

What surgeons should know about...

PQRI reporting in 2010

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The Centers for Medicare & Medicaid Services (CMS) has continued the Physician Quality Reporting Initiative (PQRI) into 2010 as required under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA). PQRI is the first CMS-crafted national program to link the reporting of quality data to physician payment. The incentive payment for those eligible professionals who successfully participate in the program is 2 percent of the total allowed charges for Medicare Part B professional services covered under the physician fee schedule and furnished during the reporting period.

How does one use the measure specifications manual?

The first step for implementing PQRI in your office is to use the 2010 PQRI *Measure Specifications Manual* to identify measures applicable for professional services for which a physician's practice routinely provides. The next step is to select those measures that make sense based upon prevalence and volume in the physician's practice, as well as their individual or practice performance analysis and improvement priorities. The 2010 PQRI *Measure Specifications Manual* can be found on the CMS PQRI Web site, http://www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage, or on the ACS PQRI Web site, <http://www.facs.org/ahp/pqri/index.html>.

This article outlines the process of claims-based reporting for PQRI 2010—in this case, perioperative measure #20: Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.

What is the description of the measure?

The measure specifications describe measure #20 as “Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiot-

ics, who have an order for prophylactic parenteral antibiotic to be given within one hour (if fluoroquinolone or vancomycin, two hours), prior to the surgical incision (or start of procedure when no incision is required).” This narrative gives a high-level description of measure #20.

What are the instructions?

The instructions explain when the measure should be reported and who should report it. According to the instructions, measure #20 should be reported every time the procedure is performed on patients 18 years and older, with the indications for prophylactic parenteral antibiotics. The instructions further state that “Clinicians who perform the listed surgical procedures as specified in the denominator coding will submit this measure,” clearly indicating who should report the measure. In addition, the instructions indicate that there is no diagnosis associated with this measure.

What is the “frequency?”

The frequency refers to how often the measure should be reported. Measure #20 should be reported each time an applicable procedure is performed during the reporting period (full or half-year).

What is the performance time frame?

The performance time frame for measure #20 is indicated as within one hour (two hours if fluoroquinolone or vancomycin) prior to surgical incision, or start of procedure when no incision is required.

How do I report measure #20 via claims?

The measure specifications for measure #20 indicate that it is a claims and registry measure, meaning it can be reported using either the

Table 1.**Measure #20: Surgical procedures for which prophylactic parenteral antibiotics are indicated**

Surgical procedure	CPT code
Integumentary	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369
Le Fort fractures	21346, 21347, 21348, 21422, 21423, 21432, 21433, 21435, 21436
Mandibular fracture	21454, 21461, 21462, 21465, 21470
Spine	22325, 22612, 22630, 22800, 22802, 22804, 63030, 63042
Hip reconstruction	27125, 27130, 27132, 27134, 27137, 27138
Trauma (fractures)	27235, 27236, 27244, 27245, 27269, 27758, 27759, 27766, 27769, 27792, 27814
Knee reconstruction	27440, 27441, 27442, 27443, 27445, 27446, 27447
Laryngectomy	31360, 31365, 31367, 31368, 31370, 31375, 31380, 31382, 31390, 31395
Vascular	33877, 33880, 33881, 33883, 33886, 33891, 34800, 34802, 34803, 34804, 34805, 34825, 34830, 34831, 34832, 34900, 35081, 35091, 35102, 35131, 35141, 35151, 35601, 35606, 35612, 35616, 35621, 35623, 35626, 35631, 35632, 35633, 35634, 35636, 35637, 35638, 35642, 35645, 35646, 35647, 35650, 35651, 35654, 35656, 35661, 35663, 35665, 35666, 35671, 36830
Spleen and lymph nodes	38115
Glossectomy	41130, 41135, 41140, 41145, 41150, 41153, 41155
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43324, 43325, 43326, 43330, 43331, 43340, 43341, 43350, 43351, 43352, 43360, 43361, 43400, 43401, 43405, 43410, 43415, 43420, 43425, 43496
Stomach	43500, 43501, 43502, 43510, 43520, 43605, 43610, 43611, 43620, 43621, 43622, 43631, 43632, 43633, 43634, 43640, 43641, 43653, 43800, 43810, 43820, 43825, 43830, 43831, 43832, 43840, 43843, 43845, 43846, 43847, 43848, 43850, 43855, 43860, 43865, 43870
Small intestine	44005, 44010, 44020, 44021, 44050, 44055, 44100, 44120, 44125, 44126, 44127, 44130, 44132, 44133, 44135, 44136
Colon and rectum	43880, 44025, 44110, 44111, 44140, 44141, 44143, 44144, 44145, 44146, 44147, 44150, 44151, 44155, 44156, 44157, 44158, 44160, 44202, 44204, 44205, 44206, 44207, 44208, 44210, 44211, 44212, 44300, 44310, 44312, 44314, 44316, 44320, 44322, 44340, 44345, 44346, 44602, 44603, 44604, 44605, 44615, 44620, 44625, 44626, 44640, 44650, 44660, 44661, 44700, 44950, 51597
Anus and rectum	45108, 45110, 45111, 45112, 45113, 45114, 45116, 45119, 45120, 45121, 45123, 45126, 45130, 45135, 45136, 45150, 45160, 45171, 45172, 45190, 45500, 45505, 45520, 45540, 45541, 45550, 45560, 45562, 45563, 45800, 45805, 45820, 45825
Hepatic surgery	47135, 47136, 47140, 47141, 47142
Biliary surgery	47420, 47425, 47460, 47480, 47560, 47561, 47570, 47600, 47605, 47610, 47612, 47620, 47700, 47701, 47711, 47712, 47715, 47720, 47721, 47740, 47741, 47760, 47765, 47780, 47785, 47800, 47802, 47900
Pancreas	48020, 48100, 48120, 48140, 48145, 48146, 48148, 48150, 48152, 48153, 48154, 48155, 48500, 48510, 48511, 48520, 48540, 48545, 48547, 48548, 48554, 48556
Abdomen, peritoneum, and omentum	49215, 49568
Renal transplant	50320, 50340, 50360, 50365, 50370, 50380
Gynecologic surgery	58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294

