

**ASTS Primer on Incentive Payments
Physician Quality Reporting System (PQRS) for Transplant Surgeons
2012 Update**

Dear Colleagues,

Below, please find the updated, 2012 ASTS primer on incentive payments available through the Physician Quality Reporting System (PQRS). In 2010, in an effort to facilitate transplant surgeons participation in PQRI (now termed PQRS), the ASTS Council approved the original guide on how transplant surgeons can join, the measures specific to transplant surgeons, and the worksheets and necessary coding information for billing. The following updated primer conveys information about PQRS in 2012.

In 2012, participating surgeons can receive a bonus of 0.5% of their total Medicare Part B Physician Fee Schedule and payment is for reporting not for performance. Those who may be concerned about the potential for public reporting of personal outcomes might keep in mind that at this point most PQRS measures are process rather than outcome measures, and CMS is considering several other groups' requests that results be attributed to the multidisciplinary team rather than the individual.

A new feature for this 2012 primer, found at the end, is a sample surgery billing form to facilitate PQRS reporting. The form is designed for internal use rather than for submission to CMS. One form is used for each individual surgery. The front page includes many CPT procedures and modifiers that transplant surgeons use – other CPTs could be added as needed to suit individual surgeons' needs (i.e. vascular access codes). The front page also includes the PQRS modifiers and on the back page there is a list of each CPT procedure and which of the four perioperative PQRS modifiers apply to each procedure. This back page is for reference to help fill the front page – nothing gets marked on the back page. There is a space on the front page to add the ICD 9 diagnosis code/s as well.

We hope that you consider joining PQRS and thereby increase your revenue and contribute to a national quality improvement initiative. By joining now, you will also be prepared when PQRS, which is currently voluntary, becomes obligatory as CMS moves to value-based purchasing and performance-based payment.

The Standards Committee is also developing transplant-related performance measures, working to facilitate registry use for PQRS reporting, and engaging with the ACS and AMA to keep abreast of quality initiatives as they relate to P4P and MOC.

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Physician Quality Reporting System (PQRS) for Transplant Surgeons 2012 Update

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Background:

In March 2007, CMS established the Physician Quality Reporting System (PQRS) as a voluntary program wherein physicians report their practice data in relation to specific performance measures. This is likely to become a precursor to a mandatory “pay-for-performance” program which may come in the ensuing years.

In the PQRS program, physicians who choose to join must report on three quality measures (one or two if less than three apply) on their Medicare Claim Forms for at least 50% of applicable procedures. Satisfactory reporting of data will result in an incentive payment (currently 0.5%) of the physicians estimated total Medicare Part B Physician Fee Schedule.

What Are The Quality Measures?

The total number of quality measures has continued to increase, and there are over 215 measures listed.

There are currently at least 4 measures which are applicable to surgical cases:

1. Measure# 20 – Perioperative Care: Timing of Antibiotic Prophylaxis
2. Measure #21 – Perioperative Care: Selection of Prophylactic Antibiotic – first or Second Generation Cephalosporin
3. Measure #22 – Perioperative Care: Discontinuation of Perioperative Antibiotic (non cardiac procedures)
4. Measure #23 – Perioperative Care: Venous Thromboembolism (VTE) prophylaxis

How Do I Code For Measures?

Each measure is given a code (CPT II code or G code), which must be entered after the CPT code of the procedure on Medicare 1500 Claim Form. To report the measures, physicians should append the appropriate code to the CMS 1500 form used to report the service for which the measures are appropriate. For example, if you are reporting the antibiotic or thromboembolic prophylactic measures, you should append the CPT level II to the CMS 1500 form used to report the procedure.

If a specific measure could not be implemented, for medical or other reasons, there are modifiers that can be attached to the G codes. These modifiers will prevent those procedures from counting against the total count (remember, 50% of all applicable procedures must have proper coding!).

