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Editor's note: All Medicare fees are par., office, national, unless otherwise noted.

PQRI feedback reports draw heavy criticism from providers

Difficulty downloading feedback reports and questions about their usefulness are two complaints your peers are making loud and clear about the results of the 2007 Physician Quality Reporting Initiative (PQRI), **Part B News** has learned. The reports have been available since Aug. 22 and have confounded many who participated in the inaugural year of the program.

“The levels of security to access the system were very cumbersome,” complains Carol Fritz, practice manager of Scott Radiological in St. Louis. “What’s more, the reports were very limited in detail. It says some of our measures weren’t reported, when we know we did report. It says insufficient data on some measures, but it won’t say what’s missing.”

Only one of Fritz’s 11 participating physicians qualified for a PQRI incentive payment, earning \$384 for six months of participation. But Fritz’s experience is hardly unique, according to a survey released Sept. 9 by the Medical Group Management Association (MGMA).

A staggering **93%** of MGMA physician members surveyed reported having difficulty accessing their feedback reports. Approximately **70%** of respondents reported “low” or “no” satisfaction with the PQRI feedback report’s effectiveness in “providing guidance about how the practice can improve patient care outcomes.”

These bleak figures aside, the MGMA survey also identifies “several important successes of the PQRI program during its first year,” says CMS official Allison Henry. “They include widespread awareness of the program, broad opportunity to participate through a large variety of measures applicable to professionals, and large numbers of physicians that earned incentives,” she adds.

Remember: While it's technically true that a majority of 2007 PQRI participants received incentive payments, 48% of participants did not; the average individual physician payment was \$600 ([PBN 7/21/08](#)).

Henry notes that the PQRI reports were not intended to provide specific quality improvement advice to physicians, only information on reporting success and performance rates. The survey showed general satisfaction with the report's ability to meet that objective, she says.

Accessibility a major problem

Many practices interviewed by **Part B News** for this story were still trying to access their PQRI feedback reports through CMS's Individuals Authorized Access to CMS Computer Services – Provider Community (IACS-PC, or “eye-axe”) system. If the name sounds familiar, it's the same system you use to register for online Medicare

enrollment ([PBN 3/3/08](#)). The registration process is lengthy and can be complicated ([see box, pg. 3](#)).

“This is a multi-week process,” says Dan Reigle, CEO of Rocky Mountain Orthopaedic Associates in Grand Junction, Colo. Reigle had already begun the process when he learned that the employee designated as the security official (SO) *can't* also access the feedback report.

“I'm the one in my practice ... that pretty much handles this [quality] stuff, so I was going to take responsibility for looking at the report. Now I'm waiting for another employee to be approved as the actual user,” Riegle says. “From a user standpoint, it is frustrating. In our practice, we don't have any IT people on staff, you have someone like me who's not an IT person trying to do the job and it's difficult.”

Alice Kater, coding coordinator at Urology As-

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sociates of South Bend (Ind.), hasn't seen her practice's PQRI report either. When she tried to register through IACS, she received a message that someone had already registered to obtain the practice's PQRI report. Kater doesn't know if that is accurate and is still trying to figure out exactly what happened.

Specifically, Kater's practice is waiting to get a copy of their CP-575 form (which grants an employer identification number or EIN) from the IRS. It could take anywhere from six to 10 weeks to get the IRS form, Kater says. "Getting these [PQRI] reports has been such a struggle and it doesn't seem like it should be."

CMS says the accessibility situation is improving steadily. The agency regrets that practices have struggled to get their results, but believes most of the initial problems have been resolved, Henry says. CMS continues to address issues as the rate of access to PQRI reports increases, she adds.

NPIs caused many disqualifications

Missing National Provider Identifiers (NPI) on claims submitted for PQRI reporting were a major reason for the high number of participants who didn't receive incentive payments, a top CMS quality measurement official tells **Part B News**. But because NPIs have been mandatory on *all* claims since May 23 ([PBN 5/19/08](#)), CMS expects that a much higher percentage of 2008 PQRI participants will receive incentive payments, the agency official says.

NOTE: You *cannot* appeal CMS's decision to not pay you for the 2007 PQRI period, the CMS official says. If your practice submitted all measures correctly but your feedback report shows some measures *weren't* submitted, you should check with your carrier or clearinghouse to find out what happened, the official says. Even though you have no way to appeal, "it's always worthwhile to go through and see how your practice is set up to handle [PQRI]," the official says.

