Medicare PQRS Update

Presented by IACP

Adapted from information contained on:
http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/PQRS/
American Chiropractic Association website: http://www.acatoday.org/

PQRS: What is it?

- Physician Quality Reporting, or PQRS, is a reporting program that uses a combination of incentive payments and negative payment adjustments to promote reporting of quality information by eligible professionals (EPs).

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_OverviewFactSheet_2013_08_06.pdf

PQRS: What is it?

- "PQRS gives participating Eligible Professionals the opportunity to assess the quality of care they are providing to their patients, helping to ensure that patients get the right care at the right time."

http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/PQRS_OverviewFactSheet_2013_08_06.pdf

Participation Incentive

- The 2014 reporting period (Jan. 1 – Dec. 31, 2014) was the last opportunity providers had to earn an incentive payment, equal to 0.5% of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges, for participating in the PQRS program.

http://www.acatoday.org/pdf/ACA_Guidebook_PQRS_2015.pdf

Penalties for Non-participation

- The Patient Protection and Affordable Care Act (PPACA) mandated that non-participation or unsuccessful/unsatisfactory reporting in Medicare's Physician Quality Reporting System (PQRS) will result in negative payment adjustments to Medicare reimbursement beginning in 2015.

http://www.acatoday.org/content_css.cfm?CID=2296

Penalties for Non-participation

- In the 2012 Medicare Physician Fee Schedule Final Rule, the Centers for Medicare and Medicaid Services (CMS) ruled that providers who did not successfully/satisfactorily participate in PQRS by the **2013 reporting period** will have their Medicare reimbursement decreased by 1.5 percent beginning on January 1, 2015.

http://www.acatoday.org/content_css.cfm?CID=2296

Penalties for Non-participation

- Non-participation or unsuccessful/unsatisfactory reporting during the 2014 performance period will result in a 2% reduction in a provider's 2016 Medicare reimbursement

http://www.acatoday.org/content_css.cfm?CID=2296

Penalties for Non-participation

- Further non-participation or unsuccessful/unsatisfactory reporting this year (Jan. 1 - Dec. 31, 2015) will affect a provider's 2017 Medicare reimbursement by applying a payment reduction of 2%.

http://www.acatoday.org/content_css.cfm?CID=2296

Reporting Methods

To participate in the 2014 PQRS program, individual EPs may choose to report quality information through one of the following methods:

1. Medicare Part B claims (likely best method)

2. Qualified PQRS registry
3. Direct Electronic Health Record (EHR) using Certified EHR Technology (CEHRT)
4. CEHRT via Data Submission Vendor
5. Qualified clinical data registry (QCDR)

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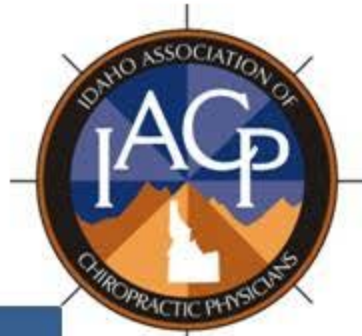

Measure Specifications Applicable to the Doctor of Chiropractic

- **NO registration** is required to begin participating in PQRS.
- DCs can only report on 2 PQRS measures and the minimum reporting requirement of "9 measures, covering at least 3 NQS domains" to avoid the 2017 PQRS payment adjustment does not apply to doctors of chiropractic.
- Two (2) quality measures doctors of chiropractic need to report in 2015:
  - Measure #131: Pain Assessment and Follow-Up
  - Measure #182: Functional Outcome Assessment

  - *__DELETED for 2015__*
    - Measure #317: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

http://www.acatoday.org/pdf/ACA_Guidebook_PQRS_2015.pdf

Measure Specifications Applicable to the Doctor of Chiropractic

- You should report Measures #131 and #182 on **every** visit, for every Medicare patient who is at least 18 years old **and** where you have reported a spinal CMT code (CPT® code 98940, 98941, or 98942).
- In 2015, you must satisfactorily report on **both** of these measures at least 50% of the eligible visits, and successfully perform each measure at least once, to avoid the 2017 payment adjustment.

