Results from ASA's 2007 PQRI Participation Study

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Medicare's voluntary Physician Quality Reporting Initiative (PQRI) was instituted in 2007 by the Centers for Medicare & Medicaid Services (CMS). The first reporting period of the PQRI ended on December 31, 2007. The 2008 reporting period will begin on January 1 and conclude on December 31, 2008. PQRI pays physicians for reporting on certain quality measures through the claims process using Current Procedural Terminology® Category II codes. Providers who report relevant PQRI measures on at least 80 percent of eligible cases (patients) will qualify for a 1.5-percent bonus. Payment is made for reporting on the measurement with a quality measure code, whether or not the desired clinical outcome is achieved. The CMS list of 119 PQRI quality measures for 2008 is available at www.cms.hhs.gov/PQRI/Downloads/2008PQRIMeasureSpecs.pdf.

In the following article, we report on three areas concerning PQRI and anesthesia. First, we report the results of a survey of Anesthesia Administration Assembly (AAA) members and whether or not their groups chose to participate in PQRI in 2007. Second, CMS just released its report of participation in PQRI. Finally, we summarize the issues around PQRI in 2008.

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1. PQRI-ASA PQRI Participation Study

Although there is a potential of increased revenue, we were not sure if anesthesiology groups chose to participate in PQRI. We wanted to know, if they did participate, what changes were needed (and how much they cost), and if they did not, why not. To answer these questions, we surveyed anesthesiology groups through the AAA members (part of the Medical Group Management Association, or MGMA).

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Methodology

After a pilot study of the members of the ASA Committee on Economics, AAA members were surveyed via e-mail to respond to a one-page questionnaire consisting of seven questions listed in Table 1.

Table 1: PQRI Survey Questions

1. Is your group participating in the 2007 PQRI program?
2. Why or why not?
3. For groups that participate, please describe the process changes you had to implement in order to capture the required data.
4. How much have these process changes cost your practice?
5. Any other comments you would like to make about the 2007 PQRI program?
6. How many anesthesia providers are in your group?
7. Do you plan on participating in the 2008 PQRI Program?

Results

Sixty-one groups representing 1,744 anesthesiologists returned the survey. The median and mean sizes of the groups were 57 and 41 anesthesiologists, respectively. The groups were comparable; the mean and median size of non-participating groups was 51 and 43 anesthesiologists, while the mean and median size of the PQRI participating groups was 60 and 40 anesthesiologists.

The majority of the surveyed practices, 38 (62 percent), decided to participate in the 2007 PQRI program. Table 2 lists the reasons practices chose to participate. Since practices commonly gave more than one reason per question, percentages are calculated for each response and do not sum to 100 percent. Half of the practices listed increased payment from Medicare as the reason they chose to participate. Almost as frequently, practices reported that they believed PQRI would be required in the future and they wanted to garner experience now. Of the 23 (38 percent) practices that opted not to participate in PQRI, the two most common reasons for not participating were that the return on the cost of implementation was too small and that PQRI seemed too complex to implement [Table 3].

Table 2: Why Practices Participated in PQRI (n=38)

Response	Count	Percent
Payment	19	50%
Will be future requirement	17	45%
Required by hospital	6	16%
Group image with hospital	6	16%
Improve patient care and quality	5	13%
Easy to do	2	5%

Table 3: Why Practices Didn't Participate (n=23)

Response	Count	Percent
Return not worth effort	10	43%
Too complex	8	35%
Too expensive	6	26%
Small gain	4	17%
IT system problem	3	13%
Not interested	3	13%

Most practices that participated in the 2007 PQRI program found that they had to make some changes in existing processes and procedures [Table 4]. Education of the anesthesia providers and changes in the charge capture document were necessary in about a third of practices.

Table 4: Needed Process Changes for PQRI Reporting

Response	Count	Percent
Billing sheet	13	34%
Educate providers	13	34%
O.R. record	10	26%
Billing system/data entry	10	26%
Educate billing staff	7	18%
EMR software changes	2	5%
Administrative costs	1	3%

Of the practices that did participate in 2007, 27 (71 percent) indicated that they would participate in 2008; the other 11 did not provide any indication of their intent for future participation.

Practices reported a range of costs associated with participating in the 2007 PQRI. Most practices reported that the indirect and direct costs of reprinting anesthesia records, changing charge capture, modifying billing software and educating staff and providers to be less than $5,000 for the practice. For groups that did participate and who quantified the cost, the mean cost of reporting PQRI was $2,582 per group, or $42.90 per anesthesiologist. Median costs were $1,980 per group, or $49.50 per anesthesiologist.

Conclusions

The results of the 2007 PQRI survey of anesthesia practices show that PQRI participation was significantly above 60 percent in the surveyed practices. All practices that participated had to make some process changes to capture the required data, with modification of the billing record and education of the anesthesiologists and billing staff being the most common.

2. Interim Participation and Reporting Statistics for 2007 PQRI

On February 29, 2008, CMS released interim participating and reporting statistics for the 2007 PQRI. Data from carrier claims for services provided from July 2007 to November 2007 that were reported by the end of November 2007 were included. Final 2007 statistics will not be available for a few months, since providers had until February 29, 2008, to submit claims for the 2007 program.

