Prevent Medicare Penalties:

2016 PQRS for PM&R Providers

Marvel J Hammer

RN CPC CCS-P ASC-PM CPCO

What Is PQRS?

- **Physician Quality Reporting System**
  - Formerly known as Physician Quality Reporting Initiative (PQRI)
  - A quality reporting program that uses negative payment adjustments to promote reporting of quality information by individual eligible professionals and group practices
  - CMS partnered with outside agencies to develop the quality measures
- PQRS gives participating EPs 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
  - Quantify how often they are meeting a particular quality metric
  - Compare their performance on a given measure with their peers

Medicare PQRS Incentive Program

- Only Medicare Part B covered services qualify
  - **Includes** Medicare Part B primary claims, Medicare Part B secondary Payer claims and Railroad Medicare Part B claims
  - **NOT** eligible for this incentive: Medicare Advantage, Tri-Care or Medicaid plans
- Private insurance plans may have separate Quality Incentive plans not associated with Medicare PQRS

Why Participate in PQRS?

- The “carrots” are gone… PQRS participation in 2016 determines if adjustment penalties will be applied to your 2018 Medicare payments:

Year	Reporting Year	Adjustment Penalty
2016	2014	**-2.0%**
2017	2015	**-2.0%**
2018	**2016**	**-2.0%**

- PQRS participation included in CMS Physician Compare data http://www.medicare.gov/physiciancompare/search.html
- Value-based modifier incentive / payment adjustment **linked** to PQRS participation – potentially additional **2-4% penalty**

Who Can Report as a PQRS Eligible Professionals (EP)?

- **Physicians**
  - MD / DO
  - Podiatrist
  - Optometrist
  - Oral Surgeon
  - Dentist
  - Chiropractor
- **Therapists**
  - Physical Therapist
  - Occupational Therapist
  - Qualified Speech-Language Therapist
- **Practitioners**
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - CRNA / AA
  - Certified Nurse Midwife
  - Clinical Social Worker
  - Clinical Psychologist
  - Registered Dietician
  - Nutrition Professional
  - Audiologist

How To Get Started…

1. **Determine eligibility to report 2016 PQRS**
2. **Decide how to participate in 2016 PQRS: Individual versus Group (must register by 6/30/16)**
3. **Choose reporting method:**

3. **Select individual measures or measures group**
4. **Perform, document & report measures**

http://tinyurl.com/2016PQRS-ImplementationGuide

2016 PQRS: Choosing How To Participate – Individual Eligible Professional (EP)

- PQRS reporting analysis is based on **each** individual NPI / Tax ID (TIN) combination
  - Individual EP reporting in multiple Tax IDs: PQRS payment adjustment would be applied to each unsuccessful NPI/TIN reporting

- Individual EP within a group practice that report as individuals are free to choose which PQRS measures / measures group to report
  - **NO** requirement to register to participate as an individual EP
  - Analysis is based on the individual/rendering NPI – not group NPI

2016 PQRS: Choosing How To Participate – Individual Eligible Professional (EP)

- Individual EP can successfully report PQRS under 1 TIN and have penalty adjustment applied for not successfully report under different TIN
- Potential for some individual EP in a group practice to successfully report while other EP in same group may be subject to penalty
- For EP in solo practices, participating in PQRS as an individual is the **only** option
- 2016 PQRS reporting options: Individual measures, Measures Groups
- 2016 PQRS reporting methods: Claims-based, Qualified Registry, EHR, Qualified Clinical Data Registry

2016 PQRS: Choosing How To Participate – Group Reporting Option (GPRO)

- Group practice: single Tax Identification Number (TIN) with **2 or more** individual EPs who have reassigned their billing rights to the TIN
  - PQRS reporting analyzed at the group or TIN level rather than individual NPI
  - **Deadline** for 2016: Group practices choosing PQRS GPRO **must** self-nominate / register between April 1, - June 30, 2016 via the Web www.qualitynet.org
  - Group practice will determine its size based on the number of EPs (NPIs) billing under the TIN at the time of registration: 2-24 EPs, 25-99 EPs, and 100 or > EPs
  - During registration, group practices must also indicate their reporting method for the 12-month period

2016 PQRS: Choosing How To Participate – Group Reporting Option (GPRO)

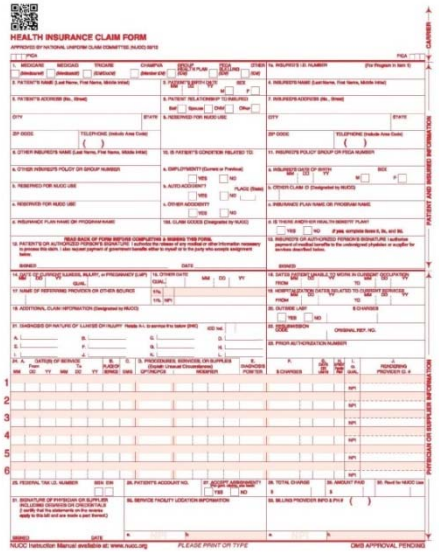
- Once a group practice (TIN) registers to participate in the GRPO, this is the **only** PQRS participation available to the group & all individual EPs who bill Medicare under the group's TIN for 2016
  - Groups who register for the 2016 PQRS GPRO will not be able to withdraw its registration
- Benefit of reporting as GPRO: less administrative burden
  - Billing and reporting staff may report one set of quality measures data on behalf of all EP within a group practice, reducing the need to keep track of individual EP's reporting efforts separately

2016 PQRS: Choosing How To Participate – Group Reporting Option (GPRO)

- PQRS for Groups (GPROs) are analyzed at the TIN level under the TIN submitted at the time of the final self-nomination / registration
  - If a group is unsuccessful at preventing a PQRS payment adjustment, **all** NPIs under the TIN during the unsuccessful reporting period will receive the payment adjustment
- 2016 PQRS reporting options: Individual measures
  - Measures Groups **not** an option for GPRO reporting
- 2016 PQRS reporting methods: Qualified Registry, Qualified Clinical Data Registry, EHR, GPRO Web-Interface (25+ EPs),CMS-certified survey vendor for CAHPS in combination with one of other methods
  - CAHPS: Consumer Assessment of Healthcare Providers & Systems

http://tinyurl.com/CMS-CAHPS http://tinyurl.com/CMS-CAHPSforPQRS

What Are the Methods to Report PQRS Measures?



- **Claims-Based Reporting**
  - Individual EP reporting as individual **only**, **no** Group EP reporting
  - No enrollment or registry requirement to begin reporting
  - Simply report appropriate PQRS denominator and numerator code(s) on the same claim as payable service
  - Can be sent either via electronic or paper 1500 claim form
  - 12 month period only
  - Individual measures: **≥ 50%** of PQRS measure applicable Medicare Part B patients
  - Measures group: **NOT** a reporting option

PQRS Claims-Based Reporting

- CMS **strongly encourages** claims-based billing of all 2016 QDCs with a **$0.01** charge
  - **Cannot** hold beneficiary responsible for nominal amount
  - The submitted charge field **cannot** be left blank
- Entire claims with a zero charge will be denied - total charge for claim **cannot** be zero
- EP will receive a Remittance Advice (RA) associated with the PQRS claim which contains a PQRS QDC line item:
  - Billed with $0.01: claims adjustment reason code CO 246 **N620** – "*This non-payable code is for required reporting only*"

☑ Check to see if QDC is being received by MAC/contractor

- The N620 claims adjustment reason code does **NOT** indicate whether the QDC was correct or that PQRS quotas were met; but rather only that the QDCs were received

http://tinyurl.com/2016PQRS-ClaimsSimple

Successful PQRS Claims-Based Reporting

- Claims for 2016 PQRS program **must** reach the NCH database by February 24, 2017 to be included in the analysis
- Claims may **NOT** be resubmitted for the sole purpose of adding or correcting QDCs
  - If you forget to report the PQRS code for the measure, **CANNOT** add code to claim that has already been processed!
    - **Only** exception is if claim for corresponding PQRS denominator service was denied for any reason, i.e. not processed for payment
  - Claims that are resubmitted only to add the PQRS QDC (numerator) code will **NOT** be included in the analysis

What Are the Methods to Report PQRS Measures?

