Pay for Participation in Medicare's Physician Quality Reporting Initiative

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Anesthesiologists who participate in Medicare's Physician Quality Reporting Initiative (PQRI) will be eligible for a 1.5-percent bonus based on the total dollar amount of their claims submitted to Medicare during the second half of 2007. This is tantamount to a 1.5-percent increase in the conversion factors for both anesthesia and for all other services for the period July 1 through December 31. To place the potential bonus in context, consider that the average annual change in the anesthesia conversion factor since 1992, the first year in which the Physician Fee Schedule was implemented, is a 1.5-percent increase.

This column will discuss the PQRI conditions for earning the bonus and the origins and significance of the program. The most important points are:

1. To participate, physicians must begin reporting the PQRI measures, using specific codes on their Medicare claim forms, on July 1.
2. Feedback reports are confidential.
3. The program is strictly voluntary. The only penalty for not reporting is the loss of the opportunity to earn the bonus.
4. Centers for Medicare & Medicaid Services (CMS) only published specifications for the measures in April. ASA members should make sure that they check www.ASAhq.org, www.cms.hhs.gov/pqri and their own carriers' Web sites frequently as more PQRI information comes out.

Eligibility for the Bonus

All physicians and certain allied health professionals will be eligible to participate in the PQRI, whether they participate with Medicare or not. No preregistration is necessary. Submitting one's first claim containing PQRI codes will trigger participation. To earn the bonus, anesthesiologists will report each measure by submitting the specified quality-data codes on all Medicare claims to which the measure applies. As long as the anesthesiologist reports each applicable measure on at least 80 percent of the claims for the cases in which that measure could have been performed and reported, he or she will qualify for the bonus.

What Are the Applicable Measures?

For the 2007 reporting period, there is only one measure that is clearly intended for anesthesiologists (and which would probably not have been included but for the considerable efforts of Alexander A. Hannenberg, M.D., Vice-President for Professional Affairs, and other ASA representatives): the timely administration of antibiotic prophylaxis to surgical patients. In order to be part of the initial set of 74 measures that CMS had adopted for the PQRI as of January, the antibiotic prophylaxis measure had to pass muster with the American Medical Association Physician Consortium for Performance Improvement and also with the Ambulatory Quality Alliance (see the December 2006 issue of the *ASA NEWSLETTER* for explanations of the role of these organizations). Although the third major entity whose endorsement is theoretically necessary, the National Quality Forum, has not yet approved a physician-level antibiotic measure, it seems certain that the PQRI will be receiving data on the measure described on its official list thus:

30. Perioperative Care: Timing of Prophylactic Antibiotic — Administering Physician Description

Percentage of surgical patients aged 18 years and older who have an order for a 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) for whom administration of prophylactic antibiotic has been initiated within one hour (if fluoroquinolone or vancomycin, two hours) prior to the surgical incision (or start of procedure when no incision is required)

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Many anesthesiologists are assuming the responsibility for the preoperative administration of beta-blockers to coronary artery bypass graft (CABG) patients, and there is also a PQRI measure for this service. The PQRI list contains a number of other measures that are so general as to be potentially applicable to all physicians; for example, screening patients over age 65 for fall risks.

The whole panoply of measures is important because physicians must report on at least three measures 80 percent of the time in order to obtain the bonus, unless fewer than three are applicable. CMS does not yet have an answer to the question whether the beta blockade, fall screening or any other measures are "applicable" to anesthesiologists. Among the answers to the frequently asked questions on the PQRI Web site is the following: The December 2006 Medicare legislation that created the PQRI, the Tax Relief and Health Care Act of 2006 (TRHCA, pronounced "Trisha") "requires CMS to validate, using sampling or other means, whether quality measures applicable to covered services of a participating eligible professional have been reported. We plan to focus on situations where eligible professionals have successfully reported fewer than three quality measures." A lot will depend on the methods of sampling and validation.

Mechanics of Reporting

CMS deserves credit for having made reporting performance of the PQRI measures as simple as possible. The PQRI grew out of the 2006 Physician Voluntary Reporting Program under which a small number of physicians opted to report on a set of 16 initial measures without a financial incentive. Both are based on including performance codes on the claim submitted to Medicare.

Like other performance reporting systems, the PQRI measures consist of a numerator and a denominator that permit the calculation of the proportion of a given patient population that receives a particular intervention or experiences a particular outcome over a stated period of time. The PQRI numerator consists of a new quality process code adopted by the Current Procedural Terminology (CPT™) Editorial Panel ("Category II" codes) or, if there is no CPT-II code, by CMS ("HCPCS" codes). These codes all have five digits, consistent with the CPT™ and CMS models.

