Physician Quality Reporting System: What it Means for Today’s Radiologist

By: Wendy Driscoll

Introduction

With all of the impending Medicare cuts that radiologists face today, radiologists must look for revenue from all possible sources. This includes revenue from Medicare incentive programs like the Physician Quality Reporting System (PQRS). The dilemma with PQRS, which was known as ‘PQRI’ until January 1st of 2011, is that the administrative burden can seem to outweigh the benefits of participation. And in today’s constantly changing radiology market, radiologists and their business managers simply do not have the time to review all of the material.

This article will provide step-by-step instructions on implementing PQRS successfully in your radiology practice. It will allow the practice to maximize the chance of receiving PQRS incentive payments, while minimizing additional steps in radiologists’ dictation.

What is PQRS? Who is eligible?

The Physician Quality Reporting System (PQRS) is a voluntary, individual reporting program for eligible professionals (physicians, etc.), who report data on quality measures for services provided to Medicare beneficiaries. The program began in 2007 as part of the 2006 Tax Relief and Health Care Act (TRHCA). Physicians who participate in PQRS are eligible to earn incentive payments for their participation through 2014; after 2014, there will be a financial penalty for non-participation.

The patients covered by PQRS include patients with Medicare Part B coverage as a primary or secondary payor, as well as Railroad Medicare patients. Also, the program and corresponding incentive payments can be applied to Medicare HMO patients given that the provider is either non-participating with the Medicare HMO or has negotiated this stipulation in their Medicare HMO contracts.

In order to be considered an eligible professional, the provider must provide services that are payable under the Medicare Part B Fee Schedule. Additionally, the provider must use their individual NPI number to submit claims. Claims that are payable under a fee schedule other than the Medicare Part B Fee Schedule and do not have an individual NPI number associated with the claim are not eligible to participate.

With the above in mind, Independent Diagnostic Testing Facilities (IDTF’s) and free-standing radiology centers cannot participate in PQRS unless the centers bill for the professional and technical component of the Medicare services separately (a practice known as ‘split billing’).

Why PQRS? Why now?

Physicians who successfully participate in PQRS will earn an incentive payment equal to 1% of their total Medicare Part B Physician Fee Schedule allowed amount in 2011. For example, if a physician’s total allowed amount for Medicare is equal to $250,000 in 2011, then that physician will
earn an incentive payment of $2,500. From 2012 through 2014, the eligible incentive payment is 0.5% of the physician’s Medicare Part B Physician Fee Schedule allowed amount. In 2015, there will be a penalty of 1.5% for non-participation. In 2016 and beyond, this penalty will increase to 2.0%. The penalty is applied to all Medicare Part B billings for that physician, not just the charges where PQRS data was reported.

While the review of the PQRS material remains quite cumbersome, the actual documentation requirements have decreased substantially. Specifically, in 2010, physicians had to have appropriate PQRS documentation on 80% of eligible cases (Medicare patients). In 2011 and beyond, the 80% threshold dropped to 50%. Also, since PQRS’s inception in 2007, the number of radiology quality measures has expanded from two to ten. Therefore, even radiologists who are sub-specialized can find PQRS measures that can be documented with relative ease.

The impending penalty for non-participation, coupled with the lowering of the documentation threshold and increased measure choices, make 2011 the perfect time to start participating in PQRS. Further, with all of the reimbursement decreases on the horizon (notably the Medicare fee schedule decrease as part of the Medicare budget neutrality impact and the combining of the CT of the abdomen and pelvis CPT codes), radiologists cannot afford to ignore incentive programs like PQRS.

So, What Must a Radiologist Actually Do to Participate? How Do Radiologists Maximize Their Chance of Successful Participation?

In order to participate in PQRS, the most efficient method for radiologists is to use a claims based reporting system. Specifically, radiologists include additional documentation elements in their radiology reports. This documentation allows the coders at the radiologist’s billing company to attach the appropriate PQRS CPT code to the HCFA. Medicare refers to these PQRS CPT codes as ‘CPT II Codes’. The addition of this CPT II Code triggers participation in PQRS; no additional forms need to be completed.

The ten radiology PQRS measures are grouped into five measures for diagnostic radiology and five measures for interventional radiology. A listing of each measure, the measure description, and the documentation requirements is listed in “Exhibit A: Measure Description and Documentation Requirements”.