- **Registry-Based Reporting**
  - Collects clinical data submitted from EP and submits PQRS individual measures or measures groups to CMS on behalf of participants
  - Provides CMS with EP's calculated reporting and performance rates at the end of the reporting period
  - **12**-month reporting period **only** (Jan 1 – Dec 31, 2016)
  - Individual measures: at least **50%** of applicable Medicare Part B patients (same as claims-based requirements)
  - Measures group: **≥ 20** patient sample, a majority (at least 11 out of 20) must be Medicare Part B patients

Registry-Based Reporting Options

- ☑ **Not** all registries report all individual measures and/or measures groups – best to check!
- **Must** use a CMS qualified PQRS registry - often specialty or membership societies
  - Responsible for providing instructions on how to submit the selected 2016 measures / measures group in 1st quarter of 2017
- CMS Qualified 2016 Registry list: http://tinyurl.com/CMS-PQRS-2016Registries

- After selecting a qualified registry, it is important that you provide the correct/accurate NPI/TIN combination for incentive payment purposes
  - Individual EPs: report the TIN & individual rendering NPI to which Medicare Part B charges are billed, **not** group NPI

What Are the Methods to Report PQRS Measures?

- **Electronic Health Record-Based Reporting;**
  2 methods:
  - **Direct** EHR-based: EPs submit PQRS quality measure data directly from the CEHRT to CMS
  - Qualified EHR **Data Submission Vendor**; PQRS quality measure data extracted from CEHRT to DSM vendor who submits to CMS on behalf of the EP or Group practice
  - **Must** use technology that is Certified EHR technology (CEHRT)
  - ✓ Best to check PQRS individual measures list as not all are allowed to be reported via EHR-based reporting

http://tinyurl.com/2016PQRS-EHRSimple

http://tinyurl.com/2016PQRS-Group-EHRreporting

Electronic Health Record-Based Reporting Options

- Reporting PQRS via CEHRT is aligned with the Medicare EHR Incentive Program (Meaningful Use)
  - **2 for 1:** report your clinical quality measures (CQM) electronically through the PQRS EHR reporting option portal - can fulfill the CQM requirements for both PQRS and Meaningful Use
  - Recommend working with your EHR vendor

http://tinyurl.com/eCQM-Specifications

http://tinyurl.com/eCQMs-2016Reporting

What Are the Methods to Report PQRS Measures?

- **Qualified Clinical Data Registry (QCDR)**
  - **New** for 2016: reporting option for not only Individual EPs, but **also GPRO** reporting
  - A CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients
    - Data submitted covers quality measures across multiple payers & is **not** limited to Medicare beneficiaries
    - Different from a qualified registry – **not** limited to measures within PQRS

http://tinyurl.com/2016PQRS-QCDRSimple

Qualified Clinical Data Registry (QCDR)

- May submit measures from one or more of the following categories with a **maximum** of **30** non-PQRS measures allowed:
  - Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS)
  - National Quality Forum (NQF)-endorsed measures
  - Current 2016 PQRS individual measures
  - Measures used by boards or specialty societies
  - Measures used in regional quality collaborations
- **Must** report on at least **2** outcome measures
- CMS Qualified 2016 Qualified Clinical Data Registry list not released yet: http://tinyurl.com/CMS-PQRS-QCDR

What Are the Methods to Report PQRS Measures?

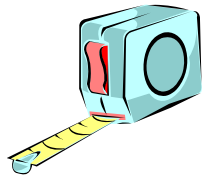
- **Group Practice Reporting Options (GPRO)**
  - **GPRO Web** interface:
    - **2-24 EPs/group**: cannot report through this option
    - **25+ EPs/group**: report designated measures on 1st consecutive 248 designated Medicare patients; if less, report 100% of assigned
  - **Qualified Registry**: 2-99 EP groups: same as individual EP reporting requirements
  - **Qualified Clinical Data Registry** : 2-99 EP groups: same as individual EP reporting requirements
  - **Direct EHR or EHR Data Submission Vendor**: 2+EP groups: same as individual EP reporting requirements.

http://tinyurl.com/PQRS-GPRO-WebInterface

Reporting Medicare PQRS

- **FYI**: If an individual EP or a GPRO organization changes TINs during reporting period, the participation under the old TIN **does not** carry over to the new TIN, nor is it combined for final analysis

What Are Quality Measures?



- Indicators of the quality of care provided by eligible professionals
- Tools that help CMS measure or quantify …
  - Health care processes, outcomes, patient perceptions and organizational structure

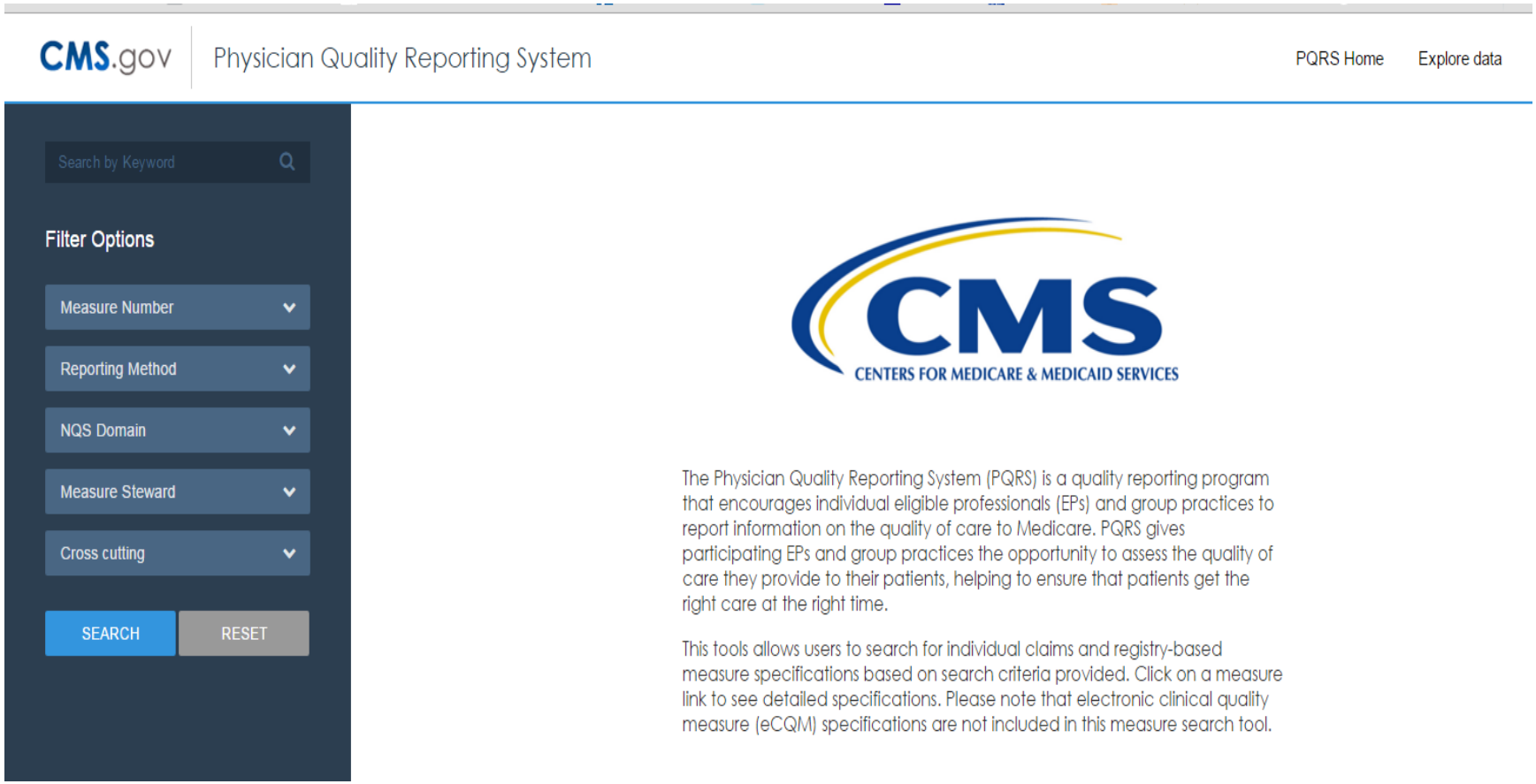
  And/or

  - Systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care
- These goals include: effective, safe, efficient, patient-centered, equitable and timely care

How Should You Determine Which Individual Measures Or Measures Group to Report?

