Physician Quality Reporting Initiative Program
Frequently Asked Questions (FAQs)

The FAQs were obtained directly from the Centers for Medicare and Medicaid Services’ web site and from general inquiries received from the AAOS membership. These FAQs have been compiled as an educational resource only.

1. What is the Physician Quality Reporting Initiative Program?

The 2006 Tax Relief and Health Care Act (TRHCA) required the establishment of a physician quality reporting system, including an incentive payment for eligible professionals (EPs) who satisfactorily report data on quality measures for covered services furnished to Medicare beneficiaries during the second half of 2007 (the 2007 reporting period). CMS named this program the Physician Quality Reporting Initiative (PQRI).

EPs who meet the criteria for satisfactory submission of quality measures data for services furnished during the reporting period will earn an incentive payment of 2 percent of their total allowed charges for Medicare Physician Fee Schedule (PFS) covered professional services furnished during that same period.

As required by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA), CMS has established 2 alternative reporting periods for the reporting of measures groups and for the submission of data on PQRI quality measures through clinical data registries. The 2 alternative reporting periods are: January 1, 2009 – December 31, 2009 and July 1, 2009 – December 31, 2009. In total, there are 9 options for satisfactorily reporting quality measures data for the 2009 PQRI that differ based on the reporting period an EP chooses to report on, whether an EP chooses to report through claims or an approved clinical registry, and whether an EP chooses to report on individual measures or measures groups.

The 2009 PQRI consists of 153 quality measures and 7 measures groups. There are 16 clinical measures, one (1) administrative measure, and (2) measure groups, Perioperative Care and Back Pain that may apply to orthopaedic surgeons. However, physicians may also report on the other measure groups if it is applicable to their patient population. Further information is listed on the AAOS web site http://www.aaos.org/research/committee/evidence/pqri_measures.asp.

2. Is registration required to participate in the Physician Quality Reporting Initiative (PQRI)?

No. There are no registration requirements for an eligible professional to participate in Physician Quality Reporting Initiative (PQRI).
3. If I want to report on a measure group, how do I submit my “intent to participate” in PQRI?

The intent G-codes is submitted to initiate a physician's intent to report on the measure groups. They will need to report the G-code once on the claim.

- **G8485**: I intend to report the Diabetes Mellitus Measures Group
- **G8487**: I intend to report the Chronic Kidney Disease (CKD) Measures Group
- **G8486**: I intend to report the Preventive Care Measures Group
- **G8490**: I intend to report the Rheumatoid Arthritis Measures Group
- **G8492**: I intend to report the Perioperative Care Measures Group
- **G8493**: I intend to report the Back Pain Measures Group


4. Can I begin claims-based reporting July 1, 2009?


If a practice started reporting a 30-consecutive-patient sample in January 2009, they should be finished reporting by now AND, if reported correctly, they should be incentive-eligible for a full year incentive. Note that the 30-consecutive-patient sample can be started at any time during the year as long as it is reported correctly – starting on claims for the date of service (DOS) that the practice submitted the intent to report a measures group G-code.

5. How is the Physician Quality Reporting Initiative (PQRI) incentive payment calculated?

CMS will review and analyze data reported to determine satisfactory reporting and eligibility for an incentive payment based on a percentage of total allowed Medicare Physician Fee Schedule (PFS) charges for Part B covered services furnished during the reporting period. For more information, please visit the Analysis and Payment page of the PQRI section of the CMS website at: [http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp](http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage).

6. How do I access 2007 PQRI feedback reports?

PQRI Feedback Reports are available on a secure website to those eligible professionals and organizations who reported PQRI quality measures in a given year. For step by step instructions for attaining an Individuals Authorized Access to CMS
Services (IACS) account which is required to access the 2007 PQRI Feedback report, please refer to the following documents:

- MLN SE0830 - Steps to Access 2007 PQRI Feedback Reports by Individual Eligible Professionals
- MLN SE0831 - Steps to Access 2007 PQRI Feedback Reports by Organizations

7. What are the PQRI helpdesk resources? How can I access these resources?

The Centers for Medicare and Medicaid Services have provided help desk information for those with questions related to the following bullet points:

A. **Provider Call Center Directory**
   - Remittance Advice Notices
   - Incentive payment distribution status
   - Adjustments made to incentive payment due to sanctions/overpayments

For contact information, visit [http://www.cms.hhs.gov/MLNGenInfo/](http://www.cms.hhs.gov/MLNGenInfo/) and select the link "Provider Center Toll-free Numbers Directory" listed under the "Downloads" section.

