Want a bonus check? CMS has a program for you

By fulfilling selected quality measures, you can garner an additional 1.5% of your total Medicare earnings

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The Centers for Medicare and Medicaid Services (CMS) launched its Physician Quality Reporting Initiative (PQRI) July 1. This program, voluntary in 2007, rewards physicians for reporting a designated set of quality measures. Physicians who successfully report these measures under established criteria earn a bonus payment, subject to a cap, of 1.5% of their total allowed charges for covered services paid under the Medicare physician fee schedule.

Quality measures are reported on the CMS claim form just as any other service would be, except that no charge is billed for the reported measure. The time frame established for the reporting of these measures is July 1 through December 31 of this year. Although there are plans to continue the program in 2008, it is unclear whether funds will be available for a bonus in 2009, and the measures for 2008 will be different from those used in 2007.

To calculate the potential bonus amount when at least 3 measures are successfully reported, use your total Medicare income for the past 6 months. If you received $60,000 for treating Medicare patients from January 1 through May 31, for example, and Medicare income has been steady, expect a lump sum bonus of $900 in mid-2008.

How do I report an intervention?

Good news: You do not have to register to participate in PQRI; you need only report the selected quality measures each time you submit a claim for the patient service to which the quality measure applies. Criteria for reporting (and then receiving the bonus in mid-2008) for these quality measures are as follows:

- Select the quality measures that apply most often to your practice (see the **TABLE** on pages 82 and 83)
  - If no more than 3 quality measures are applicable to services you provide, each measure must be reported in at least 80% of the cases in which the measure is reportable
  - If 4 or more measures are applicable, the 80% threshold must be met on at least 3 of the measures you report
- Enter the PQRI codes on block 24D of the CMS 1500 claim form with a $0.00 dollar amount; if your system does not allow this amount to be entered, change it to $0.01
- There must be a match between the acceptable CPT or ICD-9 code reported for the overall service with a CPT Category II or HCPCS "G" code designated as the quality measure, as listed in the Medicare specifications file (www.cms.hhs.gov/PQRI/15_MeasuresCodes.asp#TopOfPage)

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***FAST** TRACK*

You do not have to register to participate in PQRI, just report the selected quality measures

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FAST TRACK

Among the measures that may apply to ObGyn practice are the timing and selection of antibiotic prophylaxis in surgical patients

TABLE

The Physician Quality Reporting Initiative: 10 measures may apply to ObGyn practice in 2007

MEASURE	CONSTRAINTS AND COMMENTS
#20 Perioperative care: Timing of antibiotic prophylaxis—ordering physician	• Documentation in medical record that drug was ordered or given 1–2 hours prior to surgery • CPT codes applicable to gyn surgery: 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294 • CPT II codes: 4047F or 4048F • Allowed modifiers: 1P and 8P
#21 Perioperative care: Selection of prophylactic antibiotic—first- or second-generation cephalosporin	• Documentation in medical record that cefazolin or cefuroxime was ordered or given • CPT codes applicable to gyn surgery: 49000, 49002, 49010, 49180, 49200, 49201, 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294 • CPT II codes: 4041F • Allowed modifiers: 1P and 8P
#22 Perioperative care: Discontinuation of prophylactic antibiotic (non-cardiac procedures)	• Documentation of an order for or evidence of discontinuation of prophylactic antibiotics within 24 hours of surgical end time, or specification of an antibiotic to be given in doses within that 24-hour period • CPT codes applicable to gyn surgery: 58150, 58152, 58180, 58200, 58210, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294 • CPT II codes: 4049F and 4946F • Allowed modifiers: 1P and 8P
#23 Perioperative care: venous thromboembolism prophylaxis (when indicated in all patients)	• Documentation in medical record of 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 • CPT codes applicable to gyn surgery: 49000, 49002, 49010, 49020, 49040, 49060, 49200, 49201, 56630, 56631, 56632, 56633, 56634, 56637, 56640, 58200, 58210, 58240, 58285, 58951, 58953, 58954, 58956 • CPT II codes: 4044F • Allowed modifiers: 1P and 8P
#39 Screening or therapy for osteoporosis for women 65 years and older	• Documentation of an order for or performance of (with recorded results) a central dual-energy x-ray absorptiometry measurement performed at least once since age 60, or pharmacologic therapy prescribed within 12 months. Drugs include bisphosphonates, calcitonin, estrogens, parathyroid hormone, and selective estrogen receptor modulators • Applicable E/M codes: 99201–99205, 99212–99215, 99387, 99397, 99401–99404 • CPT II codes: 3096F, 3095F, or 4005F • Allowed modifiers: 1P, 2P, 3P, 8P