- Review the measures list
- Consider important factors - at a minimum, the following factors should be considered when selecting measures for reporting:
  - Clinical conditions usually treated
  - Types of care typically provided – e.g., preventive, chronic, acute
  - Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite
  - Quality improvement goals for 2016
  - Other quality reporting programs in use or being considered
- Review measure specifications

NEW! 2016 PQRS Individual Measure Web-based Tool



https://pqrs.cms.gov/#/home

2016 PQRS Specialty Measure Sets

- Can be used as a guide for EPs to choose individual measures applicable to their specialty; they are **not** required measures - only suggested measure for specific specialties
  - Cardiology
  - Dermatology
  - Emergency Medicine
  - Gastroenterology
  - General Practice/ Family Practice
  - General Surgery
  - Hospitalist
  - Internal Medicine
  - Mental Health
  - Multiple Chronic Conditions
  - Obstetrics/Gynecology
  - Oncology/Hematology
  - Ophthalmology
  - Pathology
  - Physical Therapy/ Occupational Therapy
  - Radiology
  - Urology

http://tinyurl.com/PQRS-SpecialtyMeasureSets

PQRS Individual Quality Measures

- 2016 – 233 quality measures
  - Includes 36 new measures; 10 measures removed
  - 106 are reportable **ONLY** through registry method
  - 33 are reportable **ONLY** through EHR method

☑ Best to check: Each measure has different specifications, codes & reporting options

Measure Title	Measure Number			Measure Description	NQS Domain	Measure Type	Reporting Method(s)						Use in Other Reporting Program(s)		
	CMS	NQF	PQRS				Claims	CSV	EHR	GPRO Web Interfa	Measure Groups	Registry	Crosscutting Measures	Meaningful Use I	Meaningful Use II
Documentation of Current Medications in the Medical Record	68v5	0419	130	Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Patient Safety	Process	X	-	X	X	X	X	X	-	X

http://tinyurl.com/PQRSMeasureCodes

How to Report PQRS Measures: Denominator

- **Key Question**: "Does this patient visit / service meet the PQRS measure criteria for the EP to report?"
- Describes **eligible cases** for a measure (the eligible patient population associated with a measure's numerator)
  - ICD-10-CM, CPT Category I & HCPCS codes
    - **G44.85** *Primary stabbing headache*
    - **M81.0** *Age-related osteoporosis without current pathologic …*
    - **99201-99205** *New patient visit*…
    - **77002** *Fluoroscopic guidance for needle placement …*
    - **G0444** *Annual depression screening*
  - Patient demographics (age, gender, etc.) & place of service
    - Patients aged 18 – 79 years

How to Report PQRS Measures: Numerator

- The specific **clinical action** required by the measure for reporting and performance (i.e., patients who received a particular service or obtained a particular outcome that is being measured)
  - Pain assessment, Functional status assessment
- **Quality Data Code** (QDC): specified CPT Category II codes with or without modifiers and/or HCPCS G-codes that describe the clinical action required by the measure's numerator

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

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

PQRS Measures

- Each measure has a **Reporting Frequency** requirement: number of times QDCs specified for a quality measure must be submitted on claims during the reporting period
  - "How often do you need to report the measure?"
    - Report only one-time per EP
    - Report three times per year
    - Report once for each procedure performed
    - Report for each acute episode / each visit
- Some measures have a **Performance Timeframe** – designated timeframe within which the action described in a performance measure should be completed; may or may not coincide with measure's data reporting frequency requirement
  - Perform within 12 months or annually
  - Perform within 4 hours of…

How Does Medicare Calculate a PQRS Individual Measure Reporting Performance?

- The PQRS individual measure final reporting rate calculation represents the percentage of the eligible population (denominator) that received a particular process of care or a particular outcome (numerator)

Numerator Codes

G8417 G4818 G4819 G4820
G4821 G4822 G8938

Denominator Codes

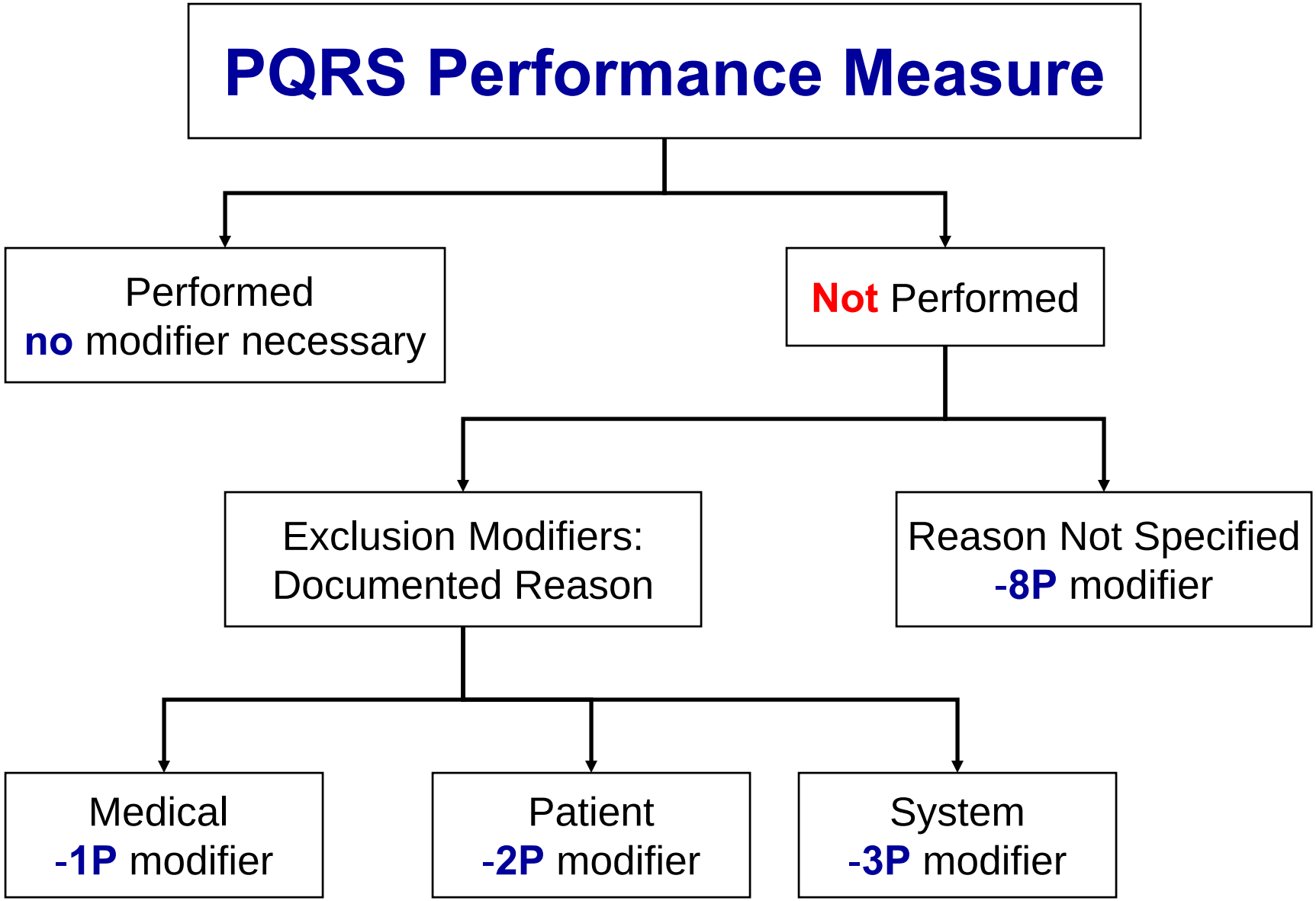
99201 99202 99203 99204
99205 99212 99213 99214
99215

- Note the difference if the PQRS individual measure requires the EP to report only once per the 12 month reporting period or **EACH** time one of the denominator codes is reported for each Medicare Part B beneficiary that meets the requirements

What Are Performance Measure Modifiers?

