E-Prescribing and the Physician Quality Reporting Initiative: Get in While the Getting Is Good!

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Whether you like it or not, e-prescribing (e-Rx) and the Physician Quality Reporting Initiative (PQRI) are here to stay. And in today's tough economy, why not reap the cash benefits?

What Is PQRI?

PQRI is a system for reporting data on quality measures. According to the Centers for Medicare and Medicaid Services[1] (CMS), "In general, the quality measures consist of a unique denominator (eligible case) and numerator (clinical action) that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome."

Some people incorrectly refer to PQRI as pay-for-performance, but at this stage it really is pay-for-reporting. PQRI is a way to prepare for future pay-for-performance programs. Robert H. Haralson III, MD, MBA, medical director of the American Academy of Orthopaedic Surgeons, states that orthopedists "need to learn how to do this without penalty because quality initiatives are here to stay."

What's in It for Me?

The incentive payment in 2009 is 2% of total Medicare Part B fee-for-service allowed charges for each e-Rx and PQRI. The bonus is on all Part B allowed charges for covered professional services, not just the charges for services for which the measure is reported.

If you participate in both programs, you can earn up to a 4% bonus. And that's per eligible professional, not per practice. For the purposes of the 2009 PQRI, eligible professionals include physicians and nonphysician practitioners (NPPs), as described in section 1842(b)(18)(C) of the Social Security Act—physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists.[2] Think of it this way: If your Medicare allowed charges are $200,000, you can earn up to $8000 in incentive payments—that's eighty-seven 99203 visits or one hundred and thirty-three 99213 visits!

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Get Paid for the Things You Are Already Doing

The Perioperative Care Measures Group (PCMG) is likely the easiest measure for orthopedic surgeons to implement. PCMG is to be reported each time a surgical procedure with the indications for prophylactic antibiotic (including first- or second-generation cephalosporin) and venous thromboembolism (VTE) prophylaxis is performed for patients 18 years old or older.

Several reporting options are available. For PCMG, the "consecutive-patient sample method" is your best bet. You report on a minimum of 30 consecutive Medicare Part B fee-for-service (FFS) patients who meet patient sample criteria for the measures group for the period January 1, 2009–December 31, 2009. Alternatively, there is a July 1, 2009–December 31, 2009 reporting period whereby you report 80% of applicable Medicare Part B FFS patients (with a minimum of 15 patients during the reporting period).

It's Easy on the Doctors

In the PCMG example, the surgeon should not have to do anything he or she isn't already doing—documenting in the medical chart that the order was given (or not given for medical reasons). Dr. Haralson agrees: "No need to audit the chart if it's a routine standing order. There is no additional work for the surgeon."

How to Report

For claim-based submissions, there are G-codes and/or *Current Procedural Terminology (CPT)* level II codes to be reported on each claim as indicated by the particular measure. In the PCMG example, you report G8492 ("I intend to report the Perioperative Care Measures Group") for the first patient. The 30 consecutive patients are counted beginning at this time.

For example, a total hip arthroplasty is performed on a 66-year-old woman. The prophylactic antibiotic is ordered to be given within the specified time frame; cefazolin is ordered; prophylactic antibiotics are given during surgery and are ordered to be discontinued within 24 hours of the end of surgery; and VTE prophylaxis is ordered within the specified time frame. The surgeon dictates the orders for the patient's medical chart.

On the Health Care Financing Administration (HCFA) 1500 claim form, the biller or coder bills *CPT* procedure code 27130, total hip arthroplasty, as usual. On the second

Table I. Additional Resources

Centers for Medicare and Medicaid Services (CMS) Web site
2009 PQRI Implementation Guide http://www.cms.hhs.gov/PQRI/Downloads/2009PQRIImplementationGuide.pdf
2009 PQRI Quality Measure Specifications Manual and 2009 PQRI Measures Group Specifications Manual http://www.cms.hhs.gov/PQRI/15_MeasuresCodes asp#Top Of Page
Getting Started With 2009 PQRI Reporting of Measures Groups http://www.cms.hhs.gov/PQRI/Downloads/GettingStartedwith2009PQRIReportingofMeasuresGroups.pdf
Qualified Registries http://www.cms.hhs.gov/PQRI/Downloads/PQRIQualifiedRegistries.pdf
American Medical Association (AMA) Web site
Data collection sheets and coding specifications for each measures groups http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/participation-tools-measures.shtml
Data collection sheets and coding specifications for each individual measure http://www.ama-assn.org/ama/pub/physician-resources/clinical-practice-improvement/clinical-quality/participation-tools-individual.shtml
American Academy of Orthopaedic Surgeons (AAOS) Web site
PQRI information related to orthopedics http://www.aaos.org/research/committee/evidence/pqri_info.asp