— G. Huang

6 steps to access your PQRI feedback report right away

Most practices that participated in the 2007 Physician Quality Reporting Initiative (PQRI) had *some* trouble accessing CMS's PQRI feedback report ([see story, pg. 1](#)). A survey by the Medical Group Management Association (MGMA) found that 81% of respondents had "considerable" or "extreme difficulty."

Follow these 6 steps to gain access to your PQRI report without as much trouble. Registering for CMS's Individuals Authorized Access to CMS Computer Services - Provider Community (IACS-PC, or "eye-axe") can take weeks, so be prepared.

1. Decide whether to register as an **individual provider** or a "**provider organization**." A physician or non-physician practitioner can register as an individual, if he's the only person who will need to access the report.
2. Decide who in your practice will be the **security official (SO)**. This person will register first and CMS must approve his registration before he can allow others in your practice to access the IACS system. **NOTE:** The SO cannot access the PQRI report, only users can.
3. The SO must **submit IRS documentation** that shows the IRS letterhead and your legal business name and tax ID number (TIN) or employer ID number (EIN).
4. Once this documentation is approved by CMS, decide who in your practice will be the **user group administrator (UGA)**. This person can grant access to other users, or access the PQRI report himself. The UGA does *not* need to register end users unless someone else needs access to the report.
5. Request the proper **PQRI application user role**. You should choose "PQRI user" unless someone other than your SO will approve PQRI user requests. Most practices leave the approving up to the SO, therefore "PQRI user" is almost always the correct choice.
6. **Sign into the PQRI feedback report** application using your IACS username and password at <http://www.qualitynet.org/pqri>. — G. Huang

On the Internet:

- MGMA survey on 2007 PQRI and feedback reports: <http://www.mgma.com/WorkArea/showcontent.aspx?id=21972>
- Computer-based training for IACS-PC registration: <https://idm.cms.hhs.gov/idm/CBT/Menu.html>

CMS postpones 2009 CAP

You won't have the option of obtaining Part B drugs through the Competitive Acquisition Program (CAP) in 2009, CMS announced. Practices currently enrolled in CAP will have that enrollment discontinued as of Jan. 1, 2009, citing its inability to agree to a contract with vendors to supply drugs under the program.

The move won't impact a large number of physicians. CMS says about 4,000 physicians are currently enrolled in CAP, which is far short of 2005 estimates of 70,000 enrolled physicians ([PBN 4/18/05](#)).

CAP allows doctors to order Part B drugs through vendors, who then bill Medicare for the payment. CMS says CAP is an alternative to the average sale price (ASP) methodology for purchasing Part B drugs administered during a physician's service and was required under the Medicare Modernization Act (MMA) of 2003.

Practices clamored for an alternative to having to buy and bill for often costly Part B drugs after the MMA revamped payment to take much of the profit for physician practices out of Part B injectable drugs.

Leslie Witkin, president of Physicians First in Orlando, says the practices she taught about the program decided in the end that CAP was too burdensome to make it worthwhile. None of her clients are enrolled in the program, she says.

CMS officials tried to make CAP more appealing in January. They encouraged providers to enroll by offering a guarantee that if providers found the program a burden after trying it for 60 days, they could leave ([PBN 1/14/08](#)).

CMS planned to keep the program going and concluded bidding for 2009-2011 vendor contracts Feb. 15. Several vendors were successful in their bidding, but the agency says "contractual issues with the successful bidders resulted in CMS post-

poning the 2009 program."

CMS will provide information to participating CAP physicians on how to transition out of the program in the next few months. The agency is also looking for feedback from providers and vendors about the program before it considers a rebid. Comments can be submitted through the CAP Web site at: <http://www.cms.hhs.gov/CompetitiveAcquisforBios/>. — C. Fiegl

Don't let templates trump medical necessity on claims

Using templates to document services are great, but watch out for an excess of documentation you can create by clicking or checking boxes in electronic templates. The result can be artificially inflated code levels that attract the attention of Medicare auditors and land you in hot water.

You should also be wary of what some have called a "cookie cutter" approach to documentation ([PBN 3/27/06](#)), that often lets your electronic medical record (EMR) system match your volume of documentation to a CPT code rather than allowing medical necessity to drive the decision.

"With EMR there is a huge potential for improving patient care, but there is also a huge risk for [EMR systems] being interpreted as taking advantage of E/M guidelines," says consultant Debra Pierce MD, CPC, of Pierce MD Consulting in Rockbridge, Ohio.