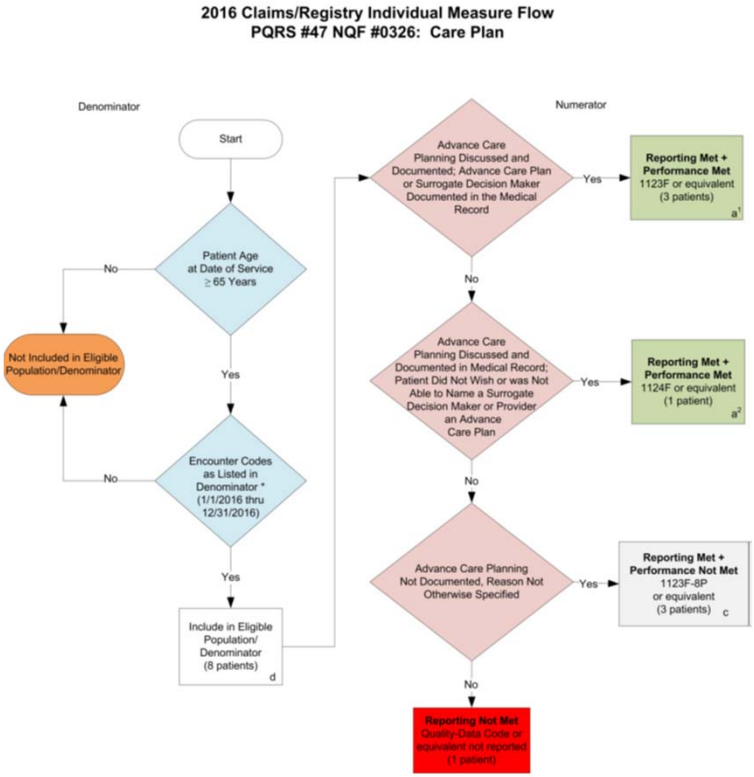
- CPT II modifiers developed exclusively for use **only** with CPT Category II codes; **cannot** be used with HCPCS G-codes
- Can only report a maximum of 1 modifier; cannot combine performance measure modifiers
- Some PQRS measures have more than one allowable exclusions
- Certain PQRS measures **have no** applicable exclusions, i.e. no modifiers can be reported

☑ Best to check the PQRS individual measure specifications to determine appropriate exclusion modifiers


PQRS Performance Measure
Performed
no modifier necessary
Not Performed
Exclusion Modifiers:
Documented Reason
Reason Not Specified
-8P modifier
Medical
-1P modifier
Patient
-2P modifier
System
-3P modifier

2016 PQRS Individual Claims Registry Measure Specifications

- ZIP file with separate PDF for each PQRS individual measure
- 2016 PQRS Measure Flows have been incorporated within each 2016 Individual Measure Specification PDF



http://tinyurl.com/2016-PQRS-IndMeasSpec

National Quality Strategy (NQS)

- The Affordable Care Act sought to increase access to high-quality, affordable care for all Americans; it required the Secretary of HHS to establish a National Strategy for Quality Improvement in Health Care (National Quality Strategy) that set priorities to guide effort and include a strategic plan for how to achieve it
  - Set of 3 overarching aims were developed to establish framework within which specific priorities could be identified and implemented
    - Better Care
    - Healthy People/Healthy Communities
    - Affordable Care
  - To advance these aims, the NQS will focus initially on **6** priority domains …

National Quality Strategy Domains

- **Patient Safety**: making care safer by reducing harm caused in the delivery of care
- **Person and Caregiver-Centered Experience and Outcomes**: Ensuring that each person and family is engaged as partners in their care
- **Communication and Care Coordination**: Promoting effective communication and coordination of care
- **Effective Clinical Care**: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- **Community/Population Health**: Working with communities to promote wide use of best practices to enable healthy living
- **Efficiency and Cost Reduction**: Making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models

2016 PQRS Cross-Cutting Measures

- Part of Medicare's mission to obtain "a better picture of the overall quality of care furnished by EP, particularly for the purpose of having PQRS reporting being used to assess quality performance under the Value-Based modifier"
- To satisfactorily report 2016 PQRS via **claims** and **registry** reporting of **individual measures**, EP or group practice is **required** to report 1 cross-cutting measure if they have at least 1 Medicare patient with a face-to-face encounter.
  - Face-to-face encounter: instance in which the EP billed for services that are associated with face-to-face encounters under the Physician Fee Schedule; includes office visits, surgical procedure codes (not telehealth visits); Cross-cutting Measures List: http://tinyurl.com/CMS-PQRS-CrossCut
- **Not** in addition to regular 9 individual measure reporting

2016 Successfully Reporting: PQRS Individual Measures to Avoid 2018 PQRS Penalty Adjustment

- Report **at least 9** measures covering **at least 3** NQS domains **AND** report each measure for **at least 50%** of the EP's measure applicable Medicare Part B patients seen during the 12 month reporting period (Jan 1 – Dec 31, 2016)
  - Claims-based & Registry Reporting: of the measures reported, if the EP sees at least **1** Medicare patient in a face-to-face encounter, the EP will report on at least **1** measure contained in the cross-cutting measure set
- Note 50% threshold reporting requirement; if an EP reports on less than 50% ➔ 2018 penalty **applies**

What happens if you can't find 9 applicable individual measures to report OR the 9 individual measures are from only 1 or 2 NQS domains?

Measure Applicability Validation (MAV)

- A measure-applicability validation (MAV) process will apply for those EP that report less than **9** individual measures and/or covering less than **3** NQS domains
- **Only** applies to PQRS individual measures reported via claims or registry reporting method
- In order for MAV to be applied, EP ….
  - **Must** satisfactorily report on at least 50% of their eligible patients / encounters for each individual measure reported
  - **Must** report at least 1 cross-cutting measure if applicable
  - **Cannot** have 0% performance on individual measure(s) reported
- MAV does **not** apply to PQRS Measure groups or individual measures reported via Electronic Health Record, a Qualified Clinical Data Registry or Group Practice Reporting Option Web Interface

http://tinyurl.com/CMS-PQRS-Analysis-Payment

What Are PQRS Measures Groups?

- A group of measures covering patients with a specific condition or preventive service that is addressed by **at least six measures** that share a common patient / visit clinical condition or focus
- **Only** the defined PQRS measures groups can be utilized when reporting the measures group options
  - All other individual measures that are included in PQRS but not defined as included in a measures group **cannot** be grouped together by EP to define a measures group
  - Some measures groups include performance measures that can **only** be reported as a group

PQRS Measures Groups

- 2016: 25 measures groups
  - Includes 3 new measures groups, 0 deleted for 2016
  - **Only** reportable by individual EP, **no** GPRO reporting option
  - **ONLY** can report by qualified PQRS registry; **no** claims-based, QCDR or EHR method reporting options
  - Each of the applicable measures in a measures group **must** be reported for each patient
- Only one 2016 reporting period for EPs to report PQRS measures groups: **12**-month (Jan 1 – Dec 31, 2016)
- Measure applicability validation process **not** an option

PQRS Measures Groups

- ☑ Best to check: Measures Group specifications may be different from those of the individual measures that form the group; use the **correct** specifications manual!