http://www.acatoday.org/pdf/ACA_Guidebook_PQRS_2015.pdf

Reporting on Part B Claims

- To report in PQRS, you will need to place G-codes on your claim.
- The G-codes will correlate to an action that was taken (or not taken) by the provider

Measure #131: Pain Assessment and Follow-Up

- The purpose of this measure is for CMS to collect data on when a pain assessment is conducted using a "standardized tool", **and** a follow-up plan that includes a reassessment of pain is planned/documented when pain is present.
  - A standardized tool is defined as an assessment tool that has been appropriately normalized and validated for the population in which it is used.

http://www.acatoday.org/pdf/ACA_Guidebook_PQRS_2015.pdf

Measure #131: Pain Assessment and Follow-Up

- Examples of "standardized pain assessment tools" include, but are not limited to:
  - Brief Pain Inventory (BPI),
  - Faces Pain Scale (FPS),
  - McGill Pain Questionnaire (MPQ),
  - Multidimensional Pain Inventory (MPI),
  - Neuropathic Pain Scale (NPS),
  - Numeric Rating Scale (NRS),
  - Oswestry Disability Index (ODI),
  - Roland Morris Disability Questionnaire (RMDQ),
  - Verbal Descriptor Scale (VDS),
  - Verbal Numeric Rating Scale (VNRS), and
  - Visual Analog Scale (VAS).
- Important: The name of the standardized tool used to assess the patient's pain must be documented in the medical record

http://www.acatoday.org/pdf/ACA_Guidebook_PQRS_2015.pdf

G-Code Dependent on 2 Questions:

1. Did you or did you not use an outcome asssessment tool?
2. Did you write a follow up plan which includes re-assessment of pain (if present)?

- On each visit, the provider should report one (1) of the six (6) quality data codes (G-codes) below on line 24 D of a paper claim or on service line 24 of an electronic claim.

G-Codes: Bill for 1 of the 6 Possibilities

- G8730:

Performance Met: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented.

  - The provider assessed the patient for pain using a standardized tool, documented a positive assessment (pain was present), and also documented a follow-up plan that specifically stated a planned reassessment of pain, a referral, or that the initial plan is still effect.

G-Codes: Bill for 1 of the 6 Possibilities

- G8731:

Performance Met: Pain assessment using a standardized tool is documented as negative, no follow-up plan required.

  - The provider assessed the patient for pain, documented a negative assessment (absence of pain), so no additional documentation was required.

G-Codes: Bill for 1 of the 6 Possibilities

- G8442:

Other Performance Exclusion: Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool.

  - The provider documented that the patient was not eligible for a pain assessment. Patients are not eligible only if one or more of the following reason(s) are documented:
    - Severe mental and/or physical incapacity where the patient is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through the use of nationally recognized standardized pain assessment tools;
    - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

G-Codes: Bill for 1 of the 6 Possibilities

- G8939:

Other Performance Exclusion: Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible.

  - The provider assessed the patient for pain using a standardized tool, documented a positive assessment (pain was present), did not document a follow-up plan because the patient was deemed ineligible. Patients are not eligible only if one or more of the following reason(s) are documented:
    - Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools;
    - Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.

G-Codes: Bill for 1 of the 6 Possibilities

- G8732:

Performance Not Met: No documentation of pain assessment, reason not given.

  - The provider did not assess the patient for pain and there is no documentation the patient was not eligible (see G8442 or G8939 for non-eligibility reasons).

G-Codes: Bill for 1 of the 6 Possibilities

- G8509:

Performance Not Met: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given.

  - The provider assessed the patient for pain, documented a positive assessment (pain was present), but did not document a follow-up plan or a reason the patient was not eligible (see G8442 or G8939 for non-eligibility reasons).