If the particular intervention is not performed, anesthesiologists and others should nevertheless report the appropriate CPT-II and HCPCS codes on the claim. Remember that the PQRI is about *reporting* not about achieving clinical perfection. Two-digit modifiers appended to the numerator code allow the physician to report that the intervention was not performed, i.e., documented, for either a specific or a "not otherwise specified" (NOS) reason. Table 1 below displays the structure of PQRI measures.

The PQRI codes are to be entered on the claim like any other CPT procedure code, except that the submitted charge must be "$0.00."

Table 1: Structure of Measures in the PQRI

Measure	Numerator	Modifier excluding this case from the denominator *(as appropriate)*	Denominator
All	CPT-II or HCPCS code	1-P: exclude for medical reason 2-P: exclude for patient reason 3-P: exclude for systems reason 8-P: exclude for reason NOS	ICD-9 and/or CPT code(s)
#30: Perioperative Care: Timing of Prophylactic Antibiotic — Administering Physician	CPT-II 4048F Documentation that prophylactic antibiotic was given within 1 hour (if fluoroquinolone or vancomycin, 2 hours) prior to surgical incision (or start of procedure when no incision is required)	8-P: Antibiotic was *not* given within 1-2 hours…, reason not otherwise specified *(There are no recognized exclusions based on medical, patient or systems reasons)*	CPT-II 4047F Documentation of order for prophylactic antibiotics to be given within 1-2 hours….
#44: Pre-Operative Beta-blocker in Patients with Isolated Coronary Artery Bypass Graft (CABG) Surgery	CPT-II 4115F Beta-blocker administered within 24 hours prior to surgery	1-P: Documentation of medical reason(s) for not administering beta-blocker within 24 hours… *— or —* 8-P: Beta blocker *not* administered within 24 hours prior to surgical incision, reason not otherwise specified	CPT procedure codes for CABG surgery 33510-33514, 33516, 33533-33536

Attribution — Who Reports and Who Gets Paid?

The individual anesthesiologist who performs the intervention, i.e., who ensures the timely administration of prophylactic antibiotics, reports the PQRI codes (4048F and 4047F) on the claim submitted under his or her name and National Provider Number (NPI). CMS will analyze whether the 80-percent threshold has been met at the individual clinician level.

Consistent with the primary objective of the PQRI program, which is to accustom health professionals to reporting quality and performance measures, if two clinicians participate in the case and both report the PQRI measure on their claim, it will count toward the 80-percent threshold for each of them. Nurse anesthetists who submit their claims independently will thus be able to report applicable measures even if the anesthesiologist does so, too.

The bonus payment will go to the anesthesiology group, or to the individual, or even to the hospital if the hospital employs the anesthesiologist or nurse anesthetist — whoever holds the Taxpayer Identification Number (TIN) that is also entered on the claim. If only one anesthesiologist in a group using a single TIN qualifies for the bonus, the group will still receive the payment. It can then pay the bonus, of course, to the member who earned it or distribute it in any other manner.

There is a statutory cap on the bonus for physicians who report low volumes of cases with a PQRI measure. This cap is unlikely to affect anesthesiologists because, if they choose to participate, the antibiotic prophylaxis measure will be reportable in every surgical procedure for which antibiotics have been ordered. The purpose of the cap is to prevent a physician or other health professional from earning, for example, $3,000 based on total Medicare allowed charges of $200,000 (1.5 percent) for reporting a measure on claims filed for as few as four out of a total of five eligible cases performed between July 1, 2007, and January 1, 2008.

Confidential Feedback

CMS will give confidential feedback reports to participating physicians at about the time that the lump sum bonus payments go out in mid-2008. There will be no interim feedback and no public disclosure.

What Happens in 2008?

