



## **PQRI General Information Revised for 2009**

- PQRI is the acronym for Medicare's Physician Quality Reporting Initiative
- No registration required to participate; however, registration is required to access 2007 feedback reports
- Confidential participation feedback reports for 2007 were available beginning mid-July 2008 (\*practice registration required through AICS). Registration can be made at: <https://applications.cms.hhs.gov/warning.html>
- For 2009 - Two Reporting Periods
  - 12 Months (January 1 – December 31, 2009)
  - 6 Months (July 1 – December 31, 2009)
- Total of 9 PQRI Reporting Methods
  - 3 Claims-based
  - 6 Registry-based
- 153 possible measures based on various disease states and aspects of care
- 7 Measures Groups for reporting period July 1 - December 31, 2009
- Practices free to choose the measures or measures groups that fit their practice best – Medicare recommends three measures but more can be chosen
- A bonus of 2% of Medicare receipts is possible
- Bonus amounts will be paid mid-2010
- Quality information will be reported on claim forms or electronic claims by reporting CPT II codes and temporary G codes with visit codes
- CPT II and G codes should be billed with a zero or one cent amount and be submitted on the same claim as the codes to be billed for the day
  - The zero dollar/one cent line items will show as a denial for payment purposes and will confirm to the practice they have been captured for PQRI reporting
- Modifiers should be used when measures can not be performed or collected
  - 1P – exclusion modifier due to medical reasons
  - 2P – exclusion modifier due to patient reasons
  - 3P – exclusion modifier due to systems reasons
  - 8P – action not performed, reason not otherwise specified
- PQRI codes must be reported at least 80% of the time to qualify when using individual measures (ex. – PQRI codes must be attached to a claim/visit 8 out of 10 times the patient visits for qualified diagnosis)
- For Measures Groups, PQRI must be reported on 15 consecutive eligible patients or 80% of eligible patients in the measures group
- Claims must reach Medicare's National Claims History file by 2/28/2010
- Claims resubmitted to add the CPT II/temporary G codes will not count
- Individual NPIs must be included on the claim

## **Medicare's E-Prescribing Incentive Program**

- Additional 2% bonus available for 2009-2010. 1% available for 2011-2012. .5% available for 2013
- Participation in PQRI not necessary to participate with E-Prescribing Incentive
- No sign up or pre-registration
- Reporting period is: 12 Months/calendar year (January 1 – December 31) for years 2009-2013
- Incentive limitations - incentive does not apply to eligible professional for the reporting period if:
  - Medicare allowed charges for all covered professional services for the codes to which the e-prescribing measure applies is less than 10% of the total of the allowed charges under Medicare Part B for all such covered professional services furnished by the eligible professional
  - If determined appropriate by the Secretary, the eligible professional does not submit (including both electronically and non-electronically) a sufficient number of prescriptions under Part D.
- Must utilize a qualified E-Prescribing system that has the following capabilities:
  - Generates a complete active medication list using electronic data received from applicable pharmacies and pharmacy benefit managers (PBM), if available
  - Allows eligible professionals to select medications, print prescriptions, transmit prescriptions electronically, and conducts all alerts. Alerts include automated prompts that offer information on the drug being prescribed and warn the prescriber of possible undesirable or unsafe situations such as potentially inappropriate dose or route of administration of the drug, drug-drug interactions, allergy concerns, or warnings/cautions
  - Provides information on lower cost therapeutically appropriate alternatives, if any. For 2009, a system that can receive tiered formulary information, if available, from the PBM would satisfy this requirement
  - Provides information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available)
  - In addition to the system functionalities mentioned above, the system or program should meet the Part D specifications for messaging that will be implemented on April 1, 2009. For more information about the new Part D requirements, please see <http://www.regulations.gov> and search for "Part D prescribing."
- Must report on 50% of Medicare Fee-for-Service patients seen throughout the calendar year
- Report using specific "G" codes:
  - G8443 - All prescriptions generated during patient visit were sent via a qualified e-prescribing system
  - G8445 - No prescriptions were generated for this patient during this visit
  - G8446 - Some or all of the prescriptions generated during patient visit were printed or phoned in as required by state or federal law or regulations, due to patient request, or due to pharmacy system being unable to receive electronic submission, or prescription was for narcotics or controlled substance.

### **For More Information**

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[www.consultPMSCO.com](http://www.consultPMSCO.com)  
[www.pamedsoc.org](http://www.pamedsoc.org)  
[www.cms.hhs.gov/PQRI](http://www.cms.hhs.gov/PQRI)