Physician Quality Reporting System (PQRS) 2014

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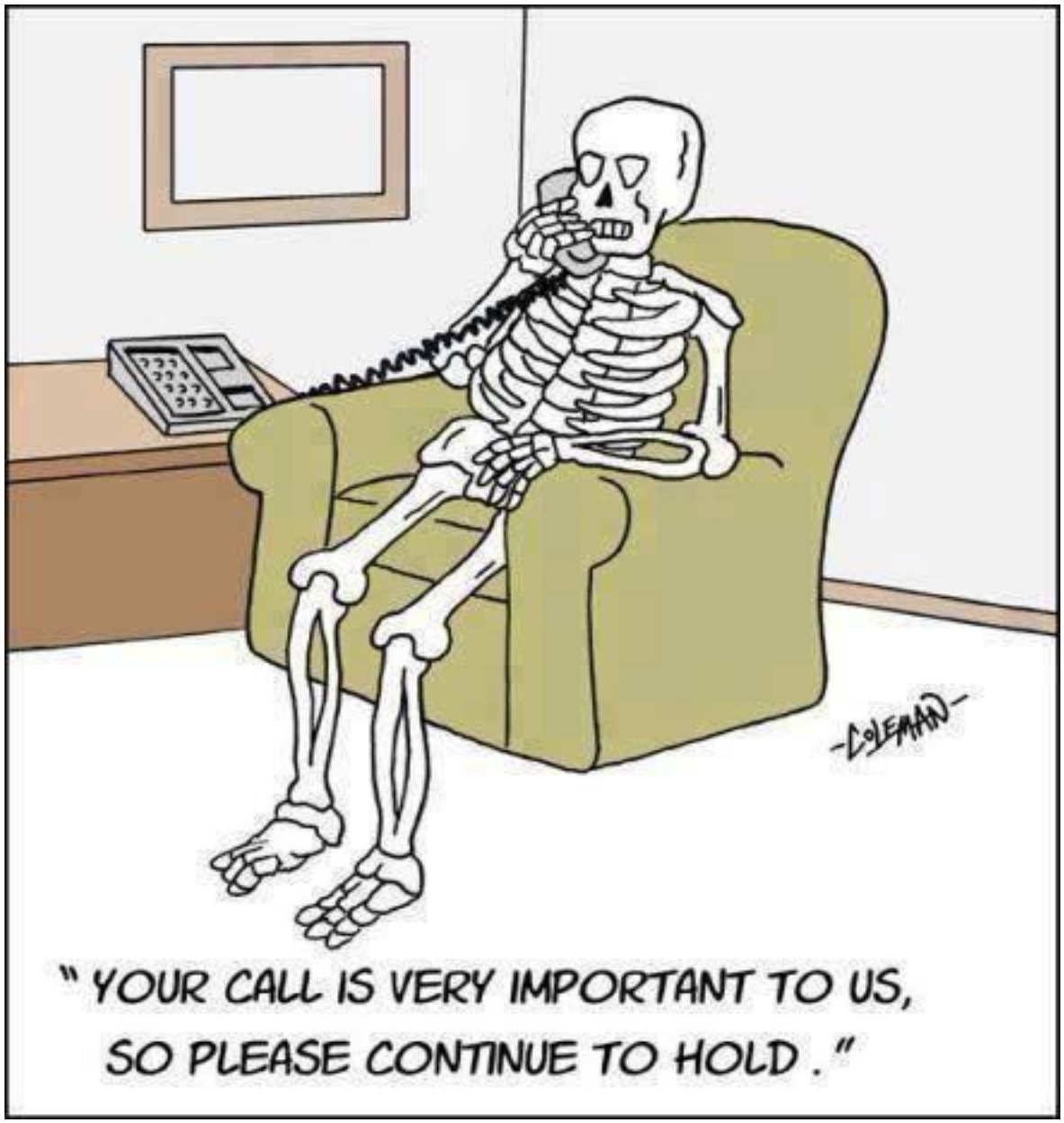
2014 IPMA ANNUAL MEETING


-COLEMAN-
" YOUR CALL IS VERY IMPORTANT TO US,
SO PLEASE CONTINUE TO HOLD . "

PQRS in 2014

Two components:

1. Incentive Payment

2. Payment Adjustment Avoidance

What is an EP when referring to the PQRS program?