continued on next page

Table 1 (continued from previous page)

Measure #20: Surgical procedures for which prophylactic parenteral antibiotics are indicated

Surgical procedure	CPT code
Acoustic neuroma	61520, 61526, 61530, 61591, 61595, 61596, 61598, 61606, 61616, 61618, 61619, 69720, 69955, 69960, 69970
Cochlear implants	69930
Neurological surgery	22524, 22554, 22558, 22600, 22612, 22630, 35301, 61154, 61312, 61313, 61315, 61510, 61512, 61518, 61548, 61697, 61700, 61750, 61751, 61867, 62223, 62230, 63015, 63020, 63030, 63042, 63045, 63047, 63056, 63075, 63081, 63267, 63276
Cardiothoracic surgery	33120, 33130, 33140, 33141, 33202, 33250, 33251, 33256, 33261, 33305, 33315, 33321, 33322, 33332, 33335, 33400, 33401, 33403, 33404, 33405, 33406, 33410, 33411, 33413, 33416, 33422, 33425, 33426, 33427, 33430, 33460, 33463, 33464, 33465, 33475, 33496, 33510, 33511, 33512, 33513, 33514, 33516, 33517, 33518, 33519, 33521, 33522, 33523, 33530, 33533, 33534, 33535, 33536, 33542, 33545, 33548, 33572, 35211, 35241, 35271
Cardiothoracic (pacemaker)	33203, 33206, 33207, 33208, 33212, 33213, 33214, 33215, 33216, 33217, 33218, 33220, 33222, 33223, 33224, 33225, 33226, 33233, 33234, 33235, 33236, 33237, 33238, 33240, 33241, 33243, 33244, 33249, 33254, 33255
Genitourinary surgery	51550, 51555, 51565, 51570, 51575, 51580, 51585, 51590, 51595, 51596, 51920, 51925, 52450, 52601, 52630, 52647, 52648, 52649, 54401, 54405, 54406, 54408, 54410, 54415, 54416, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845
General thoracic surgery	19272, 21627, 21632, 21740, 21750, 21805, 21825, 31760, 31766, 31770, 31775, 31786, 31805, 32095, 32100, 32110, 32120, 32124, 32140, 32141, 32150, 32215, 32220, 32225, 32310, 32320, 32402, 32440, 32442, 32445, 32480, 32482, 32484, 32486, 32488, 32491, 32500, 32501, 32800, 32810, 32815, 32900, 32905, 32906, 32940, 33020, 33025, 33030, 33031, 33050, 33300, 33310, 33320, 34051, 35021, 35216, 35246, 35276, 35311, 35481, 35526, 37616, 38381, 38746, 39000, 39010, 39200, 39220, 39545, 39561, 60521, 60522, 64746
Foot and ankle	27702, 27703, 27704, 28192, 28193, 28293, 28415, 28420, 28445, 28465, 28485, 28505, 28525, 28531, 28555, 28585, 28615, 28645, 28675, 28705, 28715, 28725, 28730, 28735, 28737

claims-based or the registry-based method. This article looks at the claims-based method only. The Current Procedural Terminology (CPT)⁸ codes and patient demographics identify the patients who are included in measure #20, otherwise known as the denominator. Beginning on page 51 of the *Measure Specifications Manual*, there is a listing of all surgical procedures and CPT codes that qualify patients as eligible to meet this measure’s inclusion requirements (see Table 1, page 7 and this page). It is important to review the CPT codes associated with each measure reported. Also, please note that the included procedure codes may change from year to year, so review the 2010 measure specifications before beginning to report for this year.

⁸All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2010 American Medical Association. All rights reserved.

What are the steps to be taken after identifying a patient in the denominator for Measure #20?