To receive PQRS incentive payments for 2011 claims, each radiologist must choose three or more measures to report and then report the PQRS codes on at least 50% of these eligible patients (Note: Prior to 2011, the radiologist was required to report PQRS codes on at least 80% of eligible patients). If less than three measures apply, the radiologist must report on all applicable measures.

In 2007 and 2008, only about half of the physicians who participate in PQRS actually received an incentive payment. With this in mind, measure selection by the radiologists and constant feedback from the radiologist’s billing company are essential to ensuring successful participation.

Which Measures Should I Choose?

In order to ensure that the 50% threshold requirement is met on at least three measures, a radiologist should choose a PQRS quality measure for services that are performed frequently. Other considerations would be as follows:

- How onerous are the documentation requirements for each measure?
Must we rely on outside sources of information (like the hospital) to obtain any of the necessary documentation elements? If so, will the outside party be willing to provide this information?

How will these additional documentation elements be received by the referring physicians?

A thorough billing company that focuses exclusively on radiology billing, such as Advocate Radiology and Billing Reimbursement Specialists, should be able to provide answers to all of these questions.

Based on Advocate’s vast experience in radiology billing, we have found that different measures have vastly different success rates with regards to implementation. The PQRS measures are listed below in order of ease of implementation and documentation (based on Advocate’s experience):

1. **Measure #146: Screening mammography** – This code is frequently used and requires no additional documentation efforts on the radiologist’s part (the bi-rad codes are already on the report). No information is needed from outside sources and the referring physicians will not notice a change in the reports.

2. **Measure #195: Carotid imaging** – These codes are often used and no information is needed from outside sources. Since reporting the percentage of stenosis according to NASCET or velocity flow will satisfy the PQRS reporting requirements for this measure, the extra documentation efforts are minimal. Also, as these elements are commonly seen on these types of reports, the referring physicians will likely not notice a significant change to these reports.

3. **Measure #147: Bone nuclear medicine** – While this study is likely not performed as frequently as the first two measures, this study is performed fairly often in most groups. In addition, the documentation requirements are fairly minimal (the presence or absence of comparison studies simply needs to be documented). No information is needed from outside sources and the referring physicians will likely not notice a change to these reports.

4. **Measure #145: Fluoroscopy** – Studies with fluoroscopic guidance are performed quite regularly and the additional documentation of the exposure time is not onerous. Furthermore, this added documentation would not cause a noticeable change to the report from the referring physician standpoint. One concern with this measure is that the radiologist is often dependent on obtaining this information from a hospital employee such as a technician. If this information can be obtained easily, this measure is a very good choice for radiologists that perform any interventional work.

5. **Measure #10: Stroke and stroke rehab – CT and MRI of the brain** – These codes are used quite frequently and the documentation requirements of the presence or absence of infarction, hemorrhage, and mass are not onerous and should not cause concern with the referring physicians. However, the requirement to document if the study was performed within 24 hours of the patient’s arrival to the facility may cause concern as this information will need to be obtained from the hospital. Additionally, it is a rather unusual element and may cause questions from referring physicians. If this information can be obtained easily from
the hospital, this would be a good measure to choose if the previous four measures are not an option.

6. Measure #76: CVC insertion – If a radiologist provides this type of service frequently, this measure would be a good choice. While the additional verbiage is rather lengthy regarding the sterile technique, this verbiage can often be added to report templates for ease of documentation. Also, no information is needed from outside sources. The only downsides to this code would be the frequency that the procedure is performed and the referring physicians’ view of the length of the additional documentation.

7. Measure #225: Screening mammogram reminders – Screening mammograms are performed quite often. However, the information necessary to report on this measure must be obtained from the registration staff at the hospital. Also, the requirements of the reminder system are quite specific. Therefore, the radiologists would need to check with the staff responsible for this system periodically to ensure that the requirements are met. Further, the dictation for this documentation is quite different than the documentation currently used in screening mammography reports. The reasons listed above make this measure a rather cumbersome choice for most radiology groups.

8. Measures #24 and #40: Osteoporosis follow up – Unless a radiologist has a thriving vertebroplasty line of business, along with extensive use of evaluation and management codes, this measure is not a particularly good choice. The frequency of the studies of the lack of applicability to the actual vertebroplasty code itself make this measure rather difficult to document.