EP stands for eligible provider, and podiatrists are included in the PQRS program as eligible providers.

***I am using a certified EHR system and attesting to meaningful use. Do I still need to do something with PQRS?**

Yes, meaningful use and PQRS are two different programs. You must participate in PQRS in some manner in 2014 to avoid the payment adjustment (a 2-percent reduction in all Medicare Part B FFS payments) in 2016.

Can I just report measures 126, 127, and 163 like I did in 2013 to avoid the 2016 payment reduction?

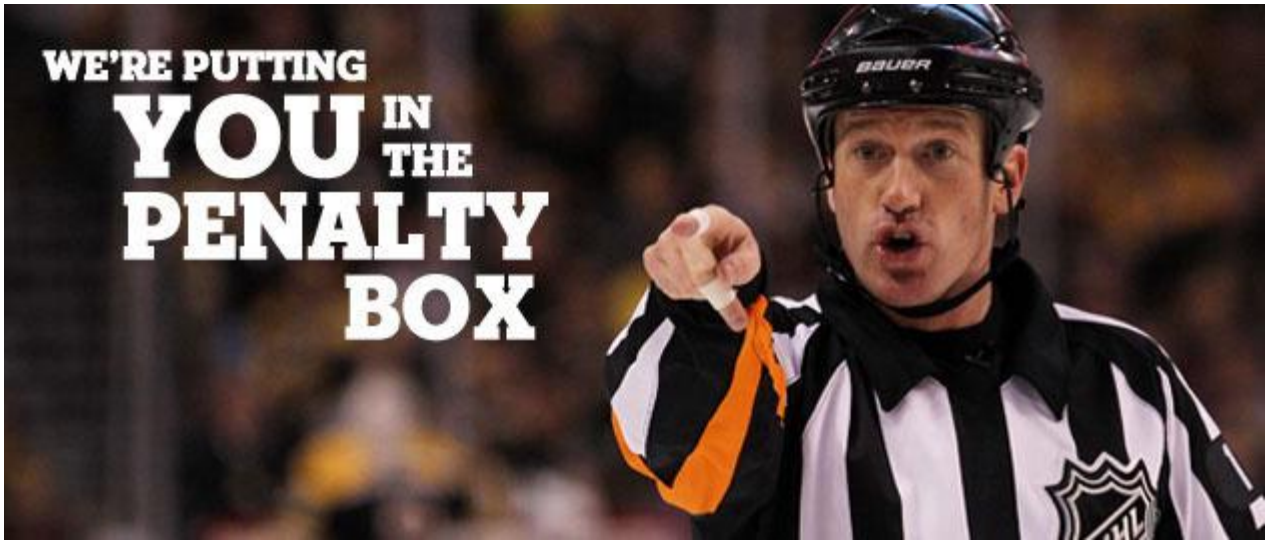
No, for 2014 there have been changes to all of these measures.

First of all, measures 126 and 127 can no longer be reported using the individual claims method; they are only available for registry reporting.

Registry reporting involves signing up with a CMS-approved registry (usually for a fee), and then the registry has a mechanism for you to transmit your PQRS quality measures. The registry then reports the PQRS quality measures to CMS on your behalf. This does not mean you have to use a registry to avoid the payment penalty—you can still submit three PQRS measures by the individual claims method, but you just have to select different measures than 126 and 127.

Measure 163 can still be reported by the individual claims method, but you must perform all three elements and you report it with the code *G9226, not 2028F*.

CMS Changes



INCENTIVE PAYMENT

-2014 will be the final year for the PQRS incentive payment

-Payment will be 0.5% of Medicare Part B FFS payments for the entire year (so on $125,000 of Medicare billings you get $625)

-Multiple methods to qualify for the incentive payment

-Significant change in requirements to qualify for the incentive payment in 2014

No Action =Penalty

If you do not do anything with regard to PQRS in 2014, then in 2016 all of your Medicare Part B FFS payments will be reduced by 2 percent .

This is in addition to any other payment adjustments—such as for EHR meaningful use non-participation or if the sequester reductions are still in place.

