Physician Quality Reporting System Update 2014

By
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Medicare Fee Schedule

- There have been press releases stating that we will receive a pay increase from Medicare this year.
- Yet, the fee schedules that have been published so far have not reflected that.
- The initial fee schedule published by the Medicare Administrative Contractors contained the 20% cut that was due to happen on January 1.
- They could not change that fee schedule until the president signed the law delaying the cut.
- After the law was signed, the MACs posted fee schedules that reflected a 0.5% increase as allowed by the law.
- CMS is currently evaluating whether or not they have collected enough to make up for the $50 million shortfall during the Chiropractic Demonstration Project.
- If they have made up the difference, that will add 2% to the fee schedule for chiropractors.
- CMS has revalued the Relative Value Units for the codes 98940, 98941, and 98942.
- That means that we will see between a 8% and a 15% increase in the value of these codes.
- This will be reflected in the fee schedule.
- We may see this as early as March.

OIG Office Audits

- The OIG is currently conducting audits of chiropractors offices.
- Their procedure is to randomly select 100 dates of service from a two year period.
- They will then come to the office and scan the selected records into their computers to take back to their offices for review.
- Once they have reviewed the claims and developed an error rate for the office, they will extrapolate the findings to cover all of the services paid for the two year period.
- It is important that you realize that, if this is happening to you, this is a serious situation.
- DO NOT let anyone convince you otherwise.
- If you are selected for this type of review, get help immediately.

Physician Quality Reporting System

- All of this material is taken from the 2014 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures and the 2014 Physician Quality Reporting System (PQRS): Implementation Guide.
- The Physician Quality Reporting System (Physician Quality Reporting or PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments (pay cuts) to promote reporting of quality information by eligible professionals.
- Beginning in 2015, the program applied a 1.5% payment adjustment to eligible professionals who did not satisfactorily report data on quality measures for covered professional services in 2013.
- In 2016 the payment adjustment increases to 2%.
- Additionally, there will be a 0.5% incentive for reporting in 2014.
- The 2016 payment adjustment will be based on your 2014 reporting.
- Those doctors that do not report PQRS measures will also be assigned the lowest level Value Based Payment Modifier of -1%.

- To avoid the 2016 PQRS payment adjustment, individual eligible professionals will have to satisfactorily report data on quality measures for covered professionals services provided in 2014.
- There is no enrollment required to report PQRS measures.
- There are three ways to report PQRS measures.
    - Direct reporting on claim forms.
    - Reporting through a Qualified Registry.
    - Reporting through EHR
- Unfortunately none of the measures that can be reported through EHR are measures that chiropractors can report.
- Also, I have not found a Qualified Registry that applies to chiropractic.
- Chiropractors are listed as eligible professionals.
- We have three measures that we can report.
    - Measure #131 Pain Assessment and Follow-Up.
    - Measure #182 Functional Outcome Assessment.
    - Measure #317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented.
- The satisfactory reporting requirements are:
    - 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.
- The reporting period is January 1, 2014 to December 31, 2014.
- There is one way an individual eligible professional may meet the criteria for satisfactory reporting for the 2016 PQRS payment adjustment:
- Meet the criteria for satisfactory reporting for the 2014 PQRS Incentive.

PQRS Measure #131

- Measure #131: Pain Assessment and Follow-Up.
- This measure documents the use of standardized pain assessment tools.
- This is different from standardized outcomes assessment questionnaires.
- This measure identifies the percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.
- This measure is to be reported for <u>each</u> visit occurring during the reporting period for patients seen during the reporting period.
- There is no diagnosis associated with this measure.
- The documented follow up plan must be related to the presence of pain.
- For example:
- "Patient referred to pain management specialist for back pain" or "Return in two weeks for re-assessment of pain"
- For chiropractors I would suggest the following:
- "Patient will be evaluated at the next visit to determine the effect of treatment on their current pain level."
- Definitions:
    - **Pain Assessment**- Documentation of a clinical assessment for the presence or absence of pain using a standardized tool is required. A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain; such as: location, intensity, description, and onset/duration.
    - **Standardized Tool** – An assessment tool that has been appropriately normalized and validated for the population in which it is used.
    - Examples of tools for pain assessment, 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)
        - Visual Analog Scale (VAS)
    - **Follow-Up Plan** – A documented outline of care for a positive pain assessment is required. This **must** include a planned follow-up appointment or a referral, a notification to other care providers as applicable OR indicate the initial treatment plan is still in effect. These plans may include pharmacologic and/or educational interventions.
    - **Not Eligible** – A patient is not eligible for pain assessment and/or follow-up if the following reason exists:
        - Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others.
        - 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.
- For chiropractors, the denominator is one of the codes 98940, 98941, or 98942.
- This is to be reported on **all** patient encounters for patients aged 18 years and over.
    - **Pain Assessment Documented as Positive and Follow-up Plan Documented**
        - **G8730:** Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented. **OR**
        - **G8731:** Pain assessment documented as negative, no follow-up plan required.
    - **Patient not Eligible for Pain Assessment for Documented Reasons**
        - **G8442:** Documentation that patient is not eligible for a pain assessment. **OR**
        - **G8939:** Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate
    - **Pain Assessment not Documented, Reason not Given.**
        - **G8732: No** documentation of pain assessment, reason not given. **OR**
        - **G8509:** Documentation of positive pain assessment; **no** documentation of a follow-up plan, reason not given.