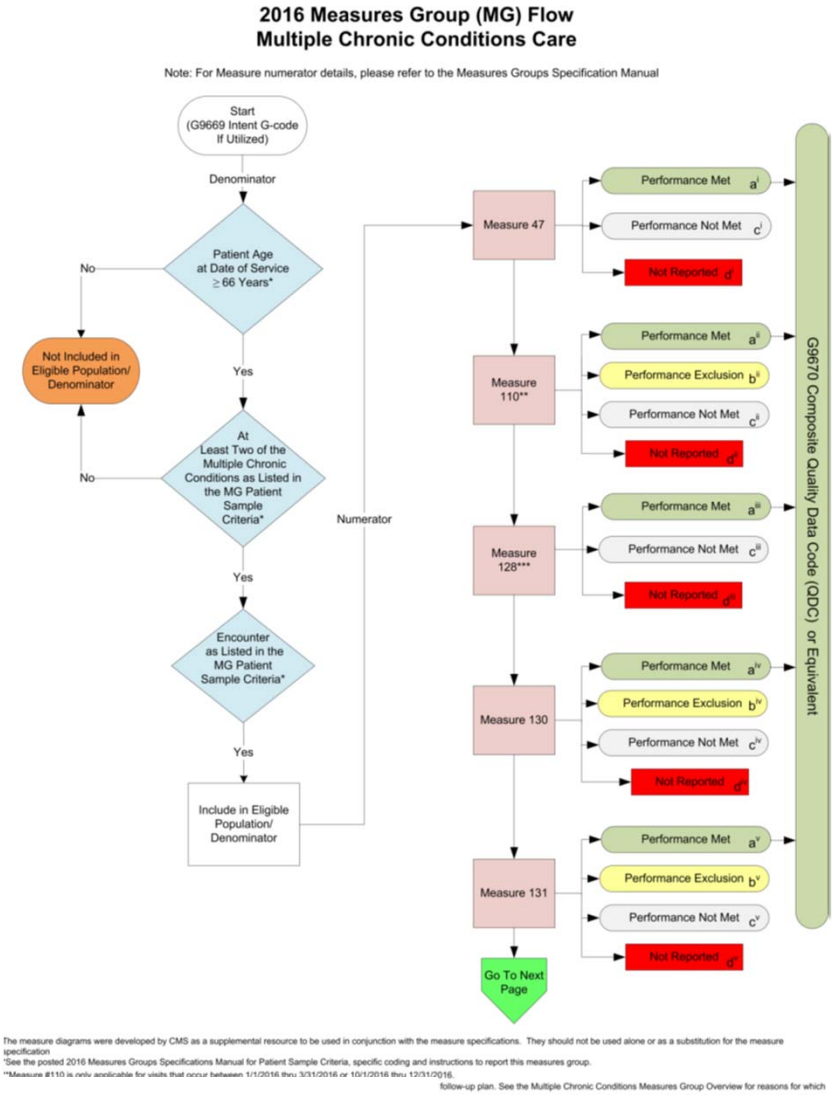
http://tinyurl.com/PQRS-2016MeasuresGroupSpec

Overview	Dementia Measures Group	225
47	Care Plan	227
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	228
280	Dementia: Staging of Dementia	230
281	Dementia: Cognitive Assessment	231
282	Dementia: Functional Status Assessment	232
283	Dementia: Neuropsychiatric Symptom Assessment	233
284	Dementia: Management of Neuropsychiatric Symptoms	235
286	Dementia: Counseling Regarding Safety Concerns	236
287	Dementia: Counseling Regarding Risks of Driving	238
288	Dementia: Caregiver Education and Support	239

- Reminder: can **only** report measures group via qualified registry, can not report via claims

2016 PQRS Measures Group Flow Documents

- ZIP file with separate PDF for each PQRS measures group
- Unlike the 2016 Individual measures, the 2016 PQRS Measures Group Flow documents are separate PDF from 2016 PQRS Measures Group Specification file



http://tinyurl.com/PQRS-2016MeasureGrpFlow

2016 Successfully Reporting: PQRS Measures Group to Avoid 2018 Penalty Adjustment

- Report **at least 1** measures group **AND** report each measures group for **at least 20** patients, a majority (at least 11 of 20) of which are required to be Medicare Part B patients
  - If the minimum number of patients **does not** meet the measures group **≥** 20 patient sample criteria, the EP **does not** prevent the 2018 penalty
- If an EP **does not** have the minimum number of patients for inclusion in the required patient sample for the reporting period, EP should report either another measures group OR select reporting of individual measures that are applicable to the EP's practice

Successfully Report PQRS

- Clinical measure(s) which you are reporting **must** be documented in the medical record
- PQRS is a reporting program; reporting of non-performance of measures potentially will count toward the prevention of payment adjustment (whether the clinical action is reported as completed or not completed via a performance measure exclusion modifier) …
- **Reminder**: **0%** performance rate on an individual measure will **not** be counted toward 2016 PQRS requirements
  - Measures groups containing a measure with **0%** performance rate will **not** be counted as satisfactorily reporting the measures group
  - Reporting that the EP did not perform the measure 100% of the time is **not** accepted!

PQRS Participation Reports

- Each year following data analysis, CMS releases PQRS feedback reports
  - Effective July 2015, CMS changed PQRS report access to the Enterprise Identity Management System (EIDM); CMS moved prior IACS users & data over to EIDM
  - Reports now available through PQRS Portal portion of the CMS Enterprise Portal at http://portal.cms.gov
    - Look at bottom left hand corner of page – "Physician Value"
  - EIDM User Guide: http://tinyurl.com/CMS-EIDM-Guide
- Reports are available for every TIN under which at least 1 EP submitted at least 1 valid PQRS measure via claims-based reporting a minimum of once during reporting period

PQRS Participation Reports

- Historically, final reports are not released until 4-6 months after end of reporting period with no method to monitor PQRS reporting during the actual reporting period
- **Interim Feedback** Dashboard reports
  - Available to those EP using **claims-based** reporting; qualified PQRS registries & EHR vendors are also required to provide interim feedback reports, if technically feasible
  - Allows organizations and EP to log-in and access their interim PQRS reported data on a quarterly basis in order to monitor the status of claims-based individual measures reporting
  - Interim Feedback Dashboard User Guide: http://tinyurl.com/PQRS-InterimRPTGuide

Where To Get PQRS Help?

- Contact the **QualityNet Help Desk** for help with program questions ranging from "How do I get started?" to accessing feedback reports
  - **866-288-8912** http://tinyurl.com/PQRS-HelpDesk
  - **Or e-mail**: Qnetsupport@hcqis.org
- **Medicare PQRS website:** http://www.cms.gov/PQRS/
- **Medicare 2016 PQRS Implementation Guide:** http://tinyurl.com/2016PQRS-ImplementationGuide
- **Medicare PQRS Reporting Made Simple:**
  - Claims: http://tinyurl.com/2016PQRS-ClaimsSimple
  - Registry: http://tinyurl.com/2016PQRS-RegistrySimple
  - EHR: http://tinyurl.com/2016PQRS-EHRSimple
  - QCDR: http://tinyurl.com/2016PQRS-QCDRSimple
  - GPRO: http://tinyurl.com/2016PQRS-GPROSimple
- **CMS Frequently Asked Questions Search Engine:** http://tinyurl.com/CMS-PQRS-FAQ

Transitioning from Volume to Value

Value-based Payment Modifier

http://tinyurl.com/Medicare-VBPM

- **CMS Physician Value Help Desk** for Value Modifier questions
  - **888-734-6433**, press option 3 (8:00 a.m. – 8:00 p.m. EST M-F)