QUALIFYING FOR INCENTIVE PAYMENT:

Methods to qualify:

1. Individual claims reporting
2. Registry Reporting
3. EHR reporting
4. Reporting through Qualified Clinical Data Registry (QCDR) (New for 2014)
5. Group Reporting Options

Individual Claims Reporting : Podiatrist Best Option

1. Report on 9 PQRS measures and for each measure report on at least 50% of eligible patients

2. The 9 measures should represent at least 3 of the 6 National Quality Strategy (NQS) domains

3. If 9 measures are not available for your specialty, submit the maximum number of measures (1-8) that are available

4. If you cannot represent 3 of the 6 NQS domains represent as many as possible

National Quality Strategy (NQS) Domains

- ☐ Patient and Family Engagement
- ☐ Patient Safety
- ☐ Care Coordination
- ☐ Population and Public Health
- ☐ Efficient Use of Healthcare Resources
- ☐ Clinical Processes/Effectiveness

Measure Applicability Validation (MAV) Process

If less than 9 quality measures are available for an eligible provider to report (because of their specialty area of practice), then they can report 1-8 measures and if the available measures do not represent at least 3 of the 6 NQS domains, they can cover less than 3 of the domains.

If either or both of these occur, then the eligible provider will be subject to the Measure Applicability Validation (MAV) process.

Essentially, using the MAV process CMS reviews to make sure that the eligible provider could not have submitted more measures (if less than 9) and that they could not have covered more NQS domains (if less than 3).

UNDERSTANDING A MEASURE

Each measure is constructed with a numerator and denominator.

Denominator: Identifies who qualifies as an eligible patient for reporting a specific measure. It may contain information such as age, gender, CPT codes, ICD-9 (10) codes, etc.

Numerator: Describes the specific action that was performed (the quality measure) on an eligible patient, e.g. lower extremity neurological exam performed.

Numerator/Denominator gives you a performance percentage on a particular measure. (This is the essence of the program. You end up with a performance score on each measure.)

Payment Adjustment Avoidance(to avoid the 2% reduction in 2016)
Meet the requirements for receiving the incentive payment

Report at least 3 measures, OR,
If less than 3 measures apply to the eligible professional, report 1-2 measures*; AND
Report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies.

Measures with a 0 percent performance rate will not be counted.

2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures

Utilized by Individual Eligible Professionals for Claims and Registry Reporting and Clinical Practices Participating in Group Practice Reporting Option (GPRO) for Registry Reporting

12/13/13

This information can be downloaded at:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

Potential Measures (for individual claims submission):

20(PS)	Perioperative Care: Timing of Prophylactic Antibiotic-Ordering
21 (PS)	Perioperative Care: Selection of Prophylactic Antibiotic
22 (PS)	Perioperative Care: Discontinuation of Prophylactic Antibiotic
46 (PS)	Medication Reconciliation
128 (C/PH)	Preventive Care and Screening: Body Mass Index (BMI) Screen
130 (PS)	Documentation of Current Medications in Medical Record
131 (C/PH)	Pain Assessment and Follow-Up
154 (PS)	Falls: Risk Assessment
155 (PS)	Falls: Plan of Care
163 (ECC)	Diabetes Mellitus: Foot Exam
226(C/PH)	Preventive Care and Screening: Tobacco Use: Screening and Cessation
245 (ECC)	Chronic Wound Care: Use of Wound Surface Culture Technique
246 (ECC)	Chronic Wound Care: Use of Wet to Dry Dressings in Patients

PQRS

For some PQRS measures, you report their completion by reporting the G code associated with the measure, and other measures have CPT-II codes associated with them.

Every measure has detailed specifications describing the measure and eligible patients, CPT codes, and ICD-9 codes associated with the measure.

For example, measure 163 (diabetic foot exam) identifies patients 18–75 years of age with a diagnosis of diabetes.

PQRS

When you see a Medicare Part B patient with diabetes, you perform the components of this measure—visual inspection, pedal pulses, and monofilament exam—and record the results.

You then report this measure using a G-code, G9226 (it is important to note that for 2014 this measure has changed—you must do all three components and it is now reported by the G-code; do not report with 2028F).

This documentation is how CMS knows you did the measure on that patient on that visit.

