

Physician Quality Reporting in 2008: What Every Physician Practice Should Know

LAURA GREENE: This is Laura Greene for the Healthcare Intelligence Network. Today I am speaking with Lorraine Larrance, consulting senior manager with Pershing Yoakley & Associates and Sue Kincer, consultant and certified professional coder with Pershing Yoakley & Associates. Lorraine and Sue are presenting at HIN's Webinar on "Physician Quality Reporting in 2008: What Every Physician Practice Should Know". Welcome and thanks for joining me today ladies.

LORRAINE LARRANCE, CONSULTING SENIOR MANAGER WITH PERSHING YOAKLEY & ASSOCIATES AND SUE KINCER, CONSULTANT AND CERTIFIED PROFESSIONAL CODER WITH PERSHING YOAKLEY & ASSOCIATES: Thank you.

LAURA GREENE: To begin with, what kind of special coding challenges do the 2008 measures pose for physician practices? Do you recommend additional training for the coding staff? Lorraine, would you like to start?

LORRAINE LARRANCE: I'm going to turn this over to Sue.

LAURA GREENE: Okay.

SUE KINCER: Thank you Lorraine. With over 100 new CPT category 2 codes added in 2008, it's imperative that the providers and the coding staff familiarize themselves with the appropriate CPT, ICD-9, and exclusion modifiers that are linked to each measure that they have chosen to report. Appendix H of the 2008 CPT book

does provide an alphabetic index performance measure, by clinical condition or topic, which does provide the CPT to category 2 codes associated with each measure. In addition, the CMS website does offer a coding handbook that identifies the CPT category 2 codes in addition to the CPT category 1 codes and the appropriate ICD-9 codes that are linked with each measure. It also gives you the information as to whether or not the exclusion modifiers apply and in some cases there are more than one exclusion modifier that does apply. It also provides us specific information related to each measure as far as irrational and the specifications and AMA website is also a valuable resource that does provide additional information related to each measure.

Familiarity with these tools, of course, will aid in the process of charge capture and accurate code assignment for the entire team. The coders translate the information that they get based on the applicable measure specifications. So it's necessary that every one in the reporting process understands the data collection process to help identify barriers for process improvement and Lorraine, would you like to add any of your thoughts to that?

LORRAINE LARRANCE: Just a comment in regards to training not only for coders but actually for, as Sue mentioned, the entire team of folks that are involved throughout the practice in the PQRI reporting process. This reporting process is truly driven by practice or a counter movement of a patient through the practice and the ability of the practice to capture the appropriate data from the time the patient enters the practice or an encounter, i.e. identifying that this patient does indeed fit the criteria for your selected measures for reporting. And

then that movement into the clinical area where the physician and clinical staff are evaluating the patient, capturing as Sue mentioned the data that will be necessary for the next stage in the reporting process of coding, of reporting the PQRI measure.

It is from my perspective, imperative that training occur with all participants within the practice environment so that each member of the team is familiar with each step of the process have an opportunity to understand the measure, hear it described and discussed in a collective group, have the opportunity to ask questions, understand not only their role in capturing the data, ensuring its documented, so that the coders have the ability to then review that data and appropriately code and submit the information for practice credit.

LAURA GREENE: Okay, thank you ladies. Is the inclusion of negative measures, for example measure number 102, inappropriate use of bone scan for staging low risk prostate cancer patients apt the confuse coders?

SUE KINCER: At first glance, yes, its possible that it can be very confusing. However, a team approach, and that includes everyone from the provider to the coding staff to the clinical staff have an understanding of the specifications of a particular measure. Sometimes using it in comparison to another measurer is imperative to successful reporting. In this particular measure, the rational is that it is written as a negative measure so that the performance goal is 100% and consistent with other measures for this condition. Lorraine, would you like to add to that?

LORRAINE LARRANCE: Absolutely. On the 119 measures that have been selected for 2008 this is the only measure that is stated or presented in a negative context. And to really get my arms around it, I had to stop and think about it from a clinical perspective. And with this particular measure, in regards to the use of bone scan, from a clinical perspective, from an evidence based medicine perspective, bone scans are generally not required for the staging of prostate cancer and then who are at low risk.