Most consultants feel the increased utilization of EMRs can help providers save time they would spend dictating notes and free up storage space, but they also encounter E/M service levels being determined by over-documentation and automation in these programs instead of medical necessity.

That was the case with one of Quinten Buechner's recent clients. Buechner is president of ProActive Consultants in Cumberland, Wis.

“The physician had 100% level fours,” Buechner says. “[The documentation] looked all the same as if one record was [copied].”

TIP: If you detect a pattern in a provider’s EMR documentation, during the next in-service session tell them “every patient that walks in here is not a level 5,” Buechner says. “You have to give me more than what you are giving.”

Make sure providers understand actual thought or discussion needs to take place and that needs to be reflected in the doctor’s notes. **Example:** A patient’s blood pressure is 160/110. Is that abnormal for the patient? Or does a patient’s liver really appear normal if they’re known to have chronic

liver disease?

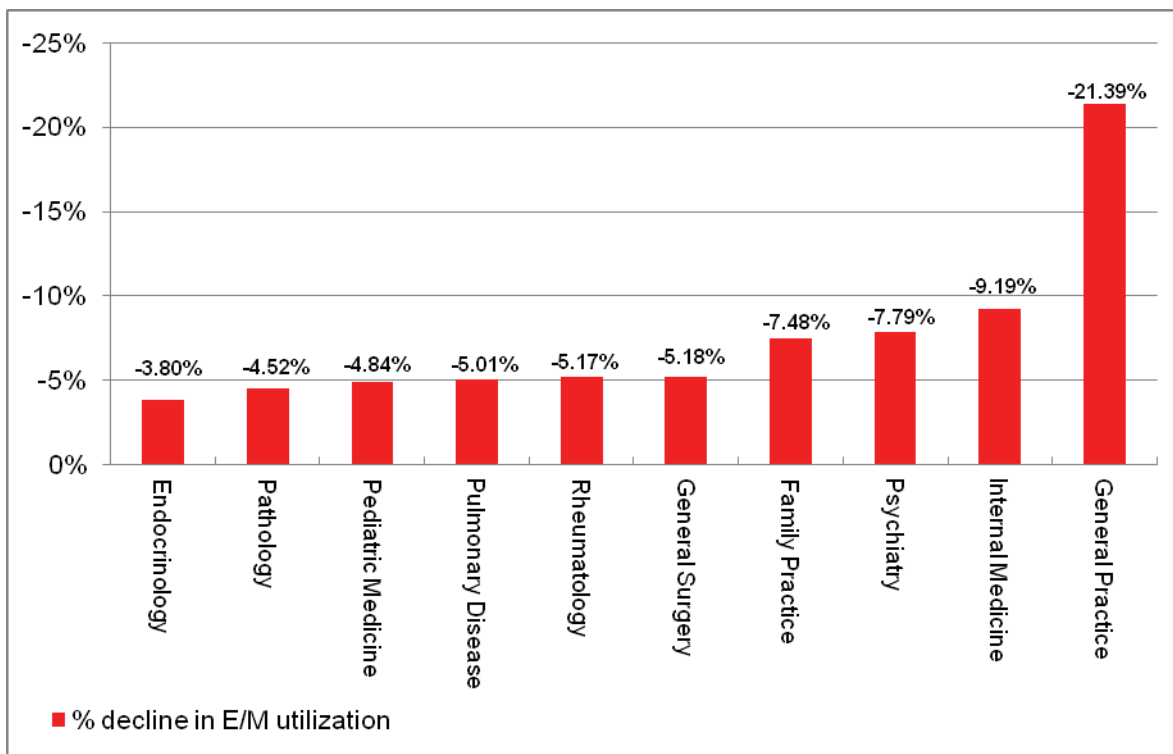
TIP: Write suggestions in templates, such as whether the patient’s blood pressure might indicate hypertension, to provoke thought and keep your documentation from looking like nothing but checks in boxes.

Templates are good in providing guidance to collect information Buechner says, but doctors still need to show that they are actively making decisions. Buechner believes some doctors mark boxes in templates out of routine and don’t realize they are doing it.