Recommended Measures

* Measure 128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

* Measure 163 Diabetes Mellitus: Foot Exam

* Measure 226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Measure #163 Diabetes: Foot Exam

- Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period
- **Diagnosis for diabetes ICD-9-CM:** 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

Measure #163 Diabetes: Foot Exam

- **ICD-10-CM [Reference ONLY/Not Reportable]:** E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69,E10.8, E10.9, E11.00, E11.01, E11.21, E11.22, E11.29, E11.311, E11.319, E11.321, E11.329, E11.331, E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

Measure #163 Diabetes: Foot Exam

- **Accompanied by:**
  99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439

Measure #163 Diabetes: Foot Exam Numerator

- Patients who received a foot exam (i.e., visual inspection, sensory exam with monofilament and pulse exam) during the measurement period
- **Note:** *Patients who received a foot exam at least once within the prior 12 months.*
- Foot examination performed (includes examination through visual inspection, sensory exam with monofilament, and pulse exam – report when **all** of the 3 components are completed)

How does this work in the real world?

66 year old NIDDM female established patient comes in for heel pain

? Between 18-75 year of age and diagnosis of DM  If no not eligible

? Seen for one of codes in measure of denominator ?

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, 99455, 99456, G0402, G0438, G0439  If no not eligible

Perform and report components of diabetic foot exam: Put **G9226** on claim form

Same patient continued

? 18 years of age or greater ? → If no then not eligible

Seen for one of these procedure codes:

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 96150, 96151, 96152, 97001, 97003, 97802, 97803, 98960, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, D7140, D7210, G0101, G0108, G0270, G0271, G0402, G0438, G0439, G0447

Perform BMI measure and report appropriate code:

G8420: BMI is documented within normal parameters and no follow-up plan is required

G8417: BMI is documented above normal parameters and a follow-up plan is documented

G8418: BMI is documented below normal parameters and a follow-up plan is documented

G8422: BMI not documented, documentation the patient is not eligible for BMI calculation

Seen for one of these procedure codes:

Patient encounter during the reporting period (CPT or HCPCS): 90791, 90792, 90832, 90834, 90837, 90839, 90845, 92002, 92004, 92012, 92014, 96150, 96151, 96152, 97003, 97004, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99406, 99407, G0438, G0439

Perform Tobacco Use measure and report appropriate code:

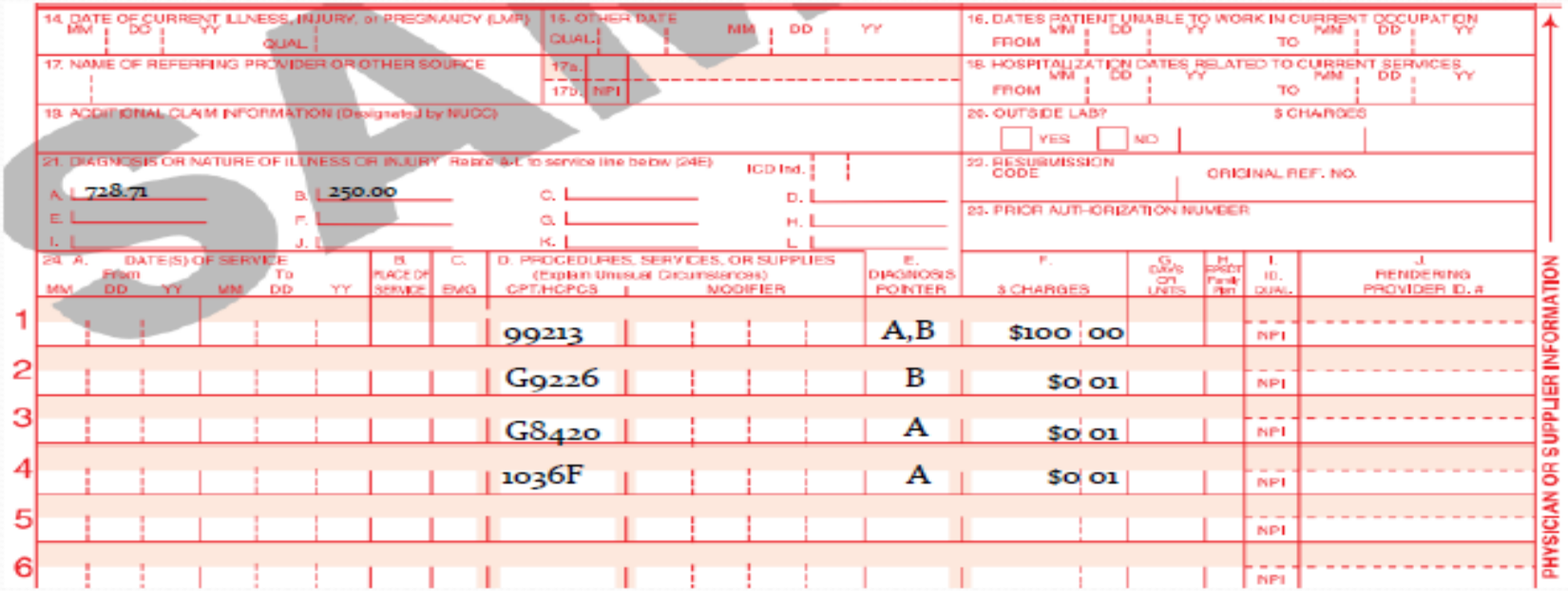
1036F: Current tobacco non-user

4004F: Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

4004F *with* 1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)

4004F *with* 8P: Tobacco screening OR tobacco cessation intervention **not** performed, reason not otherwise specified

Reporting on claim form:



14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.
15. OTHER DATE QUAL. MM DD YY
16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE
17a.
17b. NPI
18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)
20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.
A. 728.71 B. 250.00 C. D.
E. F. G. H.
I. J. K. L.
22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1				99213		A,B	$100 00			NPI	
2				G9226		B	$0 01			NPI	
3				G8420		A	$0 01			NPI	
4				1036F		A	$0 01			NPI	
5										NPI	
6										NPI	

PHYSICIAN OR SUPPLIER INFORMATION

What if patient refuses to have height and weight measurements done?

Not Eligible for BMI Calculation or Follow-Up Plan – A patient is not eligible if one or more of the following reasons are documented:

-- Patient is receiving palliative care

-- Patient is pregnant

-- Patient refuses BMI measurement (refuses height and/or weight)

--Any other reason documented in the medical record by the provider why BMI calculation or follow-up plan was not appropriate

--Patient is in an urgent or emergent medical situation where time is of the essence, and to delay treatment would jeopardize the patient's health status

REPORT: **G8422**

How Many Patients Do I Have to Report Measures On?

So the requirement is at least 3 measures on 50% of ELIGIBLE patients:

- This does not mean 3 measures on each patient
- Let's assume you decide to report measures 128, 163 and 226:
  - Over the course of 2014 you see 1,000 unique Medicare Part B FFS patients that you bill one of the eligible codes in the denominator of measures 128, 163, and 226—for sake of argument let's say E/M codes

    You would have to perform and report measures 128 and 226 on at least 500 of those patients.

  - Now 250 of the 1,000 unique patients have a diagnosis of DM and are between 18 and 75 years of age.

    You would have to perform and report measure 163 on at least 125 of those patients.

Summary

In the example given, the minimum submission would be:

- 375 patients with two measures submitted (128 and 226)
- 125 patients with three measures submitted(128, 163, 226)
- 500 patients with measures submitted in total

2015 PQRS

- No Incentive
- Success in 2015 = No 2% Penalty in 2017
- No #163 Diabetic foot exam in claims method only by registry reporting
- No prophylatic antibiotic measures (3)
- No chronic wound care measures (2)

PQRS 2015

- Quality Clinical Data Recording (QCDR) will require 3 clinical data measures to be reported vs. just one in 2014
- Then these must be reported to the public
- 2017 Value-based payment modifier is based on 2015 PQRS and could result in 4% decrease
- 2015 No CEHRT meaningful use , then a 3 % decrease

Potential 2017 Penalty

-9%

PQRS Claims Reporting 2015

- 110 (C/PH) Preventative Care: Influenza
- 111(ECC) Pneumonia Status for older adults
- 128 (C/PH) Preventive Care and Screening: Body Mass Index (BMI) Screen
- 130 (PS) Documentation of Current Medications in Medical Record
- 131 (C/PH) Pain Assessment and Follow-Up
- 154 (PS) Falls: Risk Assessment
- 155 (PS) Falls: Plan of Care
- 226(C/PH) Preventive Care and Screening: Tobacco Use: Screening and Cessation
- 317(C/PH) Screening for high blood pressure

QUESTIONS