TABLE CONTINUED

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The Physician Quality Reporting Initiative: 10 measures may apply to ObGyn practice in 2007

MEASURE	CONSTRAINTS AND COMMENTS
#41 Osteoporosis: Pharmacotherapy	• Documentation that the patient was prescribed pharmacologic therapy within 12 months. Applicable drugs are as listed in measure #39 above. • Applicable E/M codes: 99201–99205, 99212–99215, 99241, 99242, 99243, 99244, 99245, 99386–99387, 99396–99397, 99401–99404 **PLUS** • ICD-9-CM diagnosis codes: 733.00, 733.01, 733.02, 733.03, 733.09 • CPT II codes: 4005F • Allowed modifiers: 1P, 2P, 3P, 8P
#42 Osteoporosis: Counseling for vitamin D and calcium intake, and exercise	• Documentation that the patient either is receiving both calcium and vitamin D or has been counseled for both calcium and vitamin D intake, and exercise at least once within 12 months • Applicable E/M codes: 99201–99205, 99212–99215, 99241–99245, 99385–99387, 99395–99397, 99401–99404 **PLUS** • ICD-9-CM diagnosis codes: 733.00, 733.01, 733.02, 733.03, 733.09 • CPT II codes: 4019F • Allowed modifiers: 1P and 8P
#48 Assessment of presence or absence of urinary incontinence in women aged 65 years and older	• Documentation that patient was assessed for the presence or absence of urinary incontinence within 12 months • Applicable E/M codes: 99201–99205, 99212–99215, 99387, 99397, 99401–99402 • CPT II codes: 1090F • Allowed modifiers: 1P and 8P
#49 Characterization of urinary incontinence in women aged 65 years and older	• Documentation of frequency, volume, timing, type of symptoms, and how bothersome to the patient at least once within 12 months • Applicable E/M codes: 99201–99205, 99212–99215, 99241–99245, 99387, 99397, 99401–99402 **PLUS** • ICD-9-CM diagnosis codes: 307.6, 625.6, 788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 • CPT II codes: 1091F • Allowed modifiers: 8P
#50 Plan of care for urinary incontinence in women aged 65 years and older	• Documentation that a plan of care for urinary incontinence was formulated at least once within 12 months • Applicable E/M codes: 99201–99205, 99212–99215, 99241–99245, 99387, 99397, 99401–99402 **PLUS** • ICD-9-CM diagnosis codes: 307.6, 625.6, 788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.38, 788.39 • CPT II codes: 0509F • Allowed modifiers: 8P

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To report pharmacotherapy for osteoporosis, document prescription of the specific drug within the past 12 months

- Apply any applicable allowed modifier that explains why the quality measure was not assessed:
  - 1P for medical reasons (eg, the patient was already assessed, measure is contraindicated)
  - 2P for patient reasons (eg, patient declined, social or religious reasons)
  - 3P for system reasons (eg, resources to perform not available, insurance coverage/payer-related limitation)
  - 8P for reason not specified

The measure specifications are organized to provide specific information:

- Measure title
- Description
- Instructions on reporting, including frequency, time frames, and applicability
- Numerator coding
- Definition of terms
- Coding instructions

For example: Measure 48 documents the percentage of female patients age 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months. The denominator for this measure is represented by the reported evaluation and management (E/M) service approved for this measure (ie, 99201–99205 [new patient E/M service], 99212–99215 [established patient E/M service], 99241–99245 [outpatient consultation], 99387 [preventive new patient service], 99397 [preventive established patient service], 99401–99404 [preventive counseling visits]), along with the information on the claim that indicates the patient's age and sex.

The numerator part of the measure is represented by a CPT Category II code with or without a modifier. CPT code 1090F (presence or absence of urinary stress incontinence assessed) would be reported if the presence or absence of urinary incontinence was assessed, but a modifier 1P is placed in box 24E of the claim form if you have documented a medical reason why this was not assessed, or modifier 8P if it was not assessed but the reason was not documented. ■

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