“If a doctor sees 50 patients in a day, it doesn’t

Benchmark of the Week: Specialties with greatest E/M decline, 2004-2006

This chart shows ten specialties that saw some of the greatest decline in utilization of 99213 (office/outpatient visit, est., \$59.80) from 2004 to 2006. 99213 is the most commonly billed Medicare service. The striking feature here is the E/M decline in three major generalist specialties: family practice, internal medicine and general practice. This matches up with a decline in overall E/M utilization in 2006, a trend CMS believes is caused by patients switching from traditional Medicare to Medicare Advantage (PBN 11/5/07). Because CMS does not track claims data for Medicare Advantage (MA) patients, there *appears* to be a decline in E/M services, but instead the drop represents the number of visits by beneficiaries who have shifted to MA plans. All data comes from a **Part B News** analysis of 2006 CMS claims data, the latest available.



take long to memorize a template,” Buechner says.

Pierce says she’s seen cases where patient history is automatically inserted into a template or information from one patient is copied and pasted to another patient’s file. Physicians need to take precautions and make sure all documentation is applicable when using templates and further determining medical necessity, she says.

TIP: Experts say you shouldn’t be letting programs select your CPT codes ([PBN 5/1/06](#)), and you can usually turn such functions off. EMRs can serve as a guide, but ultimately codes should be decided by the physician, Buechner says.

— C. Fiegl

4 steps to boost your revenue through clinical trials

Your costs are rising faster than your Medicare payments and you’ve already tried revenue-generating measures such as appealing more claims and tightening up front desk collection. There is another option: clinical trials, which can be quite profitable if you can convince your Medicare carrier to go along, experts tell **Part B News**.

While it’s up to the sponsor of a clinical trial to pay you for actually doing the trial and collecting the data, Medicare *will* reimburse you for “routine care” procedures you perform alongside the trial procedures ([PBN 8/16/04](#)).

Duplicate claims tool

Attached to your e-mailed version of **Part B News** is a duplicate claims letter template created by DecisionHealth Professional Services. Feel free to customize this document to meet your practice’s needs when contacting your Medicare contractor or a private insurance company.

You can find the template attached to the e-mail that includes the electronic version of **Part B News**. The form letter is in PDF and Word document formats. If you cannot access the e-mailed version of **Part B News**, send an e-mail to pbncustomer@decisionhealth.com or call 877-602-3835.

Medicare will also cover the cost of the trial device, provided the device falls under the investigational device exemption (IDE), says Nicole Coustier, principal with Quorum Consulting in San Francisco. “One myth providers believe is that if it’s investigational, Medicare’s going to deny any related claims,” she says. “We spend a lot of time explaining to providers that you can go to Medicare and ask them to cover this and they’ll say ‘yes.’”

With Medicare covering routine care costs and an IDE device and the trial sponsor paying you a stipend for the trial, you’ve got a potential win-win scenario if you can find a trial that fits.

“It depends on your specialty, obviously, and the demographics of your patient mix,” says Ron Rosenberg, CEO of the Practice Management Re-

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<http://www.decisionhealth.com/conferences/A1594/home.html>

10 Things All Practices Should Do in Tough Times

Speakers: Frank Cohen & Reed Tinsley
Time: Sept. 23, 1-2:30 pm
<http://www.decisionhealth.com/conferences/A1593/home.html>

The 5 Types of Carrier Mistakes That Will Stop Your Claims Cold

Speaker: Belinda Holmes,
Time: Oct. 1, 1-2:30 pm
<http://www.decisionhealth.com/conferences/A1602/home.html>

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source Group in Tinley Park, Ill. "Beyond that ... you have to look at how disruptive running a trial would be to your normal patient flow."

There are **four basic steps to get into a clinical trial**, and negotiations between you and your carrier are key.

1. **Contract with the sponsor.** In many cases, the clinical trial sponsor will have significant "wiggle room" over how much of a stipend you'll receive, though you should always negotiate an arrangement that minimizes logistical or administrative burdens on your practice, Coustier says.

2. **Seek Medicare coverage.** You'll need to send a letter to your carrier seeking coverage for routine care costs and payment for an IDE device, if one is involved, says Beth Craig, an associate with Quorum Consulting. "The letter explains the device and briefly explains the procedures involved, then requests coverage," she says. The carrier's response often depends on the "newness" of the device, drug or procedure in question, Craig says. "If people are familiar with it and there isn't a lot of controversy about it, the coverage of the trial will be high. If it's the first [of its kind], it's probably going to be more subject to scrutiny." Don't expect a quick response. It often takes two to three months for a decision to be made, says Warren Laurita, administrator of Retina Associates of Cleveland in Ohio.

TIP: Ask the trial sponsor for help if you need to convince the medical director at your carrier to cover trial costs, Coustier says. "They will likely

have a support mechanism to get through to your carrier." But it's ultimately your responsibility to win over the Medicare carrier, she says.