9. Measure #21: Use of prophylactic antibiotics in various surgical procedures: Radiologists rarely perform the type of surgical procedures covered by this measure. Therefore, this measure is not recommended.

How Do I Make Sure that My Billing Company is Coding These Measures Appropriately?

Per CMS, “incentive payments will be calculated at the individual level based on the eligible professional’s NPI and then aggregated for payment at the tax identification level”. Because CMS tracks the use of the PQRS codes so thoroughly, it is essential that the radiologist’s billing company provides accurate and timely feedback regarding the utilization of the PQRS codes.

Thorough reporting from the billing company back to the radiology group regarding PQRS would include three elements:

1. The billing company should provide information by physician by PQRS measure to identify problem areas in the radiologist’s dictation. This information should be provided monthly at a minimum. This information will allow radiologists to address any dictation issues promptly and correct any hospital information flow as applicable.

2. The billing company should compile a listing of all CPT codes impacted by PQRS and compare these CPT codes to the number of PQRS codes billed out. This should be performed quarterly at a minimum. If there is a discrepancy in the number of PQRS codes vs. the procedure codes, this should be investigated immediately to determine the source of the problem. Quarterly review of this information will ensure that the practice meets the 50% threshold with ease.
3. The billing company should verify that Medicare is accepting the PQRS codes by checking the remittances for the ‘N-365’ code (this is the code that indicates that Medicare has accepted the PQRS code).

At Advocate, the above information is tracked with as much detail and frequency as the practice requests. Additional information is also provided at the report detail level to improve documentation. Custom queries have also been designed to capture the PQRS code to procedure code ratio, as well as Medicare’s acceptance of the PQRS codes.

**So, How Do I Get Started?**

The guidelines provided in this article are designed to assist radiologists and their managers in choosing the best PQRS measures for their practice. In order to reach the 50% threshold required in 2011, it would be prudent to decide on measures no later than April of that particular calendar year. This timeframe will provide ample time to ensure that the dictation requirements are met and that the billing company is following through with the proper billing of the CPT codes.

After the measures have been chosen by the group and the PQRS billing process has been implemented, it will be up to the radiologists’ billing company to provide feedback to the group regarding their progress. It is only through this constant feedback and reporting that the radiology group can feel comfortable that their PQRS endeavor will be successful.
EXHIBIT A – MEASURE DESCRIPTIONS AND DOCUMENTATION REQUIREMENTS

Diagnostic Radiology

1. Measure #10: Stroke and stroke rehabilitation: CT and MRI reports
   a. Measure description: Percentage of final reports for CT or MRI studies of the brain performed within 24 hours of arrival to the hospital for patients aged 18 years and older with either a diagnosis of ischemic stroke or transient ischemic attack or suspected stroke that include documentation of the presence or absence of the following: hemorrhage and mass lesion and acute infarction
   b. Documentation guidelines: For any Medicare patient that has a CT or MRI of the brain for stroke or suspected stroke, need to document:
      1. Age (date of birth is included on report)
      2. Time between the performance of the scan and patient’s arrival to the hospital (greater or less than 24 hours is needed; specific hours not required)
      3. Presence or absence of hemorrhage, mass and acute infarction

2. Measure #195 (formerly measure #11): Carotid imaging
   a. Measure description: Percentage of final reports for carotid imaging studies (neck MRA, neck CTA, neck duplex ultrasound, carotid angiogram) performed for patients aged 18 years and older that include direct or indirect reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement
   b. Documentation guidelines: For any Medicare patient, need to document:
      1. Age (date of birth is included on report)
      2. Whether or not the final report for carotid imaging studies includes measurement above
      3. Indirect reference can also be reference to NASCET technique for CTA’s, MRA’s and carotid angiograms or velocity flow measurements for Doppler

3. Measure #146: Radiology: Inappropriate use of “probably benign” assessment category in mammography screening
   a. Measure description: Percentage of final reports for screening mammograms that are classified as “probably benign”
   b. Documentation guidelines: For any Medicare patient that has a screening mammogram, need to document:
      1. Age (date of birth is included on report)
      2. The bi-rad code (all practices already document)

