

What surgeons should know about...

Medicare's Physician Quality Reporting Initiative

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A provision in the Tax Relief and Healthcare Act, which President Bush signed into law on December 20, 2006, did two things: It froze the conversion factor for physician payment in 2007 at the 2006 amount, thus averting a 5 percent payment cut, and it gave physicians who successfully report quality measures on their claims for services during the last half of 2007 a bonus of up to 1.5 percent of allowed charges for all claims during the same six-month period.

This article will discuss the new voluntary reporting program, known as the Medicare Physician Quality Reporting Initiative (PQRI). If you want to participate in the program, it is essential that you begin reporting the quality measures with dates of service effective on July 1. Physicians will choose three performance measures on which they must meet an 80 percent reporting rate.

Briefly, the PQRI works as follows:

- The physician voluntarily reports on quality measures for procedures performed during July 1 through December 31, 2007.
- Quality measures are reported on the same claim as the substantive procedure code, generally using Current Procedural Terminology (CPT) level II "procedure" codes.*
- A bonus payment of up to 1.5 percent of all allowed charges during the same period will be paid in a lump sum in mid-2008.

Complete information on the PQRI can be found on the Web site of the Centers for Medicare & Medicaid Services (CMS) at <http://www.cms.hhs.gov/PQRI>. The first Web page contains some general information about the PQRI; more detailed information is on subsequent pages listed on the left side of the screen. Additional information can be found on the College's Web site at www.facs.org/ahp/pqri.

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2006 American Medical Association. All rights reserved.

What quality measures are available for surgeons? How were they developed?

The American College of Surgeons developed six measures that are applicable to many surgical specialties. Three measures applicable to cataract surgery developed by the American Academy of Ophthalmology and four measures applicable to coronary artery bypass graft (CABG) developed by the Society of Thoracic Surgeons also are included in the PQRI. (See the text box on page 9 for a description of the measures.) There is a total of 74 performance measures available for use by physicians and many nonphysicians, including nurse practitioners and physician assistants.

The performance measures included in the PQRI were developed by physicians, including many in collaboration with the American Medical Association's Physician Consortium for Performance Improvement. In addition, the measures were vetted through the AQA (formerly the Ambulatory Quality Association) and/or the National Quality Forum (NQF), both multi-stakeholder organizations. Each of these groups has a different role to play in ensuring that the measures are scientifically valid, represent an area where quality can be improved, and can work in a claims-based system.

How do I know when I can report a quality measure?

Look at the specifications for the quality measure on the CMS Web site. In the section of the specification labeled "denominator," surgical measures have a list of CPT procedure codes to which the measure applies. Many nonsurgical measures contain diagnosis codes from the *International Classification of Diseases, Ninth Revision, Clinical Modification* (ICD-9-CM) and a range of CPT evaluation and management (E/M)

Quality measures related to surgical procedures

To facilitate searches on the Centers for Medicare & Medicaid Services (CMS) Web site, the number assigned to each measure by CMS is shown in parentheses after the description, followed by the organization that sponsored the measure. Consult the CMS Web site to see other measures surgeons may use that are not specific to a surgical procedure.