CPT II codes, or quality data codes (QDCs), are used to report the clinical action required by the measure on the claims form. For measure #20, there are four choices: 4047F, 4048F, 4047F with 1P, and 4047F with 8P. 4047F indicates the order for prophylactic parenteral antibiotics was given; 4048F indicates prophylactic parenteral antibiotic has been given; 4047F with 1P modifier indicates the order for prophylactic parenteral antibiotic was not given due to medical reasons; and 4047F with 8P modifier indicates prophylactic parenteral antibiotic was not given and the reason was not specified. Please note that both the CPT code and the appropriate CPT II code should be submitted on the same claim form.

It is important to note that for measure #20, Table 2 (this page) is included in the measure specifications and lists the antimicrobial drugs considered prophylactic parenteral antibiotics for the purposes of this measure. Code 4047F-8P should be reported when antibiotics from this table were not ordered.

Example claim form

CPT II codes can be reported on claim form CMS 1500 or via electronic form ASC X12N 837. Figure 1 on this page is an example of the CMS 1500 claim form.

Based on Figure 1, the following steps are listed for reporting via claims:

Step 1: Look in the measure specifications for measure #20 to see if this procedure is listed in the table of surgical procedures for which prophylactic parenteral antibiotics are indicated. If so, continue to step 2.

Step 2: On the CMS 1500 claim form, the CPT procedure code 44120 is listed on line 1.

Step 3: On line 2, the CPT II code, 4047F, is listed, which indicates the order of prophylactic parenteral antibiotic was given within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required). (Note: The CPT II code may be one of four options, as outlined earlier in this article.)

Step 4: Lines 3 through 6 are CPT II codes that correspond to other PQRI measures (#21, #22, and #23). Measures #21, #22, and #23 are often reported by eligible professionals

Table 2:

Measure #20: Antimicrobial drugs considered prophylactic parenteral antibiotics for the purposes of this measure

Ampicillin/sulbactam	Cefotetan	Ertapenem	Levofloxacin
Aztreonam	Cefoxitin	Erythromycin base	Metronidazole
Cefazolin	Cefuroxime	Gatifloxacin	Moxifloxacin
Cefmetazole	Ciprofloxacin	Gentamicin	Neomycin
	Clindamycin		Vancomycin

Figure 1:

Procedure: 44120: Enterectomy, resection of small intestine; single resection and anastomosis—Example claim form

Reporting PQRI Quality Data to CMS
Example Claim Form

Developed by the AMERICAN COLLEGE OF SURGEONS

LINE	ICD-9 CODE	DESCRIPTION	UNIT	CHARGE	REMARKS
1	07 10	21 44120	1	1100.00	9876543120
2	07 10	21 4047F	1	0.00	9876543120
3	07 10	21 4041F-1P	1	0.00	9876543120
4	07 10	21 4049F	1	0.00	9876543120
5	07 10	21 4046F	1	0.00	9876543120
6	07 10	21 4044F	1	0.00	9876543120

Table 3

PQRI 2010 reporting options matrix

		Claims-based methods	Registry-based methods	Electronic health record-based methods
Full-year period	Individual measures	At least three PQRI measures (one-two if less than three apply), for 80 percent of applicable Medicare Part B fee-for-service (FFS) patients of each eligible professional.	At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.	At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.
	Measures groups	One measures group for 30 Medicare Part B FFS patients. One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least 15 patients during reporting period).	One measures group for at least 30 patients (patients may include, but may not be exclusively, non-Medicare patients). One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least 15 patients during the reporting period).	
Half-year period	Individual measures	At least three PQRI measures (one-two if less than three apply), for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.	At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.	
	Measures groups	One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least eight patients during reporting period).	One measures group for 80 percent of applicable Medicare Part B FFS patients of each eligible professional (at least eight patients during the reporting period).	

when measure #20 is reported, because these four measures are perioperative care measures. CPT procedure code 44120 corresponds with these perioperative measures as well, so the CPT II codes are listed on the same claim form.

Step 5: Be sure billing software and the clearinghouse can correctly submit PQRI CPT II codes, or quality-data codes (QDCs).

Step 6: Regularly review the remittance advice notice from the carrier to ensure the denial remark code N365 is listed for each QDC submitted. This indicates that claims have made it to the CMS national claims history file.

Surgical practices that follow these steps should be able to successfully report via claims

in PQRI 2010 to receive incentive payments. There are various ways to report for PQRI, and this article has only covered the claims-based method for individual measures. Please refer to the correct measure specifications manual if you choose another method. Table 3 on this page is a matrix that lists all 11 options for reporting in PQRI 2010.

For more background information regarding the PQRI program, visit the CMS PQRI Web site at <http://www.cms.hhs.gov/pqri/> and access the resources posted at <http://www.facs.org/ahp/pqri/index.html>. If you have any further questions regarding PQRI, contact Caitlin Burley, at cburley@facs.org. 