Physician Quality Reporting System Updates for 2011

The Centers for Medicare and Medicaid Services (CMS) recently announced changes and updates to the 2011 CMS Physician Quality Reporting System (PQRS). The name change from Physician Quality Reporting Initiative (PQRI) to PQRS is just one of the changes. CMS believes that changes to PQRI, authorized under the Affordable Care Act (ACA) of 2010, lend permanency to the reporting program. To reflect the transition to a permanent program, CMS will, hereafter, refer to the program as the Physician Quality Reporting System.

Major changes include:

- The minimum “sample size” requirement of 80 percent has been reduced to 50 percent for claims-based reporting. Currently, an eligible professional (EP) must report a measure on at least 80 percent of Medicare patients for whom the measure applies. By reducing the requirement to 50 percent, CMS is acknowledging the complexity of claims-based reporting. CMS stated that the major reason PQRS participants are not successful is due to the failure to report the required 80 percent.

- The ACA requires CMS to have in place no later than January 1, 2011, an informal review process for EPs to seek a review of the determination that an EP did not satisfactorily submit data on quality measures under the PQRS. CMS will base the informal process on the current inquiry process using the Quality Net Help Desk. CMS expects that EPs will be able to use the informal review process when the 2011 PQRS feedback reports are made available in 2012. Details of the informal review process include:
  - EP must request informal review within 90 days of release of the feedback report.
  - EP can request the review by contacting the Quality Net Help Desk with a summary of concerns and reason for the request.
  - CMS will provide a response within 60 days of the original request.
  - Since the process is informal, a hearing or evidence submission process is not included, but the EP can submit information to assist the review.
  - Based upon CMS review, the EP will be provided a written response. If CMS finds that the EP did satisfactorily report, CMS will provide the applicable incentive payment.
  - Decisions based on informal review will be final.

- CMS anticipates posting additional information regarding the operational aspects of the informal review process for the 2011 PQRS by December 31, 2011. The ACA also requires CMS to provide an option for a physician to report data on quality measures through a Maintenance of Certification (MOC) Program operated by a specialty body of the American Board of Medical Specialties (ABMS). An incentive payment of .5 percent, additional to the PQRS bonus, is authorized for years 2011 through 2014 if certain requirements are met, including:
  - Must have successfully participated in PQRS for the 12-month reporting period, i.e. January 1 – December 31 (not the 6-month reporting option) for that incentive year
  - Must participate in a qualified Medical Specialty Board MOC program “more frequently” than required for continued certification. This includes practice assessments, such as the American Board of Radiology Practice Quality Improvement projects, continuing medical education and self assessment. Boards must indicate to CMS what “more frequently” means.
  - As part of the MOC program, a patient experience of care survey must be conducted. Many Boards do not require this and have not designed one yet.

Boards that have self nominated as an MOC program and are approved by CMS to submit MOC participation data on behalf of their diplomates must provide certain information to CMS regarding their program as well as specific report requirements for the diplomate. Boards may also self nominate as a registry to submit PQRS measure data on behalf of physicians.
The additional .5 percent is authorized through 2014 (as is a .5 percent bonus for PQRS participation itself). Beyond 2014, participation in the PQRS MOC Program option may be incorporated into a “composite of measures” of quality furnished under the physician fee schedule value-based payment modifier.

Measures/Codes
There is one new measure for diagnostic radiology in PQRI 2011, # 225 Radiology: Reminder System for Mammograms. The measure, developed by the AMA Physician Consortium and ACR in 2007, is described as the percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram.

There are a few code updates, terminology clarifications and verbiage changes, listed briefly in the table below. Complete 2011 measure specifications, specification release notes and 2011 program information can be found in the “Downloads” section of the CMS Web page at [www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage](http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage). Click on the 2011 Physician Quality Reporting System Measure Specifications and Release Notes [ZIP, 2MB], and then choose the PhysQualRptgMeasureSpecificationsManual 111510 PDF file. Other resources and educational materials can be found on the PQRS Web pages at [www.cms.gov/PQRI/01_Overview.asp#TopOfPage](http://www.cms.gov/PQRI/01_Overview.asp#TopOfPage).

The following table summarizes the 2011 changes that will affect radiology, nuclear medicine and radiation oncology measures.

<table>
<thead>
<tr>
<th>MEASURE #</th>
<th>MEASURE SET</th>
<th>MEASURE</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>145</td>
<td>Radiology</td>
<td>Fluoroscopy Time Recorded</td>
<td>Additions and deletions to denominator Category I codes.</td>
</tr>
<tr>
<td>225</td>
<td>Radiology</td>
<td>Reminder System for Mammograms</td>
<td>New measure</td>
</tr>
<tr>
<td></td>
<td><strong>Interventional</strong></td>
<td><strong>Radiology (may be reportable by some)</strong></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Perioperative</td>
<td>Timing of Antibiotics-Ordering Phys</td>
<td>Replaced CPT II codes with G-codes; additions and deletions to denominator Category I code listing; additional terminology, updated instructions; added denominator instruction.</td>
</tr>
<tr>
<td>21</td>
<td>Perioperative</td>
<td>Selection of Antibiotic</td>
<td>Added denominator instruction; additions and deletions to denominator Category I code listing.</td>
</tr>
<tr>
<td>22</td>
<td>Perioperative</td>
<td>Discontinuation of Antibiotic</td>
<td>Added denominator instruction; additions and deletions to denominator Category I code listing.</td>
</tr>
<tr>
<td>23</td>
<td>Perioperative</td>
<td>VTE Prophylaxis</td>
<td>Added denominator instruction; additions and deletions to denominator Category I code listing.</td>
</tr>
<tr>
<td>24</td>
<td>Osteoporosis</td>
<td>Communication Following Fracture</td>
<td>Updated instructions; replaced CPTII codes with G-codes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>71</td>
<td>Oncology</td>
<td>Breast Cancer Hormonal Therapy</td>
<td>Updated numerator statement; addition of diagnosis code</td>
</tr>
<tr>
<td>102</td>
<td>Prostate CA</td>
<td>Bone Scan Overuse - Staging</td>
<td>Deletions to Category I code listing.</td>
</tr>
<tr>
<td>104</td>
<td>Prostate CA</td>
<td>Adjuvant Hormonal Therapy</td>
<td>Deletions to Category I code listing.</td>
</tr>
<tr>
<td>105</td>
<td>Prostate CA</td>
<td>3D Radiotherapy</td>
<td>Updated measure description; deletions to Category I code listing.</td>
</tr>
<tr>
<td>143</td>
<td>Oncology</td>
<td>Pain Intensity Quantified</td>
<td>Additional and deleted Category I codes.</td>
</tr>
<tr>
<td>144</td>
<td>Oncology</td>
<td>Plan of Care for Pain</td>
<td>Added codes from Measure #143 to the Denominator Coding section to align the eligible cases for these paired measures</td>
</tr>
</tbody>
</table>

Questions regarding PQRS should be sent to P4Pquestions@acr.org. For additional information regarding the PQRS program go to the ACR Web site at www.acr.org/SecondaryMainMenuCategories/quality_safety/p4p/FeaturedCategories/P4PInitiatives/pqri.aspx