

# What surgeons should know about...

## PQRS reporting in 2012

by Sana Gokak

The Centers for Medicare & Medicaid Services (CMS) has continued the Physician Quality Reporting System (PQRS) into 2012 as required under the Medicare Improvements for Patients and Providers Act of 2008. The Affordable Care Act authorized incentive payments for eligible professionals who successfully participate in the program through 2014. The incentive payment for the 2012 reporting year is 0.5 percent of the total allowed charges for Medicare Part B professional services covered under the physician fee schedule and furnished during the reporting period. For reporting years 2013 and 2014, eligible professionals can earn an incentive payment of 0.5 percent of their total estimated allowed charges for Medicare Part B physician

**Table 1. PQRS payment incentives and penalties**

Reporting year	Incentive	Penalty
2012	0.50%	–
2013	0.50	–
2014	0.50	–
2015	–	1.50%
2016 and beyond	–	2.00

fee schedule covered professional services furnished during the respective reporting periods. Beginning in 2015, eligible professionals who fail to satisfactorily report PQRS measures will be subject to a payment

**Table 2. 2012 PQRS changes**

2011 PQRS	2012 PQRS
In 2011, "Group Practice Reporting Option (GPRO I)" and "GPRO II" were available to group practices. GPRO I consists of 200 or more physicians, and GPRO II consists of two–199 eligible professionals.	In 2012, CMS seeks to eliminate the distinction between GPRO I and GPRO II for group practices. The two groups will instead be consolidated such that a group practice GPRO will consist of 25 or more eligible professionals.
In 2011, CMS allowed for individual measures as well as measure groups to be reported via claims for the six-month reporting period.	In 2012, CMS no longer allows physicians to report the individual measures or measure groups via claims for the six-month reporting period.
In 2011, CMS allowed individual measures and measure groups to be reported via registries during the six-month reporting period.	In 2012, CMS will retain the six-month reporting option for reporting measure groups via registry only. Physicians will no longer be able to use the six-month reporting period to report the individual measures via registry.
In 2011, CMS had one option for the electronic health record (EHR)-based method of reporting PQRS. It required an eligible professional to report at least three PQRS measure for 80 percent of applicable Medicare Part B FFS patients of each eligible professional.	In 2012, CMS has created an additional option for reporting via the EHR-based method of reporting. <ol style="list-style-type: none"> <li>1. The first option is streamlined with the EHR Incentive Program. During the 12-month reporting period, you can report three Core Clinical Quality measures (if any denominators are zero, then you have to do three alternate core) and report three of the 38 additional Clinical Quality Measures for the EHR Incentive Program.</li> <li>2. The second option is the same as the option in 2011. It requires an eligible professional to report at least three PQRS measures (not necessarily core measures) for 80 percent of applicable Medicare Part B FFS patients of each eligible professional. A list of these EHR measures can be found at: <a href="http://www.facs.org/ahp/pqri/2012/ehr-reporting.pdf">http://www.facs.org/ahp/pqri/2012/ehr-reporting.pdf</a>.</li> </ol>

**Table 3. 2012 Measure Specifications Manual (pages 61-62): Measure #21: Perioperative Care: Selection of Prophylactic Antibiotic—First or Second Generation Cephalosporin**

Surgical procedure	CPT code
Integumentary	15734, 15738, 19260, 19271, 19272, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19361, 19364, 19366, 19367, 19368, 19369
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
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
Esophagus	43045, 43100, 43101, 43107, 43108, 43112, 43113, 43116, 43117, 43118, 43121, 43122, 43123, 43124, 43130, 43135, 43300, 43305, 43310, 43312, 43313, 43320, 43325, 43327, 43328, 43330, 43331, 43332, 43333, 43334, 43335, 43336, 43337, 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

*continued on next page*

Source: CMS 2012 PQRS Measure Specifications Manual, available at [http://www.cms.gov/PQRI/15\\_MeasuresCodes.asp#TopOfPage](http://www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage).

adjustment or penalty. Table 1, page 6, summarizes the payments during these years.

### What are some of the differences between the requirements in the 2011 PQRS and the 2012 PQRS?

In the Medicare physician fee schedule final rule for calendar year (CY) 2012, released on November 1, 2011, CMS finalized several changes to the PQRS for 2012. Major program changes are highlighted in Table 2, page 6.