A sample claim form can be found at
<http://www.facs.org/ahp/pqri/2010/acscclaimform.pdf>

What Commonly Performed Transplant Cases Qualify For PQRS Measures?

Each of the four listed measures applies to renal and pancreas transplant and many hepatobiliary surgeries, but only measures 20 and 23 apply to liver transplant:

1. Measure #20 - Timing of Antibiotic Prophylaxis

Liver -liver transplant, living donor hepatectomy
Kidney -kidney transplant, open donor nephrectomy, recipient native nephrectomy, transplant nephrectomy
Pancreas -pancreas transplant, transplant pancreatectomy

2. Measure #21 - Selection of Prophylactic Antibiotic

Kidney -kidney transplant, open donor nephrectomy, recipient native nephrectomy, transplant nephrectomy
Pancreas -pancreas transplant, transplant pancreatectomy

3. Measure #22 - Discontinuation of Prophylactic Antibiotic

Kidney -kidney transplant, open donor nephrectomy, recipient native nephrectomy, transplant nephrectomy
Pancreas -pancreas transplant, transplant pancreatectomy

4. Measure #23 - VTE Prophylaxis

Liver -liver transplant, living donor hepatectomy
Kidney -kidney transplant, open donor nephrectomy, recipient native nephrectomy, transplant nephrectomy
Pancreas -pancreas transplant, transplant pancreatectomy

What Are The Specific Codes For Individual Measures?

1. Measure #20 – Perioperative Care: Timing of Antibiotic Prophylaxis

Patients 18 years and older undergoing procedures that require parenteral antibiotics

- must have an order on their medical record stating antibiotic to be given within an hour (if flouoroquinolone or vancomycin, two hours), prior to surgical incision or start of surgical procedure **(G8629)**

OR

- must have documentation that prophylactic antibiotic was given within an hour of start of procedure **(G8630)**

- Note that either code may be reported to claim this measure

Measure# 20 Modifiers (Antibiotic Not Ordered):

- order for prophylactic antibiotic not given with clinical documentation of reason (**G8631**)
- order for antibiotic not given, reason not specified (**G8632**)

2. Measure #21 – Perioperative Care: Selection of Prophylactic Antibiotic – First or Second Generation Cephalosporin

Patients 18 years or older undergoing procedures with the indications for a first or second generation cephalosporin prophylactic antibiotic, must have an order for cefazolin or cefuroxime for antibiotic prophylaxis (**G code 4041F**)

Measure #21 Modifiers (Antibiotic Not Given):

- documentation of medical reason for not using cephalosporins (**Add modifier 1P to 4041F**)
- cephalosporin's not used for prophylaxis, reason not specified (**Add modifier 8P to 4041F**)

3. Measure #22 – Perioperative Care: Discontinuation of Prophylactic Antibiotic

Patients 18 years and older undergoing procedures that require parenteral antibiotics and who received them

- must have an order on their medical record for discontinuation of the antibiotic within 24 hours of surgical end time (**G code 4049F**).

AND

- must have documentation that prophylactic antibiotics were given within 4 hours prior to incision or given intraoperatively (**G code 4046F**)
- Note that both codes need to be reported to claim this measure

Measure #22 Modifiers (Antibiotics Not Discontinued):

- order for discontinuation not done with documentation of medical reason (**Add modifier 1P to 4049F**)
- order for discontinuation not done with no reason specified (**Add modifier 8P to 4049F**)
- documentation that prophylactic antibiotics were neither given within 4 hours of procedure or intraoperatively (**modifier 4042F**)

4. Measure #23 – Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis

Patients 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, must have an order for LMWH, LDUH, 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 (**G code 4044F**)

Measure #23 Modifiers: VTE Prophylaxis Not Ordered:

- VTE prophylaxis not ordered, with documentation of medical reason (**Add modifier 1P to 4044F**)
- VTE prophylaxis not ordered, reason not specified (**Add modifier 8P to 4044F**)

Other Points about Coding Transplant Procedures:

- You must report on 50% of all eligible patients. That means that if you choose to report the thromboembolic prophylaxis measure, you must report on 50% of all the operative procedures on the list of eligible procedures. For example, if you are a kidney transplanter but take emergency call and occasionally do appendectomies, you must report on them too, not just your transplants. Refer to a complete list of procedures applicable to individual codes at www.cms.gov/PQRI.