B. **External User Services (EUS)**
   Phone: 1-866-484-8049; TTY: 1-866-523-4759
   7:00 AM – 7:00 PM (EST)
   - Registering/creating an IACS account
   - Accessing an IACS account
   - Changing an IACS account
   - Approving users into an organization

C. **QualityNet Help Desk**
   Phone: 1-866-288-8912
   Hours: 7:00 AM – 7:00 PM (CST)
   - General CMS PQRI & E-Prescribing Information
   - PQRI Portal Password Issues
   - PQRI feedback report availability and access

8. We are a large orthopaedic group and are interested in using the alternative reporting method (30 consecutive claims). Please verify that each provider will need to submit 30 consecutive claims with reporting data in order for the practice to receive the maximum incentive. Another practice in our area has indicated that 30 claims in total for the entire group will make us eligible for the PQRI incentive.

Each eligible provider electing to report a group of measures must report all measures within that group that are applicable to either 30 consecutive eligible patients or 80 percent of Medicare patients for whom the measures of the measure group apply without regard to whether the patients are consecutive.
9. What is a Tax Identification Number?

The Internal Revenue Service (IRS) assigns a unique Tax Identification Number (TIN) to various entities for tax reporting purposes. Employers should provide the unique TIN of the group health plan or practice. If you do not know the TIN you may need to consult your financial officer.

10. If an eligible professional provides care and submit claims under multiple Taxpayer Identification Numbers (TINs), how will CMS divide that individual professional’s incentive payment among TINs for PQRI?

The analysis of satisfactory reporting will be performed at the individual EP level within each TIN, using individual-level National Provider Identifier (NPI) to identify each professional's services and quality data. Incentives earned by individual professionals will be issued to the TIN under which he or she earned an incentive, based on the Physician Fee Schedule (PFS) professional services claims submitted under the TIN, aggregating individual EPs’ incentives to the TIN level.

For EPs who submit claims under multiple TINs, CMS plans to group claims by TIN for analysis and payment purposes. As a result, a professional who submits claims under multiple TINs may earn a PQRI incentive under one of the TINs and not the other(s), or may earn an incentive under each TIN. The PQRI financial incentive earned by any individual professional under a given TIN, based on the claims associated with that TIN, will be included in that TIN's aggregate PQRI incentive payment.

11. Should physicians report on PQRI associated with office visits provided as a part of a global surgical package?

No. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The preoperative period included in the global fee for major surgeries is one day. The postoperative period varies for major surgery (90 days) and minor surgery (0 or 10 days) depending on the procedure. For endoscopic procedures (except for procedures requiring an incision) there is no postoperative period. The Medicare-approved amount for these procedures includes payment for services related to the surgery furnished by the physician who performs the surgery. For further information on the global surgical package, see the CMS website at http://www.cms.hhs.gov.

If a patient has an allowable Medicare Physician Fee Schedule (PFS) Part B covered professional service (not considered part of the global surgical package), that meets the denominator criteria for the quality measure(s) being reported (either PQRI or e-prescribing), then the physician should submit the appropriate quality-data code (CPT Category II and/or G-code) on the claim.

Please refer to posted detailed measure specifications to determine if the patient encounter code(s) being submitted meets the denominator criteria for the quality measure(s) being reported. Measure specifications for PQRI can be found at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage

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12. Can an NPI under 1 TIN report 3 measures (e.g. 3 perioperative measures) and then report under another TIN on another 3 different measures (diabetic foot exam, etc.)

Note that all of an NPIs claims are first analyzed regardless of TIN to determine incentive eligibility (reporting rate ≥ 80% for each measure). THEN, only if NPI is incentive-eligible, we aggregate the incentive amts for payment to each TIN. Also, it is easier for the NPIs billing and office staff to keep track of the same measures each time they bill.

In this scenario, that NPI would be reporting 6 measures under 2 TINs and if incentive-eligible (for 3 measures), the NPI would receive 2 feedback reports and two incentives (one under each TIN).

13. What happens if only one eligible professional in a group practice submits data for PQRI? How will the payment be issued?

PQRI is based on each individual eligible professional (NPI). If incentive-eligible, the incentive payment will be sent to the holder of the TIN.

14. How is the 2009 Physician Quality Reporting Initiative (PQRI) 2 percent incentive payment calculated for data submitted through a qualified registry?