Abbreviation: PQRI, Physician Quality Reporting Initiative.

line of the form, she reports G8492 ("I intend to report the Perioperative Care Measures Group") with $0.00 as the charge amount. On the third line, she reports G8501 ("All quality actions for the patient have been performed for each of the four measures in the Perioperative Care Measures Group") with $0.00 as the charge amount (see Figure 1).

Alternative Reporting Option

Another reporting option is "registry based." With this method, a practice reports its data through a certified registry (for a list of certified registries, visit the CMS Web site; also see Table I). There is a nominal fee associated with this method, but, as Marilyn Orr, MBA, CMPE, executive director of Beacon Orthopaedics and Sports Medicine in Cincinnati, Ohio, points out, the fee is well worth it. She uses www.outcome.com and chose this method because of the "minimal work involved." The registry-based method is a one-time reporting method. Beacon Orthopaedics uses electronic medical records (EMR) software, and it is easy to query the data at the end of the year and upload it to the registry. Another benefit of using this reporting method is that the 30 consecutive patients may include non–Medicare Part B fee-for-service patients. For PCMG, the patient must be at least 18 years old. Ms. Orr says that the "registry option also is a virtual guarantee of successful participation because you can perform [quality assurance] on your data prior to submission to CMS." An EMR is not required to use the registry-based option. Practices may manually enter the data for the measures selected into the registry.

But What If I Don't Have EMR?

You don't have to have EMR to participate in PQRI. Front-desk staff can identify Medicare patients and attach a PQRI worksheet (see Table I, American Medical Association [AMA] data collection sheets). Or, better yet, redesign your charge ticket to include the PQRI data. Your billers and/or coders play an instrumental role in ensuring that PQRI measures are reported on the applicable Medicare patients.

Nonsurgical Measures

Several nonsurgical measures are reported on as individual measures. Practices that choose individual measures must report on a minimum of 3 measures for at least 80% of their Medicare Part B fee-for-service patients. Given that 2009 is nearly half over, it is advised to wait until 2010 to begin reporting individual measures via claims-based reporting. However, registry-based reporting is available July 1, 2009–December 31, 2009; you must report on a minimum of 3 measures for at least 80% of your Medicare Part B fee-for-service patients.

Individual measures include:

- Inquiry regarding tobacco use
- Documentation and verification of current medications in the medical record
- Falls (risk assessment, plan of care)
- Osteoporosis: communication with the physician managing on-going care post-fracture
- Screening or therapy for osteoporosis for women aged 65 years and older
- Osteoporosis: management following fracture
- Back pain (initial visit, physical examination, advice for normal activities, advice against bed rest).

Aren't you already using patient health history forms to ask patients if they smoke? Bingo! You have a PQRI measure that you can report: "inquiry regarding tobacco use." For example, Dr. Bones sees an established patient (99213) for a new injury. The patient is a smoker. The office visit (99213) is billed as usual. On the second line of the claim form, report 1000F ("Tobacco use assessed") with $0.00 as the charge amount. On the third line, report 1034F ("Current tobacco smoker") with $0.00 as the charge amount. Alternatively, if the patient is a nonsmoker, on the third line report 1036F ("Current tobacco nonuser") with $0.00 as the charge amount.

Many practices report on both surgical and nonsurgical measures. Some do it to ensure that they meet the minimum requirements to receive the incentive payments; others do it because they want to demonstrate their commitment to patient quality. Ms. Orr and her physicians are proud that the name of their practice will be listed on the CMS Web site as successfully participating in the PQRI program.

Sign Me Up!

