physicians who can potentially receive higher bonuses for reporting additional measures. Under the current PQRI guidelines, glaucoma specialists can receive a maximum bonus of only 1.5%.

APPEALING PQRI CLAIMS

In addition to being subject to a cap, the bonus payments awarded for services provided between July 1 and December 31, 2007, can be affected by inaccuracies in the CMS' reporting and record-keeping processes.

Due to the short duration of the initial PQRI reporting period, the CMS will not provide participating physicians with an interim report for 2007. Furthermore,

DOES PQRI HAVE HIDDEN COSTS?

If you are hesitant to participate in the PQRI program because your billing company stated that you would have to purchase additional software to track the extra information, I suggest you discuss the basis for the new fees with your vendor. PQRI reporting codes are simply CPT Category II codes—which any billing system should accept readily—amended with two-digit modifiers. Furthermore, because PQRI measures must be billed on the same claim as the corresponding CPT and ICD codes, no additional claims are necessary.

despite having an inquiry process in place, the CMS does not currently allow physicians to formally appeal PQRI measures.

How often does Medicare deny a physician's claim, even if it is billed with the correct codes (CPT and ICD-9) and modifiers specified by the Local Medical Review Policy? Under normal circumstances, a doctor can appeal the claim and ultimately receive payment. Physicians do not have the same right to appeal under the PQRI reporting measures.

According to Susan Nedza, MD, the Co-Lead for the CMS' Outreach and Education subgroup of the PQRI work group, the CMS will calculate physicians' PQRI bonuses based on the first claim they file for a patient.[4] For example, a glaucoma specialist who sees a patient for POAG several times during the reporting period can bill Measure 12 for each visit. If the CMS denies the first visit, however, and the claim is not rectified before the February 29, 2008, deadline it will not include any of this patient's visits in the calculation of the physician's bonus. Of course, PQRI bonuses are based on the total payments received, not just on claims for a single patient. What if physicians do not meet their 80% threshold because the CMS processed their claims incorrectly? Unfortunately, the lack of interim reporting and appeals process leaves physicians with little recourse to correct errors and emphasizes the importance of accurate reporting.

In theory, glaucoma specialists who follow the CMS' guidelines for reporting PQRI measures could receive a 1.5% bonus in 2008, but only if they manage to avoid and overcome the obstacles described herein.

LOOKING AHEAD TO 2008

The CMS published its proposed PQRI quality measures for 2008 on August 15, 2007,[5] and is accepting public comments at http://www.cms.hhs.gov/PQRI until November 15, 2007. I encourage glaucoma specialists and their staff to submit comments or suggestions on the proposed revisions. Their input will help the CMS refine the PQRI process and improve its benefit to providers.

One proposed change to the PQRI for 2008 is the adoption of a registry-based and/or electronic record-based reporting. This means that physicians who already use these methods to report claims could potentially transmit PQRI information from these electronic sources directly to the CMS.

Physicians should also be aware of the US House Ways and Means Committee's consideration of the Children's Health and Medicare Protection Act of 2007. Section 307 of this bill proposes a repeal of the PQRI bonus fund, "but allows the program to continue on a voluntary basis."[6] If this legislation passes, physicians may not receive compensation for participating in the PQRI after 2007.

SHOULD YOU PARTICIPATE?

Glaucoma specialists can benefit from reporting PQRI measures in 2007 by receiving a 1.5% bonus, providing they meet all of the CMS' stipulations. Input from providers during the 2007 trial period could also lead to more benefits in subsequent years. Participation may be even easier in 2008 as the CMS integrates a more streamlined system for reporting claims.

In general, however, the CMS appears to derive more benefit from the PQRI than physicians or patients. Because glaucoma specialists are subject to the CMS' capitation limitations, their 2007 PQRI bonuses will be lower than those of other physicians. Under the current guidelines, physicians could expend immense effort and receive little—or no—compensation from the CMS. ❑

Renee Hatfield, BA, is Senior Consultant at Health Care Economics, LLC, in Indianapolis, Indiana. She may be reached at (317) 558-6026; reneeh@forumcu.com.

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