Incentive eligibility is calculated in the same manner as for claims based reporting. See Analysis and Payment section of CMS PQRI website, (http://www.cms.hhs.gov/PQRI/25_AnalysisAndPayment.asp#TopOfPage)

15. Under PQRI, is it easier to select and report 3 individual measures or select one measure group?

It depends on when you begin reporting. If you think you can still capture 80% of all eligible patients, individual measure reporting may be the way to go. The 30-Consecutive Measures Groups option allows you to complete the reporting more quickly, but you need to be sure you can accurately capture and report on each of 30 consecutively seen patients for a full-year incentive. The 30-Consecutive Measures Group Sample can be started at any time during the reporting year. Another option: you can report on an 80% Measures Group Sample starting July 1 for a half-year incentive for patients seen July 1-Dec 31, 2009.

16. Is the PQRI program applicable to Medicare Advantage or Medicaid patients?

Payments to physicians/non-physicians that have contracted with Medicare Advantage (MA) organizations generally are governed by the terms of the contract. It is up to the MA organization whether to take eligibility for a PQRI incentive payment into account in establishing the amount the physician is paid. If the MA organization offers a private fee-for-service (PFFS) plan that meets access requirements through deemed providers, that MA plan is required to pay the same as traditional Medicare for covered services (Part B Physician Fee Schedule).
If the deemed physician/non-physician meets incentive eligibility for the PQRI program that MA organization is required to pay an incentive amount. The amount of the incentive payment is calculated the same as for traditional Medicare (percentage of Medicare Part B estimated total allowed charges for PFFS plans).

Physicians/non-physicians who have not contracted with an MA organization, but who provide covered services to an enrollee in an MA plan, are also potentially eligible to receive PQRI incentive payment from that MA organization. If the physician/non-physician meets incentive eligibility, the physician/non-physician should expect to receive an incentive payment from any MA organization which he or she has billed as a non-contracted provider, or for which he or she has provided covered services under a PFFS plan that meets access standards by paying the Medicare payment rate. The amount of the PQRI incentive payment is calculated just as it is calculated for traditional Medicare for the reporting period.

17. How can I follow the requirement to submit a National Provider Identifier (NPI) on my Physicians Quality Reporting Initiative (PQRI) related claims when my contractor has a provider enrollment backlog?

Applying for an NPI and enrolling in a health plan are two completely separate activities. There is no backlog in NPI applications. Applying for an NPI does not enroll a health care provider in Medicare or any health plan. Having an NPI does not guarantee payment by any health plan. To participate in the PQRI, you must be a Medicare enrolled provider.

CMS requires that providers and suppliers obtain their National Provider Identifier (NPI) prior to enrolling or updating their enrollment record with Medicare. A Medicare contractor will not process your enrollment application without the NPI and a copy of the NPI Notification. The NPI Notification is required with each CMS-855 enrollment application you submit. If you are not an enrolled Medicare provider during the PQRI reporting period, you cannot submit claims to Medicare and thus CMS will be unable to capture data necessary to determine PQRI incentive eligibility or amount.

18. How and where should I place the Healthcare Common Procedure Coding System (HCPCS) CPT Category II codes or G-codes on the claim for the Physician Quality Reporting Initiative (PQRI)?

The Physician Quality Reporting Initiative (PQRI) quality-data codes HCPCS codes 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. The data element for the procedure code is SV101-2 "Product/Service ID." Note that it is also necessary to identify in this segment that you are supplying a HCPCS code by submitting the "HC" code for data element SV101-1. For claims submitted on the CMS 1500 Form, procedure codes are reported in field 24D. Whether submitting electronic or paper claims, complete all the necessary data elements (or fields) on the billing line item. Necessary data elements (or fields) include, but are not necessarily limited to, the following:

- Date of service;
• Place of service;
• PQRI quality-data code, along with modifier (if appropriate);
• Diagnosis pointer;
• Submitted charge ($0.00 should be entered for PQRI codes);
• Rendering provider number (NPI).

NOTE: The submitted charge field cannot be left blank. The amount of $0.00 should be entered on the claim as the charge. If the physician's billing software does not accept a $0.00 charge, a nominal amount can be substituted. Whether the correct, $0.00, charge or a nominal amount is submitted to the carrier or A/B MAC, the PQRI code line is denied and tracked. The Remittance Advice associated with the claim containing the PQRI quality code line item will include a standard Remark Code (N365) and a message that will read as follows: "This procedure code is not payable. It is for reporting/information purposes only."