Value-Based Payment Modifier

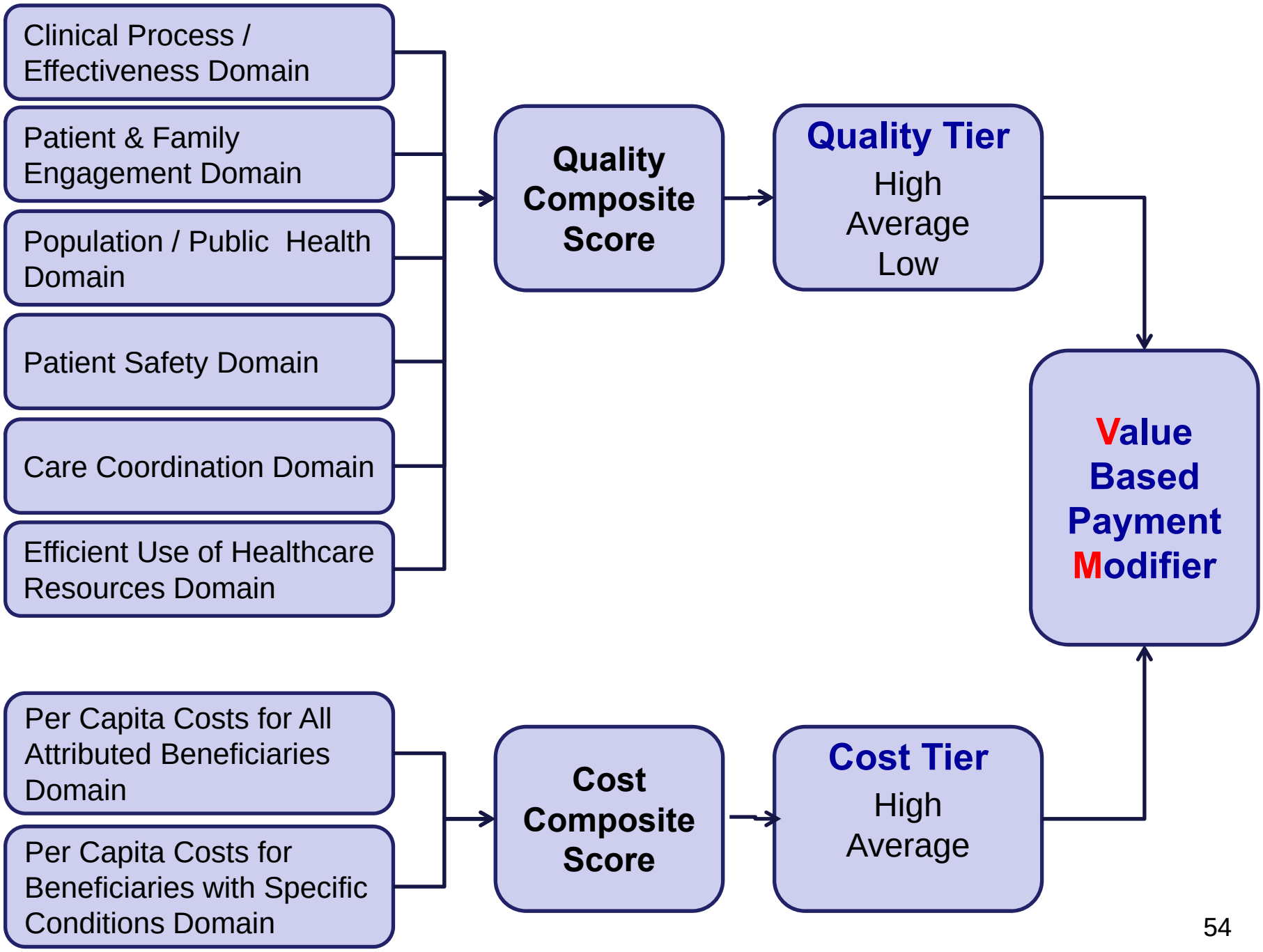
- CMS is moving toward physician payment that rewards value rather than volume.
  - CMS set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018.
- The Affordable Care Act (ACA) **required** HHS to establish a budget-neutral Value-Based Payment Modifier (**VM**)
  - Based upon **quality** of care compared to the **cost** of care furnished to Medicare beneficiaries
  - Providers practicing high-quality, low-cost medicine will earn a positive VM, while providers determined to provide low-quality and high-cost care will receive a negative VM

How Are VM Payment Adjustments Applied?

- CMS divides TINs subject to VM into two categories based on their registration and participation in the PQRS basis performance period:
  - **Category 1**: includes TINs that met the criteria as a group to avoid the corresponding PQRS payment adjustment OR at least 50% of EPs in the TIN met the criteria to avoid the corresponding PQRS payment adjustment as individuals
  - **Category 2**: includes TINs subject do **not** meet the criteria for inclusion in Category 1, including all non-PQRS reporters
- FYI: any VM payment adjustment is in **addition to** any PQRS negative payment adjustment!

How Does VM Work?

1. PQRS-reported quality information along with CMS-calculated outcomes & cost measures are analyzed
2. Each group practice receives two composite scores: a **quality** and a **cost** composite
3. CMS classifies each score into "**high**", "**average**" or "**low**" based on whether the score is at least 1 standard deviation above/below the national mean score, which IDs statistically significant outliers
4. "**Quality Tiering**" Analysis: CMS assigns outliers to their respective quality and cost "tiers" to determine whether the score will earn the practice a bonus, penalty or no adjustment to their payment based on their performance in these categories


Clinical Process / Effectiveness Domain
Patient & Family Engagement Domain
Population / Public Health Domain
Patient Safety Domain
Care Coordination Domain
Efficient Use of Healthcare Resources Domain
Quality Composite Score
Quality Tier
High
Average
Low
Value Based Payment Modifier
Per Capita Costs for All Attributed Beneficiaries Domain
Per Capita Costs for Beneficiaries with Specific Conditions Domain
Cost Composite Score
Cost Tier
High
Average

Value-Based Payment Modifier

- Medicare adjusts eligible provider payments using quality outcomes data from the Physician Quality Reporting System (PQRS) and cost data from Medicare claims for fee-for-service patients
  - This is a pay for value (i.e., quality relative to cost) program – higher value gets higher pay; lower value gets lower pay, based on quality tiering
- Quality and Resource Use Reports (QRUR) provide the quality-related feedback
- VM is separate from PQRS and EHR Meaningful Use programs

Who Is Subject to the VM?

- **Jan 1, 2017**: VM will be applied to Medicare PFS physician payments for physician **solo practitioners** and physicians in groups of **2 or more** EPs as identified by their TIN.
  - **2015** was the performance basis period for the 2017 VM
- **Jan 1, 2018**: VM will be applied to Medicare PFS payments for physician **and non-physician** EPs who are solo practitioners or in groups of 2 or more EPs as identified by their TIN.
  - **2016** is the performance basis period for the 2018 VM

Quality Resource and Use Reports (QRURs)

- Confidential feedback reports provided to physicians and groups of physicians under the Medicare Physician Feedback Program
  - Provide information about the resources used and the quality of care furnished to their Medicare fee-for-service (FFS) patients
  - Can be used to compare with other physicians and groups of physicians caring for Medicare patients
  - Contain quality of care and cost performance rates on measures that will be used to compute the VM

  - Provide meaningful and actionable information to providers so they can improve the care they deliver

Quality Resource and Use Reports (QRURs)

- **2012 QRURs**: made available in September 2013 based on care provided in 2012 to group practices that had at least 25 EPs
- **2013 QRURs**: made available September 2014, based on care provided in 2013 to all groups as well as solo physicians who met specific criteria
- **2014 QRURs**: made available in September 2015 to every group practice and solo practitioner nationwide; groups and solo practitioners are identified in the QRURs by their TIN;
  - Also available for groups / solo practitioners that participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2014 as well as those TINs consisting only of non-physician EPs