Nationally, 99,319 (15.7 percent) physicians and qualified health care providers identified by their TIN/NPI numbers attempted to participate in the 2007 PQRI. Surprisingly, both participation and successful reporting — of *Measure #30: Perioperative Care: Timing of Prophylactic Antibiotics-Administering Physician* — was very high. Of the 18,854 eligible anesthesiologists and anesthetists, 15,270 (81 percent) of eligible providers reported on measure number 30, and 14,433 (94 percent) of them hit the ≥80 percent reporting mark. Furthermore, according to the report, there were 355,372 opportunities to report this measure, and it was reported 344,093 times — *almost 97 percent*. Note that the PQRI participation rate in the ASA survey was only 62 percent.

3. 2008 PQRI — Updates

If you report relevant PQRI measures on at least 80 percent of your eligible cases, you will qualify for the 1.5-percent PQRI bonus. Reporting on three measures is only a requirement if three or more measures are applicable to your practice. If only one or two are applicable, you need only report on 80 percent of your cases on each of those measures. It is important to note that the relevant measures must be structured in such a way that you can report them accurately. The PQRI certainly does not discourage anesthesiologists from providing preoperative beta-blockers, but that measure (number 44) is not structured in such a way that most of you can report it accurately, at least in 2007. Note that if you did report measure number 44 some of the time, not achieving the 80-percent threshold for that measure might disqualify you from receiving the bonus at all even if you report the antibiotic prophylaxis measure 100 percent of the time.

There are three 2007 PQRI codes relevant to anesthesiologists that have had some additional instructions for 2008:

Measure number 30: Perioperative Care: Timing of Prophylactic Antibiotics — Administering Physician

- Clarified the instructions to read as follows: "It is anticipated that clinicians who provide anesthesia care for surgical procedures with an order for prophylactic antibiotics will submit this measure" and added "Only" CPT II codes are to be used.
- Added Numerator Instructions: "This measure seeks to identify the timely administration of prophylactic antibiotic. This administration should begin within one hour (if fluoroquinolone or vancomycin, two hours) prior to surgical incision."

Measure number 75: Prevention of Ventilator-Associated Pneumonia — Head Elevation

- If you report CPT code 99291 critical care, and your patient is receiving mechanical ventilation, then measure number 75 may be reported once for each episode of care. There is no diagnosis associated with this measure.

Measure number 76: Prevention of Catheter-Related Bloodstream Infections (CRBSI) — Central Venous Catheter Insertion Protocol

- This measure is to be reported each time a CVC insertion or replacement is performed during the reporting period. There is no diagnosis associated with this measure.

In addition, a new smoking cessation PQRI code has been added:

Measure number 114: Inquiry Regarding Tobacco Abuse

This measure is to be reported a minimum of once per reporting period for all patients seen during the reporting period. Tobacco use is to be queried at least once within 24 months prior to the date of service. There is no diagnosis associated with this measure. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding. However, because these codes were designed for office-based practices, a CPT evaluation and management (E/M) service code is required to

identify patients for denominator inclusion. Valid CPT E/M service codes are 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214 and 99215. If you report an E/M service code for your patients and inquire regarding tobacco use, you may report the measure.

4. Medicare — SGR Six-Month Reprieve

On January 29, 2007, President Bush signed into law S. 2499, the "Medicare, Medicaid, and SCHIP Extension Act of 2007" (MMSEA). This law provided a number of changes to Medicare; most importantly, this legislation postponed for six months the 10.1-percent across-the-board cut in Medicare physician payments that were scheduled to go into effect on January 1, 2008, as a result of the statutory "sustainable growth rate" (SGR) formula. Under the SGR formula, CMS must adjust the Medicare physician fee schedule update depending on how actual expenditures compare to target for Medicare spending growth. In recent years, this would have resulted in negative updates, but Congress has repeatedly overridden the formula by specifying update factors to avoid cuts in physician payments. If the SGR formula is not changed, physicians face substantial cuts for the next decade.

The MMSEA *temporarily* stayed the 10.1-percent cut and replaced it with a 0.5-percent increase, effective for services provided from January 1 through June 30, 2008. During this period, the national anesthesia conversion factor is $19.97. Unless Congress acts, the national anesthesia conversion factor will be reduced to $17.82 for services provided from July 1 through December 31, 2008. Congressional leadership has committed to additional action on Medicare policy in the first half of 2008 to prevent the reimbursement cut.

The MMSEA also extended the PQRI through 2009. Under this program, eligible professionals who voluntarily report on certain quality measures are eligible for a 1.5-percent "transitional bonus incentive payment." Bonus payments to professionals for 2008 and 2009 are not subject to the cap that was applied in 2007.

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tice. An ASA task force concluded that the literature was inconclusive.[4] Despite this, public demand for the routine use of CFMs grows, fueled by commercial interests and well-intentioned victims of awareness. In response, ASA took the unusual step of commissioning an independent research study to "to prove or disprove to a reasonable degree of scientific probability whether brain function monitoring reduces the incidence of intraoperative awareness under general anesthesia" and provided funding to the Foundation for Anesthesia Education and Research specifically for such an investigation. When completed, we expect that this study will allow us to take a scientifically sound position in the court of public opinion on this controversy.

Such a commitment to unbiased scientific research in areas of public controversy is in the best interests of the specialty and the public. We cannot allow others to frame the questions and generate the answers in areas vital to the future of the specialty and the safety of our patients. And we cannot successfully advocate for these interests without the data to support our positions. While acknowledging that integrity requires that we be prepared to alter our positions when the science demands, support for research to inform our advocacy agenda is nonetheless a critical and strategic investment.

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