It isn't too late to get started reporting PQRI measures groups for 2009. First, acquaint yourself with all the measures and determine which are applicable to your practice. Visit the

Table II. Denominator Codes

90801, 90802, 90804, 90805, 90806, 90807, 90808, 90809, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245, G0101, G0108, G0109

Table III. Numerator Codes

G8443	ALL prescriptions generated for this patient during this visit were sent via a qualified e-prescribing system
G8445	NO prescriptions were generated for this patient during this visit
G8446	SOME or ALL of the prescriptions generated for this patient during this visit were printed or phoned in as required by state or federal law or regulations, due to a patient request, or due to the pharmacy system being unable to receive electronic transmission, OR because they were for narcotics or other controlled substances

CMS and AMA Web sites for a complete listing of measures and their requirements (Table I). AMA-developed worksheets for each measure can be used in your practice. Each measure is associated with a "denominator" code—*CPT* codes clinically applicable to the measure. Ensure that your practice uses these *CPT* codes frequently enough to meet the minimum requirement of the measures you select.

As Vicki Horton, administrator of Spectrum Orthopaedics in Ohio, says, "training is essential." She credits her group's success to the fact that one person at each of its 4 locations takes ownership in the project. Staff receive up-front training on what the program is and why they are participating in it. Spectrum Orthopaedics also has one staff member assigned to perform a prebilling review of all Medicare claims for all possible measures and accuracy.

When Do I Receive the Incentive?

All claims for 2009 must be submitted by February 28, 2010. Eligible professionals who satisfactorily report data in the PQRI should receive their payments mid-2010. Payments are in a lump sum paid to the tax identification number of the practice. However, the PQRI feedback report breaks the payments down by national provider identifier.

E-Prescribing

If you are not e-prescribing by 2013, you will face a 1% cut in your Medicare payments, and cuts will increase each year thereafter. Bonuses are still available: 2% for 2010, 1% for 2011, and 0.5% for 2012. However, beginning in 2011, if you participate in the incentive program under the stimulus bill for using a qualified EMR in a meaningful way, you are ineligible for e-Rx or PQRI incentive bonuses—no double-dipping.

To earn the incentive payment, a practice must have a qualified e-Rx system. Many EMRs have e-Rx capabilities. There are several products; Allscripts offers a free one (visit www.nationalerx.com for more details).

To get started, determine if denominator codes (Table II) make up at least 10% of your total Medicare Part B fee-for-service allowed charges for the year. This may be an issue for some orthopedic practices.

Reporting is similar to PQRI reporting—*CPT* denominator code on line 1 and numerator code (Table III) on line 2 with $0 as the charge.

Qualification for the bonus requires reporting a numerator code on the qualifying denominator code at least 50% of the time.

The incentive is paid for reporting on all applicable claims—not on the number of times a prescription is e-prescribed. For example, a 72-year-old woman presents to Dr. Spine for medical care. She is a returning patient (99213) on follow-up for lumbar spinal stenosis. Her pain is so severe, and she is not a surgical candidate, that Dr. Spine e-prescribes a narcotic for analgesia. Dr. Spine reports G8446 because this prescription must be provided on paper to the pharmacy (see Figure 2).

Payments are made to successful participants in the same manner as PQRI.

Don't Delay—Start Reporting Today

Get paid for the things you are already doing and prepare for the pay-for-performance future. As Ms. Orr states, "you want to have a proactive orthopedic practice rather than a reactive practice."

Author's Disclosure Statement

The author reports no actual or potential conflict of interest in relation to this article.

References

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24. A. DATE(S) OF SERVICE From MM DD	B. PLACE OF SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS		E. DIAGNOSIS POINTER	F. $ CHARGES	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 14	24	27130	Total hip arthroplasty	1	3930 00	NPI	0123456789
2 09 14	24	G8492	I intend to report the Perioperative Care Measures Group (report only the first time)	1	0 00	NPI	0123456789
3 09 14	24	G8501	All quality actions for the patient have been performed for each of the four measures in the Perioperative Care Measures Group	1	0 00	NPI	0123456789

Figure 1. Sample claim form reporting Physician Quality Reporting Initiative for Perioperative Care Measures Group using claims-based reporting.

24. A. DATE(S) OF SERVICE From MM DD	B. PLACE OF SERVICE	D. PROCEDURES, SERVICES, OR SUPPLIES CPT/HCPCS		E. DIAGNOSIS POINTER	F. $ CHARGES	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 14	11	99213	Office visit	1	125 00	NPI	0123456789
2 09 14	11	G8446	The prescriptions generated for this patient during this visit were printed because they were for narcotics		0 00	NPI	0123456789

Figure 2. Sample claim form reporting e-prescribing.