http://tinyurl.com/CMS-2014-QRUR

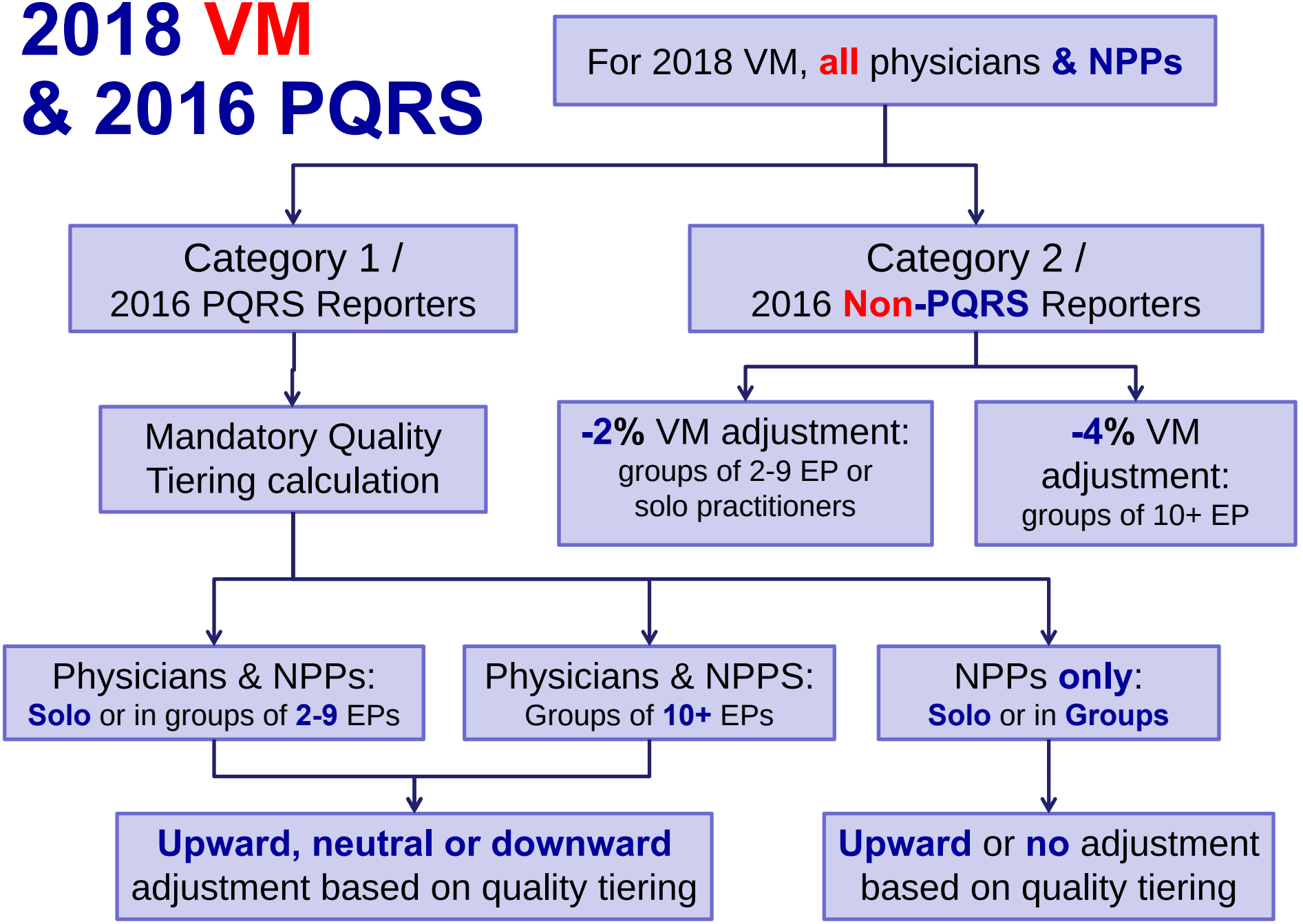
VBPM & QRUR Resources

- QRUR report accessible through CME Enterprise portal: https://portal.cms.gov/wps/portal/unauthportal/home/
- CMS "How to obtain a QRUR" website: http://tinyurl.com/CMS-ObtainQRUR
- An Enterprise Identity Management System (EIDM) account is required – same registration necessary in order to access PQRS reports http://portal.cms.gov
- "Quick Reference Guide for Accessing the 2014 QRURs" http://tinyurl.com/Access-2014QRUR
- "How to Understand Your 2014 Annual QRUR…" http://tinyurl.com/CMS-Understand-2014QRUR
- FAQ about 2014 QRUR & 2016 VM: http://tinyurl.com/CMS-FAQ-2014QRUR

VM Implementation

- **2018** VM phased in to apply to **all** EPs, including non-physician practitioners (PAs, NPs, CNSs, CRNAs)
  - **2016 PQRS** reporting used to determine the EP's 2018 VM score
  - TINs that consist of non-physician EPs only will be held harmless from downward adjustments
  - All other TINs will be subject to upward, neutral or downward adjustments
- **Reminder**: the VM payment adjustment is **separate** from the PQRS and other Medicare sponsored programs payment adjustments

2018 VM & 2016 PQRS



2018 VM / 2016 PQRS:
Physician & NPP Groups with 10+ EP

Cost / Quality	Low Quality	Average Quality	High Quality
Low Cost	+ 0.0%	+ 2.0x*	+ 4.0x*
Average Cost	-2.0%	+ 0.0%	+2.0x*
High Cost	-4.0%	-2.0%	+ 0.0%

- Under quality-tiering, successful 2016 PQRS reporters: potential upward adjustment is up to **+4x**; payment at risk is **-4%**
- * the "x" in the upward adjustment represents the payment redistribution adjustment factor
- Automatic downward **4**% adjustment for **NOT** successfully reporting PQRS in 2016

2018 VM / 2016 PQRS:
Physician & NPP Groups with 2-9 EP & Solo Practitioners

Cost / Quality	Low Quality	Average Quality	High Quality
Low Cost	+ 0.0%	+ 1.0x*	+ 2.0x*
Average Cost	-1.0%	+ 0.0%	+1.0x*
High Cost	-2.0%	-1.0%	+ 0.0%

- Under quality-tiering, successful 2016 PQRS reporters: potential upward adjustment is up to **+2x**; payment at risk is **-2%**
- * the "x" in the upward adjustment represents a payment redistribution adjustment factor
- Automatic downward **2**% adjustment for **NOT** successfully reporting PQRS in 2016

2018 VM / 2016 PQRS:
PAs, NPs, CNSs, & CRNAs who are Solo Practitioners or in Groups of NPP EPs Only

Cost / Quality	Low Quality	Average Quality	High Quality
Low Cost	+ 0.0%	+ 1.0x*	+ 2.0x*
Average Cost	+0.0%	+ 0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+ 0.0%

- Under quality-tiering, successful 2016 PQRS reporters: earn only an upward or neutral adjustment in 2018; **no** downward adjustment
- Reminder: automatic negative **2**% payment adjustment for **NOT** successfully reporting PQRS in 2016

Actions for all Group Practices or Solo Practitioners in 2016 for the 2018 VM

- Be sure to satisfactorily report quality data under PQRS for 2016
  - Decide how to participate in the 2016 PQRS program – individual versus group reporting
  - Choose a PQRS reporting mechanism and become familiar with the measures and data submission timeframes
- Download your 2014 Annual QRUR report, which shows 2016 VM information
  - Watch for announcements about availability of the 2015 Mid-Year QRUR & 2015 Annual QRUR
  - Review quality measure benchmarks under the VM, understand what is required for above avg. performance

What Happens Next Year In 2017?

- 2016 is the last year for participation in the individual Medicare PQRS, VM and EHR programs
  - Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) creates a new framework for rewarding health care providers for giving better care, not just more care as well as combines the existing quality reporting programs into one new system
  - **M**erit-based **I**ncentive **P**ayment **S**ystem (MIPS) – will incorporate penalties and bonuses, which will be based on performance scores that are above or below annual thresholds; maximum penalties top out at 4% in 2019 and reach up to 9% in 2022 and beyond
  - Alternate Payment Models (APMs) – Accountable Care Organizations, Patient Centered Medical Homes and bundled payment models

Merit-Based Incentive Program

- New program that combines parts of the current Physician Quality Reporting System, Value Modifier and Medicare Electronic Health Record Incentive programs based on:
  - Quality
  - Resource use
  - Clinical practice improvement
  - Meaningful use of certified EHR technology
- Starting in 2017, MIPS will annually measure Medicare Part B providers in four performance categories to derive a MIPS score which can have a positive or negative effect on the provider's Medicare reimbursement

Proposed 2017 MIPS (0 – 100 points)			
Quality (50%) (replaces PQRS measures)	**Cost** (10%) (replaces VM program)	**Advancing Care Information** (25%) (replaces MU)	**Clinical practice Improvement** (15%) (CPIA – new)