- If multiple procedures were performed on the patient at the same time, the G codes only need to be reported once on the billing form.

- If co-surgeons operate together on a case, both surgeons need to submit G codes on their respective billing forms. However, if an assistant scrubs in on a case, the assistant does not need to submit G codes.

- Note that for liver transplants, only 2 measures qualify (measures #20 and #23), not the minimum of three. CMS will subject these claims-based submitted quality-data codes to the two-step measure-applicability validation (MAV) process to determine whether you should have submitted quality-data codes for additional measures. Those who fail the validation process will not earn the PQRI incentive payment. For detailed information on the validation process, see the CMS document at www.cms.hhs.gov/PQRI under the "Analysis and Payment" link.

- The above four measures are for surgeries on adults (>18 years old); as yet, there are no measures relevant to pediatric surgical patients.

- At the present time, there are some transplant procedures (including laparoscopic donor nephrectomies) that do not have any measures applicable to them. This may change in the future.

- PQRS provides pay for reporting, not pay for performance. You must only report and document that you ordered an antibiotic to be given within one hour of the operative procedure. You do not have to ensure that it is given.

- In addition to the above claims-based reporting option, it is permissible to report prospectively using a registry that is recognized by CMS for PQRS purposes.

How do I get started?

The first step is to understand the PQRS measures and how to report them. For surgeons this is relatively easy, as there are only four measures that generally apply to perioperative care. Review each of the quality measures you wish to use and determine which of your procedures qualifies for that measure (available on ACS and CMS websites). You need to ensure that you report on at least three measures, using the CPT II codes, and for each measure, that you report on at least 50% of your qualified procedures.

The reporting period for this program is from January 1 to December 31. A previous provision for a six month reporting period has been discontinued. Individual physicians who satisfactorily submit PQRS quality measures data via one of the reporting mechanisms above for services furnished during the 2012 reporting period will qualify to earn an incentive payment of 0.5% of their total allowed Medicare Part B Physician Fee Schedule (PFS) charges for covered professional services furnished during that same reporting period. Bonus payments for reporting in 2012 will be issued in a lump sum, in the following year.

Payments will be made to the holder of the taxpayer identification number (TIN). The data is collected by CMS using the National Provider Identifier (NPI); however, the bonus payment will be made using the Taxpayer Identification Number (TIN). This means that a multi-physician practice that bills under one TIN will have to distribute the bonus to the individual participating physicians.

Further details about the PQRS program for surgeons can be accessed at <http://www.facs.org/ahp/pqri/> or <http://www.cms.hhs.gov/MLNMArticles/downloads/mm6514.pdf>

A sample claim form can be found at <http://www.facs.org/ahp/pqri/2010/acsclaimform.pdf>

A sample surgery billing form to facilitate PQRS reporting is attached. The form is designed for internal use rather than for submission to CMS. One form is used for each individual surgery. The front page includes many CPT procedures and modifiers that transplant surgeons use – other CPTs could be added as needed to suit individual surgeons' needs (i.e. vascular access codes). The front page also includes the PQRS modifiers and on the back page there is a list of each CPT procedure and which of the four perioperative PQRS modifiers apply to each procedure. This back page is for reference to help fill the front page – nothing gets marked on the back page. There is a space on the front page to add the ICD 9 diagnosis code/s as well.

The ASTS thanks the AAOS (American Academy of Orthopaedic Surgeons) for sharing their web copy on PQRS, which was helpful in preparing this PQRS primer.