4. Measure #147: Nuclear Medicine: Correlation with existing imaging studies for all patients undergoing bone scintigraphy
   a. Measure description: Percentage of final reports for all patients, regardless of age, undergoing bone scintigraphy that include physician documentation of correlation with existing relevant imaging studies (e.g. x-ray, MRI, CT, etc.) that were performed
   b. Documentation guidelines: For any Medicare patient that has a nuclear medicine bone scan, need to document:
      1. Documentation of correlation with existing relevant imaging studies
2. If no documentation, document reason (i.e. ‘no relevant studies exist’)

5. Measure #225: Radiology: Reminder System for Mammograms
   a. Measure description: Percentage of patients aged 40 years and older undergoing a screening mammogram whose information is entered into a reminder system with a target due date for the next mammogram
   b. Documentation guidelines: For any Medicare patient aged 40 years and older that has a screening mammogram, need to document:
      1. If the patient is entered into a reminder system with a target due date for the next mammogram
      2. If the patient is not entered into a reminder system, need to document that the patient was not entered into a reminder system.
      NOTE: The reminder system must include the following elements: patient identifier, patient contact information, date(s) of the prior screening mammogram(s) if known, and the target due date for the next mammogram.

Interventional Radiology

1. Measure #145: Radiology: Exposure time reported for procedures using fluoroscopy
   a. Measure description: Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time
   b. Documentation guidelines: For any Medicare patient that has a procedure using fluoroscopy, need to document:
      i. Whether or not the radiation exposure or exposure time was documented
      ii. No exclusions exist for this measure (based on age, etc.)

2. Measure #76: Critical care: Prevention of catheter-related bloodstream infections – Central venous catheter insertion protocol
   a. Measure description: Percentage of patients, regardless of age, who undergo CVC insertion for whom CVC was inserted with all elements of maximal sterile barrier technique [(cap AND mask AND sterile gown AND sterile gloves AND a large sterile sheet AND hand hygiene AND 2% chlorhexidine for cutaneous antisepsis (or acceptable alternative antiseptics per current guideline)] followed
   b. Documentation guidelines: For any Medicare patient that has a central venous catheter placement, need to document:
      i. Whether or not you followed all elements of maximal sterile barrier technique
      ii. If technique was not followed, need to document reason

3. Measure #24: Osteoporosis: Communication with the physician managing ongoing care post fracture
   a. Measure description: Percentage of patients aged 50 year and older treated for a hip, spine or distal radial fracture with documentation of communication with the physician managing the patient’s ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
b. Documentation guidelines: For any Medicare patient age 50 or older that has an E & M code or vertebral procedure for the diagnosis of a fracture of the hip, spine or distal radius, need to document:
   i. Age (date of birth is included on report)
   ii. Whether or not you communicated to the clinician managed the patient’s ongoing care that a fracture occurred and that the patient was or should be tested or treated for osteoporosis
   iii. If this was not performed, need to document reason

4. Measure #40: Osteoporosis: Management following fracture
   a. Measure description: Percentage of patients aged 50 years and older with fracture of the hip, spine or distal radius who had a central dual-energy X-ray absorptiometry measurement ordered or performed or pharmacologic therapy prescribed
   b. Documentation guidelines: For any Medicare patient age 50 or older that has a vertebral procedure billed by the practice for the diagnosis of a fracture of the hip, spine or distal radius, need to document:
      i. Age (date of birth is included on report)
      ii. Whether or not you ordered or performed a central DXA measurement OR whether or not you prescribed pharmacologic therapy (other than minerals/vitamins) for osteoporosis
      iii. If this was not ordered/perform, need to document reason

5. Measure #21: Perioperative care: Selection of Prophylactic Antibiotic – First or second generation cephalosporin
   a. Measure description: Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for cefazolin OR cefuroxime for antimicrobial prophylaxis
   b. Documentation guidelines: For any Medicare patient that has a variety of surgical codes (various joint, thoracic codes, etc), need to document:
      i. Age (date of birth is included on report)
      ii. Whether or not there was an order for cefazolin or cefuroxime for antimicrobial prophylaxis OR whether or not cefazolin or cefuroxime was given for antimicrobial prophylaxis
      iii. If antibiotic not ordered/given, need to document reason