

Health Information Compliance Alert

Physician Quality Reporting System: Know These 5 Common Pitfalls When Using PQRS

Once again, provider documentation could be the linchpin in your success.

Whether you're new to CMS's Physician Quality Reporting System program or you've been collecting bonuses from it for a while, you can use some tips on how to avoid common PQRS mistakes. CMS reps shed light on these issues during a March 22 call, and shared the following information about the five most common PQRS pitfalls.

1. **Missing Your Eligible Population.** When you're selecting measures to report, you should "carefully review all ICD-9- CM diagnoses and CPT service codes that will qualify claims for inclusion in physician quality reporting measurement calculations," said CMS' **Christine Estella** during the call.

Keep in mind that some measures have specified patient demographics that must be met before you can report them, such as age or gender parameters, Estella said. For those measures that require you to capture specific clinical values for coding, make sure that the people in your practice who code your claims have access to them -- otherwise they won't know the claims are eligible for PQRS.

For example: When submitting codes for measure number three (High blood pressure control in diabetesmellitus), be sure to include codes for both the systolic and diastolic blood pressure, and make sure those numbers are available to the coder or other person submitting your PQRS measures.

2. **Reporting Incorrect Information.** This means that you've used incorrect specifications, quality data codes, or individual NPI numbers.

"Be sure to use correct measure specifications for the current year and reporting method," Estella said. For measures that require more than one QDC (quality data code, which refers to a CPT or G code), ensure that you've reported all of the codes on the claim, and that any applicable modifiers are applied.

"Be sure to include the individual rendering NPI number(s) on the claim," Estella said. "QDCs should be submitted on the line item of the claim as a zero charge." If your billing software does not permit a zero charge line item, you can enter one cent as your charge, because you cannot leave the submitted charge field blank.

3. **Missing the Reporting Frequency.** Each PQRS measure has its own reporting frequency or time frame requirement for each eligible patient seen during the reporting period per eligible professional (NPI), Estella said. Some measures require you to report once per patient, per NPI, each reporting period (also called "patient-level,") while others may need to be reported once per procedure performed, once per acute episode, or once per visit.

You can find the reporting frequency (also called a "measure tag") in the instructions section of each measure specification -- but even if you know the frequency requirements, you won't be able to find them if the practitioner's documentation isn't thorough. "Ensure that all members of the team understand and capture this information in the clinical record to facilitate reporting," Estella said.

4. **Confusing PQRS With Other CMS Programs.**

PQRS is separate from the EHR program, but because the programs have similar requirements, many eligible professionals confuse them. The programs have different materials and requirements, and you'll need to call a separate help desk for assistance on them.

5. Knowing Who to Call for Help. If you've got questions about PQRS, don't simply abandon the program. Instead, contact the QualityNet Help Desk at 866-288-8912 or send an email to qnetsupport@sdps.org, Estella advised.

Remember: "Several reporting errors can be avoided," Estella said. "Please report carefully, since all diagnoses listed on the CMS-1500 or electronic equivalent at an encounter during the reporting period will be counted in analysis."