Measure #182: Functional Outcome Assessment

- The purpose of this measure is for CMS to collect data on when functional outcome assessments are conducted, using a standardized tool, along with the creation of a treatment plan based on the functional deficiencies found.

Measure #182: Functional Outcome Assessment

- Functional outcome assessments are designed to measure a patient's physical limitations/deficiencies in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.
- Functional outcome deficiencies which result in impairment or loss of physical function, related to musculoskeletal/neuromusculoskeletal capacity, may include but are not limited to:
  - restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.

Measure #182: Functional Outcome Assessment

- Examples of standardized functional outcome assessment tools include:
  - Oswestry Disability Index (ODI),
  - Roland Morris Disability/Activity Questionnaire (RM),
  - Neck Disability Index (NDI),
  - Physical Mobility Scale (PMS),
  - Patient-Reported Outcomes Measurement Information System PROMIS),
  - Disabilities of the Arm, Shoulder and Hand (DASH), and
  - Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).
- Important: Documentation of a current functional outcome assessment must include identification (the name) of the standardized tool used.

G-Code Dependent on 2 Questions:

1. Did you conduct a functional outcome assessment of the patient?
2. Did you document a care plan when functional outcome deficiencies were identified?

A care plan describes expected/planned activities based on identified deficiencies (e.g., goals, services, appointments and procedures).

Measure #182: Functional Outcome Assessment

- The intent of the measure is for the functional outcome assessment tool to be utilized at a minimum of every 30 days, but reporting is required each visit due to coding limitations.
- Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the code G8942 should be used for reporting purposes.
  - On each visit, the provider should report one (1) of the seven (7) quality-data codes (G-codes) below on line 24 D of a paper claim or on service line 24 of an electronic claim.

G-Codes: Bill for 1 of the 7 Possibilities

- G8539:

Performance Met: Functional outcome assessment documented as positive using a standardized tool AND a care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented.

  - The provider performed a functional outcome assessment, using a standardized tool, and documented a care plan which included goals based on the deficiencies found.

G-Codes: Bill for 1 of the 7 Possibilities

- G8542:

Performance Met: Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required.

  - The provider performed a functional outcome assessment, using a standardized tool, but a care plan is not required because no functional deficiencies were identified.

G-Codes: Bill for 1 of the 7 Possibilities

- G8942:

Performance Met: Functional outcome assessment using a standardized tool is documented within the previous 30 days and care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented.

  - The provider has documented a functional outcome assessment, using a standardized tool, and a care plan which included goals based on the deficiencies found, within the last 30 days.

G-Codes: Bill for 1 of the 7 Possibilities

- G8540:

Other Performance Exclusion: Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool.

  - The provider documented the patient was not eligible for a functional outcome assessment. Patients are not eligible only if one or more of the following reason(s) are documented:
    - The patient refuses to participate
    - The patient is unable to complete the questionnaire
    - 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

G-Codes: Bill for 1 of the 7 Possibilities

- G9227:

Other Performance Exclusion: Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan.

  - The provider performed a functional outcome assessment, using a standardized tool, and found functional deficiencies, did not document a follow-up plan because the patient was deemed ineligible. Patients are not eligible only if one or more of the following reason(s) are documented:
    - Patient refuses to participate
    - Patient unable to complete questionnaire
    - 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

G-Codes: Bill for 1 of the 7 Possibilities

- G8541:

Performance Not Met: Functional outcome assessment using a standardized tool not documented, reason not given.

  - The provider did not perform a functional outcome assessment and there is no documentation the patient was not eligible (see G8540 or G9227 for non-eligibility reasons).

G-Codes: Bill for 1 of the 7 Possibilities

- G8543:

Performance Not Met: Documentation of a positive functional outcome assessment using a standardized tool; care plan not documented, reason not given.

  - The provider performed a functional outcome assessment, using a standardized tool, and found functional deficiencies, but did not document a care plan. In addition, there is no documentation the patient was not eligible (see G8540 or G9227 for non-eligibility reasons).