This remittance advice confirms that the PQRI code(s) passed into the National Claims History (NCH) file for use in calculating incentive eligibility. Eligible professionals (EPs) should note that the submission of a non-zero charge amount with PQRI codes may complicate secondary payers' processing of the claims. Physicians and other EPs are not allowed to collect any monies from beneficiaries for charges submitted for the PQRI codes. http://www.cms.hhs.gov/PQRI/Downloads/2009PQRIImplementationGuide.pdf

19. When will incentive payments be issued for 2007 and 2008 reporting periods?

2008 incentive payments will be made in October 2009. 2007 re-run incentive payments will be made in November 2009.

20. When will feedback reports become available for 2007 and 2008?

2007 re-rerun and 2008 feedback reports will be available by early October 2009.

21. How will the eligible professional know if they have successfully reported for 2009 PQRI?

After submitting your claim, all quality-data codes (CPT II & G-codes) for PQRI incentive program will be denied by the carrier using the standard denial remark code “N365” on the Remittance Advice (RA) Notice (some practices refer to this as the “EOB”) that the Carrier/MAC will send to them after processing the claim. Practices need to check these notices on a regular basis to ensure each QDC receives that denial code. If you don’t see it, you will need to contact the carrier to determine why. It is possible that there is something else wrong with the claim that resulted in either a claim rejection by the carrier or a claim denial. The N365 will appear on the RA for each claim that contains a QDC whether submitted on an electronic 837-P claim or a paper CMS 1500 claim. The RA with denial code N365 is your indication that the PQRI codes were passed into the National Claims History (NCH) file for use in calculating incentive eligibility.
22. For the Physician Quality Reporting Initiative (PQRI), how do I include the quality-data codes (QDCs) on a paper claim that has more than four diagnoses (eight diagnoses for electronic claims)? Some PQRI measures require reporting additional codes and there are insufficient lines available on a single claim to accommodate all measures that apply to the patient.

Submitting codes for Physician Quality Reporting Initiative (PQRI) is no different than submitting for any Medicare patient. Physicians or other eligible professionals can submit one claim for multiple services that occurred on the given service date. Up to four diagnoses can be reported in the header on the CMS-1500 paper claim and up to eight diagnoses can be reported in the header on the electronic claim. However, only one diagnosis can be linked to each line item, whether billing on paper or electronically. The line items containing the quality-data codes (QDCs) should point to one of the diagnosis codes already present on the claim for the payable service. Note: Providers need to work with their clearinghouses/vendors regarding line limitations for claims. Make sure your clearinghouse or billing software vendor does not drop diagnoses or QDCs. For more information, you may contact your Carrier or A/B MAC. Reference: http://www.cms.hhs.gov/pqri

23. Does a quality data code on a claim need to point to a diagnosis code?

Yes. Each claim detail line containing a Physician Quality Reporting Initiative (PQRI) QDC must be completed the same way as any other claim detail line item. This means using the diagnosis pointer field. PQRI QDCs should point to one of the diagnosis codes already present on the claim for the payable service. Without a diagnosis pointer on the line item, the line item will be rejected and returned to the provider as unprocessable.

24. Is the primary diagnosis the only diagnosis that is applicable to the quality measure being reported or will the PQRI consider all diagnoses reported on a claim?

All diagnoses and quality-data line items are considered for Physician Quality Reporting Initiative (PQRI) reporting. There is no requirement to sequence diagnoses into primary and secondary categories for PQRI. Quality-data codes (QDCs) should be submitted for any measures that are applicable to each Medicare Physician Fee Schedule (PFS) claim, as determined by all the diagnosis (ICD-9-CM) and service (CPT Category I) codes submitted on the claim line items for payment. Each QDC should point to one of the diagnosis codes already present on the claim for the payable service. Without a diagnosis pointer on the QDC line item, the line item will be rejected and returned to the provider as unprocessable. The PQRI Quality Measure Specifications Manual is available in a download from the CMS PQRI Measures/Codes page found at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp.

25. Is Medicare Railroad qualified to participate in the PQRI program?

Yes, the PQRI program encompasses both Railroad Retirement and Medicare Secondary Payer claims.
26. If claims submitted for services do NOT have Physician Quality Reporting Initiative (PQRI) quality-data codes (QDCs) on them, can the provider go back and resubmit them to include the QDCs?

No. Claims may not be resubmitted simply to add or correct QDCs. The QDCs which supply the numerator must be submitted on the same claim that contains the denominator information (i.e., CPT Category I or HCPCS codes). Refer to the claims-based reporting principles delineated in the PQRI Implementation Guide available on the CMS website at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage.

27. Should providers include the Physician Quality Reporting Initiative (PQRI) quality-data codes (QDCs) on claims submitted to payer's primary to Medicare?

