Doctors Want Registry Data in PQRI

BY ALICIA AULT
Associate Editor, Practice Trends

BALTIMORE — Outcomes registries, not claims data, should be the base for the Physician Quality Reporting Initiative next year, physicians and their representatives said at a forum held in May by the Centers for Medicare and Medicaid Services.

CMS officials said they are gathering comments on how to evolve from claims-based information to a registry model, in an effort to prevent duplicative efforts to collect data and to encourage quality improvement. The agency's final recomendations will be published in the Federal Register in mid-August as a proposed set of 2008 reportable measures, agency officials said.

PQRI is a hot topic among physicians. According to a Department of Health and Human Services spokeswoman, more than 600 people attended the forum via conference call. The initiative was mandated as part of the Tax Relief and Health Care Act of 2006. Beginning in July, physicians can take part in the initiative by reporting on specialty-specific measures. This year, CMS has listed 74 measures (posted at www.cms.hhs.gov/PQRI).

To participate, physicians submit data on those measures through December on at least 80% of their cases. Those who participate will get a bonus lump-sum payout of 1.5% of claims submitted, some time in mid-2008. Many physicians already report on such measures to specialty societies.

The longest-running registry is maintained by the Society of Thoracic Surgeons. The 17-year-old registry contains more than 3 million records, Dr. Jeffrey Rich of the STS said at the forum. The STS supports the PQRI effort, but "we feel that it must go further, and we feel that can be accomplished through the use of registries."

This year, PQRI is structured to collect data on processes, not outcomes, he said. Registries allow for the collection of clinical data on patient outcomes, which is more useful for quality improvement.

STS suggested that outcomes measures should be vetted through groups such as the American Medical Association's Physician Consortium for Performance Improvement and the AQA (formerly the Ambulatory Care Quality Alliance). Measures that cut across disciplines should be harmonized, preferably by the National Quality Forum, he said. And input standards should be established to ensure that the data cover all patients, not just a random sample, Dr. Rich said. Finally, registries should be subject to validation and an audit mechanism.

CMS officials also heard about registries developed by the American Osteopathic Association, the Wisconsin Collaborative for Healthcare Quality, users of GE Healthcare's electronic medical records, the American Medical Group Management Association, and the American Society of Plastic Surgeons.

The ASPS launched its Tracking Operations and Outcomes in Plastic Surgery (TOPS) registry in 2002. TOPS collects data from all surgical settings, including office-based procedures. About 10% of the organization's 6,000 members use TOPS now, said an ASPS representative at the forum. The ASPS is currently redesigning the registry in the hopes that it will integrate more smoothly with PQRI, she said.

Jean Harris of the American College of Surgeons said that organization is exploring registry development through the Surgical Quality Alliance.

The American Board of Neurological Surgery has developed 15 procedure-specific outcomes measures that are available online, said Dr. Robert Harbaugh of the American Association of Neurological Surgeons. The ABNS envisions using the measures to teach neurosurgery residents how to collect outcomes data and to use the data for quality improvement, for neurosurgeons to prepare for board certification, and as part of the maintenance of certification process.

In 2006, the American Board of Internal Medicine began requiring internists to begin using Practice Improvement Modules (PIMs) in order to maintain certification. With PIMs, physicians enter medical data about patients, and then receive reports back from ABIM, which they are supposed to analyze and use to develop a self-improvement plan.

More than 5,000 physicians completed a PIM in 2006, and 5,000 more are currently working on PIMs, Dr. Cary Sennett, ABIM senior vice president of strategy and clinical analytics, said at the forum.

Aetna, UnitedHealthcare, Humana, and several regional Blue Cross and Blue Shield plans have recognized PIMs as fulfilling quality improvement criteria, said Dr. Sennett, who added that ABIM supported the PQRI effort. ■

Reporting Program May Require Modifiers

Physicians who choose to participate in Medicare's pay for reporting program do not have to satisfy quality indicators to receive a bonus. But in some cases, they will need to cite why they did not follow evidence-based guidelines.

Under the Physician Quality Reporting Initiative (PQRI) slated to begin July 1, reporting for certain measures will include adding a coding modifier explaining why a service was not performed. For example, the service may not have been provided because it was not medically indicated or the patient declined.

The PQRI is a voluntary program that allows physicians to earn a bonus payment of up to 1.5% of total allowed Medicare charges for reporting on certain quality measures. The program will run from July 1 through the end of the year. CMS officials have selected 74 quality measures and physicians are expected to report on between one and three measures, depending on how many apply to their patient populations.

When reporting on measures, physicians must include a CPT-II code or G-code. Some measures may also require that physicians add a modifier to the CPT II code if the service was not provided. These modifiers are not used when reporting G codes. The CPT-II modifiers include performance measure exclusion modifiers and a performance measure reporting modifier. For example:

► Modifier 1P is used to show that the service was not indicated or is contraindicated for medical reasons.

► Modifier 2P is used to indicate that the service was not provided for patient reasons, such as the patient declining or religious objections.

► Modifier 3P is used to indicate that the service was not provided for systems reasons such as insurance coverage limitations or a lack of resources to provide the service.

► Modifier 8P is a performance measure reporting modifier and indicates that the action was not performed and the reason has not been specified.

Specific instructions on when to use a modifier in the 2007 PQRI Specifications Document, which is available online at www.cms.hhs.gov/pqri. CMS officials also plan to issue a detailed handbook on how to implement PQRI measures in clinical practice, which will include when to use CPT-II modifiers.

—Mary Ellen Schneider