So as I think about that clinical evidence and then translate it into the measure and this negative statement of the inappropriate use of bone scan for staging and I have to think about if it were written in a positive statement, use of bone scan for staging of low risk of prostate cancer, the reporting outcome would really be reported out at a low percentile. Let's say somewhere between 1 and 20% percent, as opposed to placing it in a negative connotation of inappropriate use of bone scan allows the reporting to match or follow the sequencing of all other measure reporting of being somewhere between 80% and 100% occurrence. So again thinking from a global perspective that the entire team needs to be able to truly discuss and understand the measures that have been selected so that in their process implementation that they're very clear on what that needs to be captured as well as what does this mean and why would this apply in this situation.

LAURA GREENE: Okay, thank you ladies. What has been the greatest challenge for physicians to this point to the reporting of quality measures?

LORRAINE LARRANCE: I'll start with this Laura. Looking back on 2007 and the initiation of the PQRI process beginning in July of that year, the challenges that we heard most prevalently from the physicians, as well as the physician office practice were those related to what measures really apply to our practice? What are the measures that we have to use? At that point in time we had 74 measures and it was a new process, one in which it was requiring a physician office environment to take on new operational procedures to capture data and then to report it out through to CMS. Additionally, the operational component of how do we ensure that the data that we need to collect is present on the medical record for the coder to be able to then process that data appropriately, assign the appropriate measure codes and then report off to CMS.

LAURA GREENE: Okay. Sue, would you like to add anything?

SUE KINCER: Yes. Based on the experience with the PQRI process in 2007, those practices that are coming on board in 2008 and if they have participated in 2007, I think well have less difficulty in identifying the measures that are applicable to their practice. If they've had an opportunity to identify certain measures out of the 74 that were available in 2007, I believe it's broadened the opportunity for them to have more to choose from in 2008. I think that will pose this to be as a lesser challenge to them.

LORRAINE LARRANCE: And Laura, I think Sue makes an excellent point in terms of the practices. You have participated last year being able to expand the number of measures. Certainly we all understand a minimum of three is the ideal place to be. But certainly as practices have established their internal working

mechanisms, next year offers the opportunity to expand the number of reporting measures that we're using as well as the practices you were just coming on board with PQRI in 2008. What a wonderful resource of information will be available to practices and their local environment as well as through the various specialty medical associations in regards to how other practices manage that implementation, that startup process what worked, what didn't work and kind of use the best practice scenario to initiate their processes during this next year.

LAURA GREENE: And finally, for physicians you've advised on PQRI thus far, has participation in this program led to improvements in practice quality and/or efficiency? Lorraine?

LORRAINE LARRANCE: Based on the feedback that I've received from physicians and their practices, one of the most positive outcomes of PQRI participation in 2007 has been noted to be the improvement in practice efficiencies. With the implementation of the reporting of their selected measures, the practice environment has really taken on a performance improvement approach to look at the throughput of the patient in the clinical office environment. And in doing so have identified opportunities for improving patient registration, clinical documentation by the physician as well as improving the level of clinical information that is being received by the coder. So the efficiency outcome of the participation within a PQRI process certainly has positively impacted the physician office environment.

LAURA GREENE: Okay, thanks. Sue, would you like to add anything?

SUE KINCER: I would. Also, with what Lorraine just said and kind

of adding to that. A heightened awareness of clear concise documentation in the medical record to support the reporting of the clinical services delivered, has led and will continue to lead to greater efficiency in supporting the measures that have been reported and application to the PQRI process.

LAURA GREENE: Okay. Those are all the questions that I have for you today. Thanks for being with us and were looking forward to hearing from both of you during the webinar.

SUE KINCER: Thank you.

LAURA GREENE: To register or get more information about this webinar, please call 1-888-446-3530. This is Laura Greene for the Healthcare Intelligence Network.