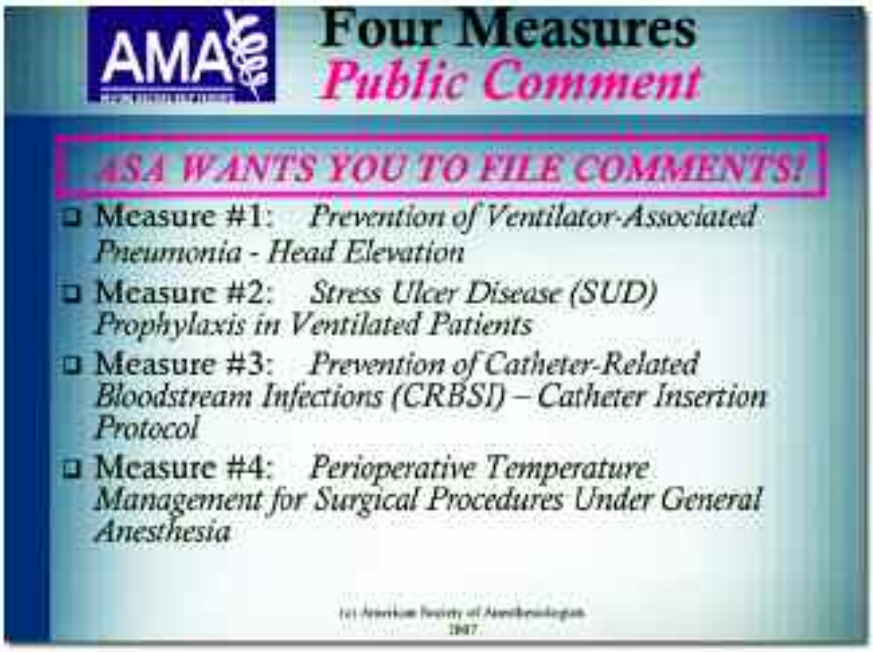
Congress created a quality reporting program for 2007 when it enacted TRHCA. Without additional legislation — and funding — it is not clear whether the PQRI will continue into 2008. CMS expects to be administering the PQRI or a similar program next year, however, and TRHCA does give CMS the discretion to expand measures to include structural measures such as the use of electronic health records and electronic prescribing technology. Proposed measures for 2008 will be published by August 15, 2007, and finalized by November 15, 2007. The law directs CMS to consider the use of medical registry-based reporting.

ASA, in addition to beginning to explore potential registries for reporting by its members, has brought four draft measures for anesthesiologists to the AMA Physician Consortium for Performance Improvement and is working to ensure the adoption of as many as possible. See Figure 1 — and watch the ASA Web site for information on when the Consortium Web site will be ready to receive your comments.

Conclusion: Is the PQRI Going to Be Important to Us?

Yes. CMS sees the PQRI as a first step toward the agency's transformation "from a passive payer of claims to an active purchaser of health care services." As we already know, the objective of CMS and other payers is now *"Value-Based Purchasing,"* and "value" depends on ensuring quality,

Figure 1.



Slide by Karin Bierstein from New Orleans presentation, March 30.

objectively measured and transparent. Performance reporting will be the foundation of incentives and rewards for the improvement and maintenance of quality.

Finally, is the bonus going to be worth it? Take a hypothetical 10-anesthesiologist group providing 1,800 Medicare anesthetics from July through December. Assuming that the average number of cases per unit is 14, because Medicare cases take longer, and that the 80-percent threshold is met, the group will receive a $6,119.82 bonus payment next summer:

Medicare cases	1,800
Average units per case	14
Total allowed units	25,200
National average anesthesia conversion factor	$16.19
Total allowed charges	$ 407,988.00
PQRI Bonus	1.50%
Payment	$6,119.82

The more significant incentive is undoubtedly going to be the professional satisfaction of moving the group's performance up into the highest decile. With a national average rate of 77 percent of surgical patients receiving prophylactic antibiotics within one hour before incision, according to hospital data reported to CMS and published at www.hospitalcompare.hhs.gov, and the top decile performing at the 95-percent level, there is room for improvement in many anesthesiology departments. A study published in the December issue of *Anesthesia & Analgesia* (see Source Material below) shows one hospital's successful strategy.

See page 22 for detailed information on performance measures and the Physician Quality Reporting Initiative.

Source Material:

- PQRI Web site: www.cms.hhs.gov/pqri
- CMS "Medlearn Matters" PQRI paper: www.cms.hhs.gov/mlnmattersarticles/downloads/mm5558.pdf
- To receive e-mail updates on physician issues, including PQRI, individuals can sign up for the Physician Open Door listserve at: www.cms.hhs.gov/apps/mailinglists/default.asp?audience=4
- Hannenberg A, Merrill D. Pay for performance in pain medicine. *ASA Newsletter.* 2006; 70(12): 15-17.
- Bierstein, K. Anesthesiology is in the P4P Game. *ASA Newsletter.* 2006; 70(12): 28-31.
- Kanter G, Connelly NR, Fitzgerald JA. System and Process Redesign to Improve Perioperative Antibiotic Administration. *Anesth Analg.* 2006; 103:1517-1521.