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This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of the written law or regulations or local payer guidelines. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

MG46115

Medicare Physician Quality Reporting Initiative (PQRI) Begins July 1st

The next step toward pay-for-performance for Medicare starts this month with the official start of Physician Quality Reporting Initiative (PQRI). Although PQRI is technically a pay-for-reporting program, it would appear to be inching Medicare closer to true pay-for-performance based reimbursement. Physicians reporting certain quality measures will be eligible for a lump sum payment of 1.5% of qualified Part B allowed charges subject to a cap based on the number of physicians that participate. Industry sources estimate average bonuses could range from \$2,500 to \$6,000 per oncologist. Bonuses will be paid in mid 2008.

In order to earn the additional payment, physicians must report on certain quality measures. There are eight oncology-specific quality measures and physicians must report on at least three of the measures in at least 80 percent of the cases. Reporting will be as simple as submitting a HCPCS code on each claim along with the services for that day. Additional resources can be found on the CMS website including:

2007 PQRI Fact Sheet

http://www.cms.hhs.gov/PQRI/Downloads/2007_pqri_fact_sheet.pdf

2007 PQRI Measure Specifications

http://www.cms.hhs.gov/PQRI/downloads/Measure_Specifications_060107.pdf?agree=yes&next=Accept

2007 PQRI Code Master

http://www.cms.hhs.gov/PQRI/Downloads/2007_PQRI_Code_Master_052507.zip

Physicians must now consider and decide whether the potential bonus is worth the cost. As was proven during the 2005 Chemotherapy Demonstration Project and the 2006 Oncology Demonstration Project, providers that have electronic medical records (EMRs) are typically better positioned to integrate such reporting requirements into their practices. The same is true for the 2007 PQRI program. For practices that do not have EMRs, manual PQRI worksheets may be an option. Many practices have worked with physicians, nursing, billing, and medical records staff to develop worksheets and implement processes that identify appropriate patients for PQRI, insert worksheets in the patients chart on the day of treatment, and have the appropriate HCPCS posted (with a \$0.00 charge) on the same claim as the services provided.

ASCO Reimbursement Update

Joe Bailes, M.D. and Terry Coleman, Esq. presented the reimbursement update at the ASCO national meeting in early June. The session was not as well attended as in previous years which may be a sign of fewer big changes. The outlook for oncology is no better than in recent years. The overall message from Dr. Bailes and Mr. Coleman was one of continued budget pressures from all payers indicating an even greater emphasis on payments being tied more closely to outcomes, coverage for drugs tied to proven effectiveness, and increased cost shifting to patients.

Dr. Bailes summarized the current state of reimbursement for Medicare. He also discussed the scheduled drop in the Medicare Physician Fee Schedule (MPFS). The MPFS is slated to decrease by ten percent in 2008, and by five percent each year thereafter until 2013 due to the Sustainable Growth Rate (SGR) formula. He noted the current formula does not account for the “fix” to the 2007 conversion factor (CF) which kept it at the same rate as the 2006CF. Proposed cuts will continue to loom large for oncology.

Other topics of particular interest discussed by Dr. Bailes and Mr. Coleman included:

- A budget proposal to eliminate bad debt payments to hospitals,
- CMS spending exceeding the 45% general revenue threshold,
- MedPAC reports exploring rising coinsurance obligations and outcomes-based payments,
- CMS’ apparent willingness to consider separate J-codes for single source drugs,
- Physician Quality Reporting Initiative, and
- Compendia changes.

Pending National Coverage Determination (NCD) for ESAs

The comment period on the proposed NCD for Erythropoetin Stimulating Agents (ESAs) ended June 12, 2007. A final determination is expected by the middle of August. The American Society of Clinical Oncology (ASCO), Association of Community Cancer Centers (ACCC), Community Oncology Alliance (COA), and other large oncology related groups have submitted their responses to CMS and must now wait to see how far CMS will go. Some oncology practices have estimated the net impact of the proposed changes could be a 10 to 20 percent decrease on net income.

Quarterly Update to Medically Unlikely Edits (MUEs), Version 1.2, Effective July 1, 2007

MLN Matters Article #[MM5603](#) explains that in order to lower the Medicare fee-for-service paid claims error rate, the Centers for Medicare & Medicaid Services (CMS) established units of service edits referred to as MUEs. An MUE is defined as an edit that tests claim lines for the same beneficiary, Healthcare Common Procedure Coding System (HCPCS) code, date of service, and billing provider against a criteria number of units of service. If a unit of service exceeds MUE criteria, Medicare carriers will deny the entire claim line that exceeds and pay the other services on the claims. Excess charges due to units of service greater than the MUE may not be billed to the beneficiary (this is a “provider liability”) even with an Advanced Beneficiary Notice (ABN).