Potential 2016 PQRS Individual Measures for PM&R Providers

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Communication & Care Coordination	**24**	Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women …	C, R	Each occurrence
	46	Medication Reconciliation After Inpatient Facility Discharge **X-Cutting**	C, R	Within 30 days after inpatient discharge
	47	(Advanced) Care Plan **X-Cutting**	C, R	Once / year
	131	Pain Assessment & Follow-Up **X-Cutting**	C, R	Each visit
	155*	Falls: Plan of Care **X-Cutting**	C, R	Once / year

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Communication & Care Coordination (continued)	**325**	Adult Major Depressive Disorder: Coordination of Care of Patients w/ Spec Comorbid Conditions	R	Once / year
	374	Closing the Referral Loop: Receipt of Specialist Report **X-Cutting**	EHR	
	411 New	Depression Remission at Six Months	R	Once / year
Community / Population Health	**110**	Influenza Immunization **X-Cutting**	C, R, EHR, GPRO Web Interface	2 time periods: once each
	111	Pneumonia Vaccination for Older Adults **X-Cutting**	C, R, EHR, GPRO Web Interface	Once / year

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Community / Population Health (continued)	**128**	Body Mass Index (BMI) Screening & Follow-up **X-Cutting**	C, R, EHR, GPRO Web Interface	Once / year
	134	Screening for Clinical Depression & Follow-Up Plan **X-Cutting**	C, R, EHR, GPRO Web Interface	Once / year
	226	Tobacco Use: Screening & Cessation Intervention **X-Cutting**	C, R, EHR, GPRO Web Interface	Once / year
	317	Screening for High Blood Pressure & Follow-up Documented **X-Cutting**	C, R, EHR, GPRO Web Interface	Once / year
	431 **New**	Unhealthy Alcohol Use: Screening & Brief Counseling **X-Cutting**	R	Once / Year

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Effective Clinical Care	**9**	Anti-Depressant Medication Management	EHR	
	32	Stroke & Stroke Rehabilitation: Discharged on Antithrombotic Therapy	C, R	At each discharge from hospital
	39	Screening or Therapy for Osteoporosis for Women Aged 65 – 85 years old	C, R	Once / year
	41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older	C, R	Once / year
	48	Urinary Incontinence: Assessment of Presence or Absence of Women $\geq$ 65	C, R	Once / year

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Effective Clinical Care (continued)	**107**	Adult Major Depressive Disorder: Suicide Risk Assessment	EHR	
	127	Diabetes: Foot & Ankle: Peripheral Neuropathy Neurological Evaluation	R	Once / year
	128	Diabetes: Foot & Ankle: Ulcer Prevention – Footwear Eval	R	Once / year
	163	Diabetes – Foot Exam	EHR	
	178	Rheumatoid Arthritis: Functional Status Assessment	R	Once / year
	236	Controlling High Blood Pressure **X-Cutting**	C, R, EHR, GPRO Web Interface	Once / year

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Effective Clinical Care (continued)	**281**	Dementia – Cognitive Assessment	EHR	
	367	… & Major Depression: Appraisal for Alcohol & Chemical Substance Use	EHR	
	370	Depression Remission at 12 months	R, EHR, GPRO Web Interface	Once / year
	371	Depression: Utilization of PHQ-9 Tool	EHR	
	408 New	Opioid Therapy Follow-up Evaluation	R	Once / year
	412 New	Documentation of Signed Opioid Treatment Agreement	R	Once / year

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Effective Clinical Care (continued)	**414** **New**	Evaluation or Interview for Risk of Opioid Misuse	R	Once / year
	418 **New**	Osteoporosis Management in Women Who Had a Fracture	C, R	Each occurrence of a fracture
	435 **New**	Quality of Life Assessment for Patients with Primary Headache Disorders	C, R	Once / year
Patient Safety	**130**	Documentation of Current Medications in the Medical Record **X-Cutting**	C, R, EHR, GPRO Web Interface	Each visit
	145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy	C, R	Each time

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Patient Safety (continued)	**154**	Falls: Risk Assessment (partnered with #155) **X-Cutting**	C, R	Once / year
	181	Elder Maltreatment Screen & Follow-up Plan	C, R	Once / year
	238	Use of High-Risk Medications in the Elderly	R, EHR	Once / year
	318	Falls: Screening for Fall Risk **X-Cutting**	EHR, GPRO Web Interface	
Efficiency & Cost Reduction	**312**	Use of Imaging Studies for Low Back Pain	EHR	
	419 New	Overuse of Neuroimaging for Patients with Primary Headache & a Normal Neurological Examination	C, R	Each Visit

National Quality Strategy Domain	PQRS #	Individual Measure Description	Reporting Options	Reporting Frequency
Person & Caregiver-Centered Experience & Outcomes	**50**	Plan of Care for Urinary Incontinence in Women Aged 65 and Older	C, R	Once / year
	109	Osteoarthritis: Function and Pain Assessment	C, R	Each visit
	342	Pain Brought Under Control Within 48 Hours After Admission to Palliative Care	R	Once / year
	375	Functional Status Assessment for Knee Replacement	EHR	
	376	Functional Status Assessment for Hip Replacement	EHR	
	377	Functional Status Assessment for Complex Chronic Conditions	EHR	

Potential 2016 PQRS Measure Groups for PM&R Providers

2016 PQRS: Measures Group – Registry Reporting Only

PQRS #	Individual Measure Description
DEMENTIA MEASURES GROUP	
47	(Advanced) Care Plan
134	Screening for Clinical Depression and Follow-up Plan
280	Dementia: Staging of Dementia
281	Dementia: Cognitive Assessment
282	Dementia: Functional Status Assessment
283	Dementia: Neuropsychiatric Symptom Assessment
284	Dementia: Management of Neuropsychiatric Symptoms
286	Dementia: Counseling Regarding Safety Concerns
287	Dementia: Counseling Regarding Risks of Driving
288	Dementia: Caregiver Education and Support

2016 PQRS: Measures Group – Registry Reporting Only

PQRS #	Individual Measure Description
PARKINSON'S MEASURES GROUP	
47	(Advanced) Care Plan
289	Annual Parkinson's Disease Diagnosis Review
290	Parkinson's Disease: Psychiatric Disorders or Disturbances Assessment
291	Parkinson's Disease: Cognitive Impairment or Dysfunction Assessment
292	Parkinson's Disease: Querying about Sleep Disturbances
293	Parkinson's Disease: Rehabilitative Therapy Options
294	Parkinson's Disease Medical & Surgical Treatment Options Reviewed

2016 PQRS: Measures Group – Registry Reporting Only

PQRS #	Individual Measure Description
PREVENTIVE CARE MEASURES GROUP	
39	Screening for Osteoporosis for Women Aged 65-85 Years of Age
48	Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years of Age or Older
110	Influenza Immunization
111	Pneumonia Vaccination Status for Older Adults
112	Breast Cancer Screening
113	Colorectal Cancer Screening
128	Body Mass Index Screening & Follow-up Plan
134	Screening for Clinical Depression and Follow-up Plan
226	Tobacco Use: Screening and Cessation Intervention
431	Unhealthy Alcohol Use: Screening & Brief Counseling

2016 PQRS: New Measures Group – Registry Reporting Only

PQRS #	Individual Measure Description
MULTIPLE CHRONIC CONDITIONS	
047	Care Plan
110	Preventive Care and Screening: Influenza Immunization
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:
130	Documentation of Current Medications in the Medical Record:
131	Pain Assessment and Follow-Up:
134	Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:
154	Falls: Risk Assessment:
155	Falls: Plan of Care:
238	Use of High-Risk Medications in the Elderly:

2016 Multiple Chronic Conditions PQRS Measures Group

- Patient sample criteria for the Multiple Chronic Conditions Measures Group are patients:
  - Aged 66 years and older
  - With at least of the two conditions as listed in the Chronic Conditions Data Warehouse (CCW)

    http://tinyurl.com/CMS-CCWdata

  - Accompanied by a specific encounter:
    (one of the following patient encounter codes)

    99487 *Complex chronic care management services, …*

    99490 *Chronic care management services, …*

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