It is important to note that 2012 PQRS includes 210 individual quality measures and 22 measures that are part of a 2012 measures group. For a copy of the 2012 PQRS measure list, visit [https://www.cms.gov/PQRS/Downloads/2012\\_PhysQualRptg\\_ImplementationGuide\\_MeasuresList\\_12152011.zip](https://www.cms.gov/PQRS/Downloads/2012_PhysQualRptg_ImplementationGuide_MeasuresList_12152011.zip) and click on “measures list.” Whereas 2011 PQRS quality measures may be continued in the 2012 PQRS, measures speci-

fications may have been updated for the new program year. Surgeons who are not currently reporting in the 2011 PQRS should review the *2012 PQRS Measure Specifications Manual* for updates and changes.

### How do I use the measure specifications manual?

The first step for implementing PQRS in your office is to use the *2012 PQRS Measure Specifications Manual* to identify measures applicable for professional services that your practice routinely provides. Next, select those measures that make sense based on prevalence and volume in your practice, as well as your individual or practice performance analysis and improvement priorities. The *2012 PQRS Measure Specifications Manual* can be found at [http://www.cms.gov/PQRI/15\\_MeasuresCodes.asp#TopOfPage](http://www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage).

This article outlines the process of claims-based reporting for PQRS 2012—in this case, perioperative measure

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**Table 3. 2012 Measure Specifications Manual (pages 61-62): Measure #21: Perioperative Care: Selection of Prophylactic Antibiotic—First or Second Generation Cephalosporin**

Surgical procedure	CPT code
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
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
General thoracic surgery	0236T, 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, 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

Source: CMS 2012 PQRS Measure Specifications Manual, available at [http://www.cms.gov/PQRI/15\\_MeasuresCodes.asp#TopOfPage](http://www.cms.gov/PQRI/15_MeasuresCodes.asp#TopOfPage).

## #21: Perioperative Care: Selection of Prophylactic Antibiotic—First or Second Generation Cephalosporin.

### What is the description of the measure?

The specifications describe measure #21 as “Percentage of surgical patients aged 18 years and older 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.” This narrative gives a high-level description of measure #21.

### What are the instructions?

The instructions explain when the measure should be reported and who should report it. According to the instructions, measure #21 should be reported “each time a procedure is performed during the reporting period for patients who undergo surgi-

cal procedures with the indications for a first or second generation cephalosporin prophylactic antibiotic.” The instructions further state that “there is no diagnosis associated with this measure.” The instructions additionally 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.

### What is the “frequency?”

The frequency refers to how often the measure should be reported. Measure #21 should be reported each time an applicable procedure is performed during the reporting period.

### How do I report measure #21 via claims?

The measure specifications for measure #21 indi-

*continued on page 10*

**Reporting PQRI Quality Data to CMS**  
**Example Claim Form**

Developed by the  
**AMERICAN COLLEGE OF SURGEONS**

**1500**  
**HEALTH INSURANCE CLAIM FORM**  
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE  MEDICAID  TRICARE  CHAMPVA  GROUP HEALTH PLAN  FECA ELIG LUNG  OTHER  2. PATIENT'S NAME (Last Name, First Name, Middle Initial) 3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M F) 4. INSURED'S NAME (Last Name, First Name, Middle Initial) 5. PATIENT'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code) 6. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other) 7. INSURED'S ADDRESS (No., Street) CITY STATE ZIP CODE TELEPHONE (include Area Code) 8. PATIENT STATUS (Single Married Other) EMPLOYED (Employed Full-Time Student Part-Time Student) 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) 10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) b. AUTO ACCIDENT? c. OTHER ACCIDENT? 11. INSURED'S POLICY GROUP OR REGA NUMBER 12. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M F) 13. EMPLOYER'S NAME OR SCHOOL NAME 14. INSURANCE PLAN NAME OR PROGRAM NAME 15. IS THERE ANOTHER HEALTH BENEFIT PLAN? 16. INSUREE'S OR AUTHORIZED PERSON'S SIGNATURE (authorizes payment of medical benefits to the undersigned physician or supplier for services described below.) 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES 19. RESERVED FOR LOG 20. OUTSIDE LAB? 21. ICD-9 Code 22. MEDICARE RESUBMISSION CODE 23. AUTHORIZATION NUMBER 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG OPT/PCS D. PROCEDURES, SERVICES, OR SUPPLIES (Obtain Unusual Circumstances Modifier) E. ICD-9-CM Diagnosis Code F. CHARGES G. DAYS OF UNITS H. RESULT Fee/Qual I. ID. QUAL J. RENDERING PROVIDER ID. # 25. FEDERAL TAX ID. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH#