- **Perioperative care: Selection of prophylactic antibiotic—First or second generation Cephalosporin:** Percentage of patients undergoing procedures with the indications for a first- or second-generation cephalosporin prophylactic antibiotic who had an order for cefazolin or cefuroxime for antimicrobial prophylaxis (21) (ACS)
- **Perioperative care: Timing of antibiotic prophylaxis—Ordering physician:** Percentage of patients undergoing procedures with the indications for prophylactic parenteral antibiotics who have an order for it to be given within one hour (if fluoroquinolones or vancomycin, two hours) prior to the start of procedure (20) (ACS)
- **Perioperative care: Timing of prophylactic antibiotic—Administering physician:** Percentage of patients for whom administration of prophylactic parenteral antibiotic has been initiated as ordered (30) (ACS)
- **Perioperative care: Discontinuation of prophylactic antibiotics (noncardiac procedures):** Percentage of patients undergoing noncardiac procedures who received a prophylactic antibiotic and who have an order for discontinuation of prophylactic antibiotics within 24 hours of surgical end time (22) (ACS)
- **Perioperative care: Venous thromboembolism (VTE) prophylaxis:** Percentage of patients undergoing procedures for which VTE prophylaxis is indicated in all patients who had an order for low molecular weight heparin, low-dose unfractionated heparin, adjusted-dose warfarin, fondaparinux, or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time (23) (ACS)
- **Preoperative beta-blocker in patients with isolated coronary artery bypass graft (CABG) surgery:** Percentage of patients undergoing CABG surgery who received a betablocker preoperatively (44) (Society of Thoracic Surgeons [STS])
- **Use of internal mammary artery (IMA) in CABG surgery:** Percentage of patients undergoing CABG surgery using an IMA (43) (STS)
- **Perioperative care: Discontinuation of prophylactic antibiotics (cardiac procedures):** Percentage of patients undergoing cardiac procedures who have an order for discontinuation of prophylactic antibiotics within 48 hours of surgical end time (45) (ACS)
- **Cataracts: Assessment of visual functional status:** Percentage of patients who were assessed for visual functional status within 12 months (15) (American Academy of Ophthalmology [AAO])
- **Cataracts: Presurgical dilated fundus evaluation:** Percentage of patients who had a fundus evaluation performed within six months prior to the procedure (17) (AAO)
- **Cataracts: Documentation of presurgical axial length, corneal power measurement, and method of intraocular lens power calculation:** Percentage of patients who had the presurgical axial length, corneal power measurement, and method of intraocular lens power calculation performed within six months prior to the procedure (16) (AAO)

codes; the measure is suitable if both the ICD-9-CM and the CPT codes are present on the claim form. While visiting the CMS Web site, look at the material ahead of the “denominator” section to see the details about the measure, including the CPT Category II codes.

Who decides which quality measures I should report? What constitutes successful reporting?

It is up to the surgeon to decide which quality measures to report. However, reporting must meet certain criteria to be considered successful, and only physicians who are considered successful qualify for the bonus. If one, two, or three measures are selected, the reporting will be considered successful if each measure is reported 80 percent of the time. If four or more measures are selected, at least three of them must be reported 80 percent of the time.

CMS will count the number of times a quality measure could have been reported, determine whether the quality measure was also reported, and do the arithmetic to determine if the surgeon was successful in reporting the measures. This analysis is performed at the individual physician level.

How much will the bonus be?

For participants who meet the reporting thresholds, the bonus will be equal to 1.5 percent of the allowed amount for all services performed under the Medicare physician fee schedule in the last six months of the year. However, a cap has been placed on the amount of the bonus for someone who reports relatively little quality data. Unfortunately, the cap can only be calculated when the bonus payments are made. The formula is: $Cap = (I) [300\% (A \div M)]$, where I = Number of measures an *individual* reported, A = National *allowed charges* associated with measures, and M = National instances of *measures* reported.

For example, assume the national allowed charges associated with measures (A) divided by the national instances of measures reported (M) is \$100 and that an individual reports only 15 quality measures. The cap for that individual

is (15) [(3.00)(\\$100)], or \$4,500. That is the maximum that can be paid to that individual.

How and when will the bonus be paid?

The statute specifies that for 2007 the payment will be made to the holder of the taxpayer identification number. A single bonus payment will be made in mid-2008. The statute requires that the bonus be based on all claims paid as of February 29, 2008, so CMS cannot do final calculations until after that date. Surgeons should be sure they know how the bonus payment will be handled by the holder of the taxpayer identification number.

How do I report the quality measure?

Report the quality measure on either the same claim form (CMS-1500) or the same electronic transaction (ASC X12N 837) as the substantive procedure code is reported. Necessary data elements include date of service; place of service; PQRI quality data code and modifier, if appropriate; submitted charge in dollars and cents; and the rendering provider number. The date of service should be the same as the date of the substantive procedure code even though orders for or actual performance of the quality measure may have occurred on a different date. If your system cannot accept a charge of the specified dollar amount, a small amount may be substituted. However, no beneficiary copayment is allowed for quality measures.

On the ASC X12N 837, the codes are submitted on the SV1 “Professional Service” segment of the 2400 “Service Line” loop. The data element for the procedure code is SV 101-2, “Product/Service ID.” You must identify in this segment that you are supplying a “procedure” code by submitting the “HC” code for data element SV101-1.