No. Providers should not include the Physician Quality Reporting Initiative (PQRI) quality-data codes (QDCs) on claims submitted to primary payers (when Medicare is secondary) unless notified or approved to do so by that payer. Providers should, however, place the PQRI QDCs on claims submitted to Medicare for secondary payment at the time these claims are submitted to Medicare.

28. If the quality-data code (QDC) (CPT II or G-) is entered on the claim sent to the primary payer, what if that QDC is stripped before the claim is forwarded to Medicare for Physician Quality Reporting Initiative (PQRI)?

Claims, submitted to Medicare for primary or secondary payment that include reportable instances of measures or measures groups a professional is submitting, must include the quality-data codes (QDCs) (CPT II or G-codes), since all of these claims will be included in the PQRI analysis. Because many primary payers may be unable to properly process QDCs, the QDCs must usually be applied to the claim after the primary payer has processed it and prior to its submission to Medicare for secondary payment. (Although Medicare routinely passes processed claims to other payers for secondary payment, other primary payers do not pass processed claims automatically to Medicare.)

29. If all billable services on the claim are denied, will the measure's quality-data code(s) (QDCs) still be included in Physician Quality Reporting Initiative (PQRI) analysis because I received the N365 remark code on the remittance advice?

No, the QDCs will not be included in PQRI analysis if the billable services tied to those QDCs on the claim are denied. However, some denied claims can be corrected and paid through an adjustment, reopening, or the appeals process. Contact your carrier/AB MAC for instructions on how request a correction. If you are correcting a claim for a previously denied service, the accurate QDCs, numerator, and denominator that correspond to the measure should also be included on that corrected claim.

Also, the processing of any adjustments, re-openings, or appeals must be completed by the carrier/AB MAC and forwarded to the National Claims History file by February 28, 2010, to be included in the PQRI analysis. Please submit any requests for a correction to the carrier/AB MAC with enough time for this process to be completed. Note: Claims may not be resubmitted only to add or correct QDCs. Also, claims containing only QDCs with a zero total dollar amount may not be submitted to the carrier.
30. My billing software limits the number of line-items available on a claim and this cannot be changed. How can I bill multiple Physician Quality Reporting Initiative (PQRI) measures for an office visit without going into a second claim, which would then contain only quality-data code (QDC) line-items, each with a zero dollar charge, for a total charge of zero dollars? The Carrier/AB MAC would then reject this second claim and the QDCs would not get passed into the National Claims History file for PQRI analysis.

Although CMS does not impose line-item limits on claims, CMS claims processing systems cannot accept an entire claim with total charge of $0 and, therefore, will reject the claim. As your software limits the line-items on a claim, you may add a nominal amount, such as a penny to one of the line-items on that second claim for a total charge of one penny. PQRI analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

Note: Claims submitted with only QDCs will not be counted in the analysis of PQRI reporting or performance rates. Providers need to work with their clearinghouses/vendors regarding line limitations for claims. Make sure your clearinghouse or billing software vendor does not drop QDCs. See the CMS-1500 Claim Sample for PQRI Measures Groups in the Measures/Codes section of the CMS PQRI website at http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopofPage.

31. Can Independent Diagnostic Testing Facilities (IDTFs) submit Physician Quality Reporting Initiative (PQRI) codes on claims to participate in PQRI to potentially qualify for the incentive?

No. Providers not defined as eligible professionals (EPs) in the Tax Relief Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRI and do not qualify for an incentive. An IDTF is enrolled in Medicare as an organization with supplier specialty 47 (not a physician specialty) and, therefore, bills under its own facility national provider identifier (NPI). An IDTF claim cannot show a physician's individual NPI on the rendering/performing provider ID line on the claim. If an IDTF claim is submitted with a rendering NPI of a physician on the claim, that claim would be rejected by the Carrier/AB MAC.

Also, the physician cannot reassign her/his benefits to the IDTF. Therefore, when an IDTF enrolls in Medicare, it is set up much like an Independent Lab (IL) in that there is no individual rendering/performing provider billed on the claim. Since IDTFs are an organization and not a group, they are not able to participate in PQRI through claims-based reporting.

32. Do I have to participate in the Physician Quality Reporting Initiative (PQRI) in order to qualify for the E-Prescribing Incentive Program?

Eligible professionals are not required to participate in the PQRI program in order to participate in the E-Prescribing Incentive Program. However, eligible professionals may choose to participate in both the E-Prescribing and PQRI incentive programs.
Additional References:

