Medicare PQRS Bonus Tips – 2011

(Bonus potential = 1% of Total Allowable Charges per physician)

1. Physicians communication of perioperative PQRS clinical information can be as simple as dictating one extra line into the operative note. The practice's biller can translate this line into PQRS codes.

2. Perioperative measures #20-#23 can be coded individually (see the SCLLC compact coding chart for the detailed codes) or as a PQRS Measures Group which is described below in more detail. Individual measure coding will require a 50% successful submission rate on 3 measures for any physician to earn the 1% bonus. You must understand the detailed specifications of each individual measure and its code for successful submission.

3. A Measures Group allows the full 1% bonus if all applicable measures are *fully and correctly* coded for 30 Medicare patients (or for 50% of 15-29 patients). You must understand the detailed specifications of each individual measure and code for all 4 measures in the Perioperative Measures Group if this reporting method will be used. See the Measures Group Introduction more information. The list of applicable surgical cases for the Perioperative Measures Group should be reviewed to determine if an appropriate volume of Medicare cases can be projected for the year (before committing to this reporting method).

4. There are some procedure codes where Medicare is not looking for the coding (the recommended care process does not apply). Coding these non-applicable Medicare patients does no harm. However, it will not count towards the 30-patients requirement or the 50% successful submission rate.

5. Metrics, bonus, and processes are all applied to and tabulated for each individual physician.

6. In general, the PQRS and eRx Medicare bonus programs apply to patients with Medicare primary or secondary coverage, who are processed by CMS's fiscal intermediary contractor (National Heritage for most of Massachusetts).

7. Retrospective coding will not be accepted. The PQRS clinical measurement codes must be submitted by the practice on the same bill as that used to submit the procedure code for reimbursement. The $ charge field on the bill cannot be left blank (use $0 or $.01).

8. To see if coding is being sent through your billing system, clearinghouse, CMS fiscal intermediary, and finally registered by CMS, please review your remittance advices. A payment rejection code of "N356" should be seen on the PQRS line item codes. This is appropriate and indicates that the PQRS code has been received and counted.

9. Second Surgeon case – coding needed/applicable patient. For Surgical Assist – coding not needed/non-applicable patient. The assisting surgeon is not "in the driver's seat."

10. Use modifier 8P for "unknown" clinical care when coding individual measures– a code must be submitted to get credit towards the 50% rate.

11. If submitting the perioperative Measures Group, the following detailed steps are recommended: develop office processes, submit several Medicare bills with the PQRS coding, check remittance advices for "N365" reimbursement rejection on these codes, then indicate that you are officially submitting for physician #1/patient #1 by submitting G8492 code and the 4 perioperative codes on the 1st of 30+ Medicare billings for that physician. The starting date does not matter, but each physician using the Measures Group method must have 30 correct submissions by the end of the year. Otherwise, CMS will look for 50% of all potential measurement opportunities to be documented for 3 individual measures.