3. **Perform the trial.** The trial sponsor usually provides training on performing the trial, especially if the sponsor expects your physicians to use their software to track and report results and outcomes, Coustier says.

4. **File the claims.** If your carrier agreed to pay for an IDE device, the cost of the device is billed on the *first* claim form as a one-time fee, Coustier says. Only routine care procedures should appear on subsequent claims.

Remember: Use modifier **Q1** (routine clinical service provided in a clinical research study) with CPT codes and include the V70.7 (examination of participant in a clinical trial) ICD-9 code. Use modifier **Q0** (investigational clinical service provided in a clinical research study) for covered IDE devices or routine care associated with these devices ([PBN 4/19/04](#)). — *G. Huang*

On the Internet:

- Registry of clinical trials maintained by the National Institutes of Health: <http://clinicaltrials.gov/ct2/home>

Artificial hearts will receive coverage as part of clinical trial

Medicare will provide coverage for implanting artificial hearts as part of an approved clinical study, CMS says.

Ask Part B News

This week's question is answered by Sean Weiss CPC, vice president and John Bishop PA-C, senior consultant of DecisionHealth Professional Services.

Q. I've heard about radiologists and cardiologists who contract to share the professional component revenue from computed tomography angiography (CTA) reads. I'm concerned this could violate a number of rules, particularly when the radiologist splits the fee with the cardiologist for reads of the images of the cardiologist's own patients.

A. These fee-splitting arrangements could violate rules against physician self-referrals (Stark). CTA services covered by Stark include:

- **0144T** (Ct heart wo dye; qual calc).
- **0146T** (Ccta w/wo dye).
- **0148T** (Ccta w/wo, strxr).
- **0150T** (Ccta w/wo, disease strxr).
- **70496** (Ct angiography, head).
- **70498** (Ct angiography, neck).

Unless the arrangement fits exactly into one of the Stark "exceptions," it could violate the rule. CMS does not have to prove intent on the provider's part under Stark so even innocent mistakes can lead to penalties.

The plan could also violate the Anti-Kickback Statute. If members of your practice are determined to go forward, first request Advisory Opinions from CMS **and** the Office of Inspector General (OIG). The process is lengthy and costly but if both agencies give your plan a "seal of approval" you'll know the arrangement won't trigger fines, penalties and exclusion.

Codes covered by Stark are available here: http://www.cms.hhs.gov/PhysicianSelfReferral/11_List_of_Codes.asp.

If you'd like to submit a question to the staff of DecisionHealth Professional Services, e-mail: askpbn@decisionhealth.com. **Part B News** will not print any information that identifies you or your practice. We cannot guarantee your question will be answered.

Transmittal 93 to the Medicare National Coverage Determinations manual says **0051T** (implant total heart system, carrier priced) can be used with the required National Clinical Trial

Number when billing for an artificial heart implant. CMS had released the transmittal along with Transmittal 1583 to the Medicare Claims Processing manual on Aug. 29.

The CPT code and trial number should be reported with diagnosis code V70.7 (examination of participant in a clinical trial) as the primary diagnosis and modifier **Q0** (investigational clinical service provided in a research study) for payment, CMS says. The code is currently listed with a status of "C" for carrier-priced.

An artificial heart is a "biventricular replacement device," the transmittals say. Coverage includes ventricular assist devices (VAD) and left ventricular assist devices (LVAD) when surgically attached to the heart's ventricles. The devices help "a damaged or weakened native heart in pumping blood," Transmittal 93 states. "Improvement in the performance of the native heart may allow the device to be removed."

CMS says Medicare Advantage (MA) plans are not responsible for payment because coverage is only allowed under clinical studies. Claims would then be submitted to a fee-for-service contractor for payment. In 2002, CMS said Medicare should pay you for a VAD implant ([PBN 11/18/02](#)).

American College of Cardiology President James Dove MD sent a memo to CMS supporting the coverage of artificial hearts on Feb 29. "It is our sincere hope as well that this research will lead to additional breakthroughs in these and future treatment options for those heart failure patients left without other current clinical alternatives," Dove wrote. — *C. Fiegl*

On the Internet:

- Artificial heart clinical study approvals: www.cms.hhs.gov/MedicareApprovedFacilitie/06_artificialhearts.asp
- Transmittal 93: www.cms.hhs.gov/transmittals/downloads/R93NCD.pdf
- Transmittal 1583: www.cms.hhs.gov/transmittals/downloads/R1583CP.pdf

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