Which data are to be released to inform me of the quality of my data reporting? Is any of this information going to be made public?

Physicians who report quality data will get a single, confidential report at approximately the same time the bonus payment is released. CMS is still working out the details of what is

to be in that report, but the agency says that, at minimum, the report will contain the data necessary to compute the bonus payment. CMS will not release to the public any data from the 2007 PQRI. The aim of the 2007 PQRI is for physicians to get experience in reporting quality data and calculating bonus payments.

Although CMS is precluded by statute from having an appeals process under the PQRI, the group is planning some sort of an inquiry process that would permit the correction of obvious errors.

What are some factors I should consider when deciding whether to pursue a bonus payment?

- You need to know whether it will be worthwhile financially to participate in reporting quality information. When doing a cost-benefit analysis, remember that the results of the third five-year review, which dramatically changed reimbursement, went into effect on January 1. Keep that in mind when you decide to use data from the last half of 2006 or the first half of 2007.

- Remember that it may be worthwhile for you to get some experience in reporting quality data even though it is not financially viable for your practice. If you are not already reporting quality data to a payor, the PQRI may represent a good opportunity to get some experience in a program that will not be exposed to the public.

- You will need some way of knowing when to collect the quality data and some way of getting it from the hospital medical record into the billing operation.

- As stated previously in this article, you need to be able to capture quality data on or very soon after July 1. A two-week delay in beginning participation in the PQRI is probably an insurmountable hindrance.

What will be the fate of the PQRI in 2008?

It is difficult to predict the future of the PQRI. With the change of leadership in the Congress, some newly ranking members object to programs such as the PQRI. On the other hand, by not basing reimbursement on outcomes, the biggest payor, Medicare, would be out of step with a rap-

idly growing phenomenon. Physicians are facing a 10 percent cut under the current statute, so there will be sympathy for taking some action to give physicians a freeze or a small update in exchange for paying for quality. But such an outcome is far from being a “done deal.”

Why do I have to report quality measures on the same claim as the substantive procedure?

CMS has no way to reliably associate a claim or electronic transaction with a substantive procedure code with a claim or electronic transaction with quality measures on it. Remember that most of the quality measures are related to evaluation and management (E/M) codes reported by a primary care physician; there typically will be several encounters reported by the physician during the reporting period. A surgeon, on the other hand, typically will do only one operation on a patient during the six-month period that quality measures are reported.

Do I have to register to report quality measures? Do I have to sign a Medicare participation agreement to accept assignment on all claims?

No registration is necessary, nor do you have to be a participating physician. You simply begin reporting the measures.

Is the quality measure to be reported on Medicare secondary payor claims? What about claims subject to the deductible?

The quality measures are applicable to all claims.

What will I get back from my carrier on the quality line items on the remittance advice statement?

The carrier will deny the quality items and pay the substantive procedure code. However, the quality codes will be routed through the CMS payment system, analyzed, and considered in bonus eligibility calculations.

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What is the College going to do to evaluate PQRI?

The College is recruiting a number of practices of differing sizes, geographical locations, and so on, to track their experience under PQRI. We will report any problems to CMS and, if necessary, to Congress. If you are interested in being a part of this effort, contact the Division of Advocacy and Health Policy via e-mail at ahp@facs.org.

It seems like the College's Case Log System is an excellent tool for capturing these data. Can we use it for quality reporting?

The ACS Case Log System is an excellent tool for capturing the data, but there simply was not enough time to adapt the program to be compatible with the PQRI for the last half of 2007. CMS also has some concerns about dealing with all the databases in existence, so the agency wants to determine a way of reducing the variance in

data. For more information about the College's Case Log System, see the article on page 17 of this issue.

It is well established that something like the National Surgical Quality Improvement Program (NSQIP) is a far more robust means of measuring outcomes than claims-based data. Where does it fit in with the PQRI?

NSQIP is a very successful program for measuring systems of care. However, due to the limited sampling methodology, it is not possible to consistently measure the data for individual physicians. In addition, NSQIP is in a limited number of hospitals and does not apply to physicians who practice in ambulatory surgery centers or physician offices. As NSQIP and physician quality initiatives evolve, the College will continue to look for methods to reduce the burden on physicians by building on existing data collection systems. Ω