**ICD-9 Code** 152.2  
**Procedure Code** 44120  
**CPT II Codes** 4047F, 4041F 1P, 4049F, 4046F, 4044F

1. 07 10 21 44120 1 1100.00 NPI 9876543120  
 2. 07 10 21 4047F 1 0.00 NPI 9876543120  
 3. 07 10 21 4041F 1P 1 0.00 NPI 9876543120  
 4. 07 10 21 4049F 1 0.00 NPI 9876543120  
 5. 07 10 21 4046F 1 0.00 NPI 9876543120  
 6. 07 10 21 4044F 1 0.00 NPI 9876543120

25. FEDERAL TAX ID. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? 28. TOTAL CHARGE 29. AMOUNT PAID 30. BALANCE DUE  
 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE OR CREDENTIALS 32. SERVICE FACILITY LOCATION INFORMATION 33. BILLING PROVIDER INFO & PH#

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**Table 4. PQRS 2012 Reporting options matrix**

		Claims-based methods	Registry-based methods	EHR-based methods
Full-year period	Individual measures	1. At least three PQRI measures (one–two if less than three apply), for 50 percent of applicable Medicare Part B FFS patients of each eligible professional	4. At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional	8. A. During the 12-month reporting period, you can report three core measures (if any denominators are zero, then you have to do three alternate core) and report three out of the 38 additional measures for the EHR Incentive Program or B. At least three PQRI measures for 80 percent of applicable Medicare Part B FFS patients of each eligible professional
	Measures groups	2. One measures group for at least 30 Medicare Part B FFS patients 3. One measures group for 50 percent of applicable Medicare Part B FFS patients of each eligible professional (at least 15 patients during reporting period)	5. One measures group for at least 30 Medicare Part B FFS patients 6. 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)	Not applicable
Half-year period	Individual measures	Not applicable	Not applicable	Not applicable
	Measures groups	Not applicable	7. 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)	Not applicable

cate that it is a claims and registry measure, meaning it can be reported using either the claims-based *or* the registry-based method. This article looks at the claims-based method only. The Current Procedural Terminology (CPT)\* codes and patient demographics identify the patients who are included in measure #21, otherwise known as the denominator. Beginning on page 61 of the *2012 PQRS 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 3, pages 7–8). It is important to review the CPT codes associated with each measure reported. Also, please note that the included proce-

\*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2011 American Medical Association. All rights reserved.

dures codes may change from year to year, so review the 2012 measure specifications before beginning to report for this year.

**I’ve identified a patient in the denominator for measure #21; now what?**

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 #21, there are three choices: 4041F, 4041F with 1P, and 4041F with 8P. 4041F indicates documentation of order for cefazolin or cefuroxime for antimicrobial prophylaxis (written order, verbal order, or standing order/protocol); 4041F with 1P modifier indicates order for first or second generation cephalosporin not ordered for medical reasons; and 4041F with

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8P modifier indicates order for first or second generation cephalosporin not ordered, reason not specified. Please note that both the CPT code and the appropriate CPT II code should be submitted on the same claim form.

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### Can you provide a step-by-step overview of the process for submitting a claim form?

CPT II codes can be reported on claim form CMS 1500 or via electronic form ASC X12N 837. The Figure on page 9 is an example of the CMS 1500 claim form.

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

*Step 1:* Look in the measure specifications for measure #21 to see if this procedure, 44120, is listed in the table of surgical procedures for which there are indications for a first or second generation cephalosporin prophylactic antibiotic. 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 4041F with 1P is listed, which indicates the order for first or second generation cephalosporin not ordered for medical reasons. Note that the CPT II code may be one of three options, as discussed earlier in this article.


*Step 4:* Lines 3 through 6 are CPT II codes that correspond to other PQRS measures (#20, #22, and #23). Measures #20, #22, and #23 are often reported by eligible professionals when measure #21 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 PQRS CPT II codes or 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 PQRS 2012 to receive incentive payments. There are various ways to report for PQRS, 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 4 on page 10 is a matrix that lists all six options for reporting in PQRI 2012.

For more background information regarding the PQRS program, go to <http://www.cms.hhs.gov/pqrs/> and access the resources posted at <http://www.facs.org/ahp/pqri/index.html>. If you have any further questions regarding PQRS, contact Sana Gokak at [sgokak@facs.org](mailto:sgokak@facs.org). 

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