PQRS Measure #182

- Measure #182 Functional Outcome Assessment.
- This measure documents the use of standardized outcome assessment questionnaires.
- Percentage of patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool AND documentation of a care plan based on identified functional outcome deficiencies.
- This measure is to be reported **each visit** for patients seen during the 12 month reporting period.
- The functional outcome assessment is required to be **current** as defined in the definition section.
- This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- **Note:** A functional outcome assessment is multi-dimensional and quantifies pain and neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does **not** meet the criteria of a functional outcome assessment standardized tool.
- 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 numerator quality-data code **G8942** should be used for reporting purposes.
- Definitions:
    - **Standardized Tool** – An assessment tool that has been appropriately normalized and validated for the population in which it is used.
    - Examples of tools for functional outcome assessment include, but are not limited to:
        - Oswestry Disability Index (ODI)
        - Roland Morris Disability/Activity Questionnaire (RM)
        - Neck Disability Index (NDI)
        - Patient-Reported Outcomes Measurement Information System (PROMIS)
    - **Functional Outcome Assessment** – Patient completed questionnaires designed to measure a patient's limitations in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms.
    - **Current (Functional Outcome Assessment)** – A patient having a documented functional assessment within the previous 30 days.
    - **Functional Outcome Deficiencies** – Impairment or loss of physical function related to 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.
    - **Care Plan** – A care plan is an ordered assembly of expected/planned activities or actionable elements based on identified deficiencies. These may include observations goals, services, appointments and procedures, usually organized in phases or sessions, which have the objective of organizing and managing health care activity for the patient, often focused on one or more of the patient's health care problems. Care plans may also be known as a treatment plan.
    - **Not Eligible** – A patient is not eligible if the following reasons(s) exist:
        - 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.
- For chiropractors, the denominator is one of the codes 98940, 98941, or 98942.
- This is to be reported on **all** patient encounters for patients aged 18 years and over.
    - **Functional Outcome Assessment and Care Plan Documented**
        - **G8539:** 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. **OR**
        - **G8542:** Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required. **OR**
        - **G8942:** 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.
    - **Functional Outcome Assessment not Documented, Patient not Eligible.**
        - **G8540:** Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool. **OR**
        - **G9227:** Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan
    - **Functional Outcome Assessment not Documented, Reason not Given.**
        - **G8541:** Functional outcome assessment using a standardized tool not documented, reason not given. **OR**
        - **G8543:** Documentation of a current functional outcome assessment using a standardized tool; care plan **not** documented, reason not given.
- Functional Timeline
    - At the initial assessment visit you administer an outcome assessment questionnaire and find a functional deficiency.

    - From this you develop a treatment plan.
    - You would use **G8539** for that visit.
    - For the next 30 days you follow the treatment plan with treatment visits.
    - You would use **G8942** for each of these visits.
    - At the end of the 30 days you would re-evaluate the patient at an assessment visit.
    - You would administer another outcome assessment questionnaire, find functional deficiencies and develop a new treatment plan.
    - You would use **G8539** for this visit.
- Standardized outcome assessments, questionnaires or tools are a vital part of evidence-based practice.
- Despite the recognition of the importance of outcomes assessments, questionnaires and tools, recent evidence suggests their use in clinical practice is limited.
- Selecting the most appropriate outcomes assessment, questionnaire or tool enhances clinical practice by:
- (1) identifying and quantifying body function and structure limitations;
- (2) formulating the evaluation, diagnosis, and prognosis;
- (3) informing the plan of care; and
- (4) helping to evaluate the success of physical therapy interventions.

Measure #317

- Measure # 317; Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
- Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated
- This measure is to be reported a minimum of once per reporting period for patients seen during the reporting period. (January 1 to December 31)
- Eligible professionals who report the measure must perform the blood pressure screening at the time of a qualifying visit and may not obtain measurements from external sources.
- This measure may be reported by eligible professionals who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.
- The documented follow up plan must be related to the current BP reading as indicated.
- For example: "Patient referred to primary care provider for BP management."
- Definitions:
    - **BP Classification** - BP is defined by four BP reading classifications as listed in the "Recommended Blood Pressure Follow-Up" table below including Normal, Pre-Hypertensive, First Hypertensive, and Second Hypertensive Readings.
    - **Recommended BP Follow-Up** - The current *Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure* (JNC) recommends BP screening intervals, lifestyle modifications and interventions based on the current BP reading as listed in the "Recommended Blood Pressure Follow-Up" table below.
    - **Lifestyle Modifications** - The current JNC report outlines lifestyle modifications which must include one or more of the following as indicated: Weight Reduction, Dietary Approaches to Stop Hypertension (DASH) Eating Plan, Dietary Sodium Restriction, Increased Physical Activity, or Moderation in Alcohol (ETOH) Consumption.
    - **Second Hypertensive Reading** - Requires a BP reading of Systolic BP $\geq$ 140 mmHg OR Diastolic BP $\geq$ 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months Systolic BP $\geq$ 140 mmHg OR Diastolic BP $\geq$ 90 mmHg.
    - **Second Hypertensive Reading Interventions** - The current JNC report outlines interventions based on BP Readings shown in the "Recommended Blood Pressure Follow-Up" table and **must** include one or more of the following as indicated: Anti-Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG).

Recommended Blood Pressure Follow-Up Table

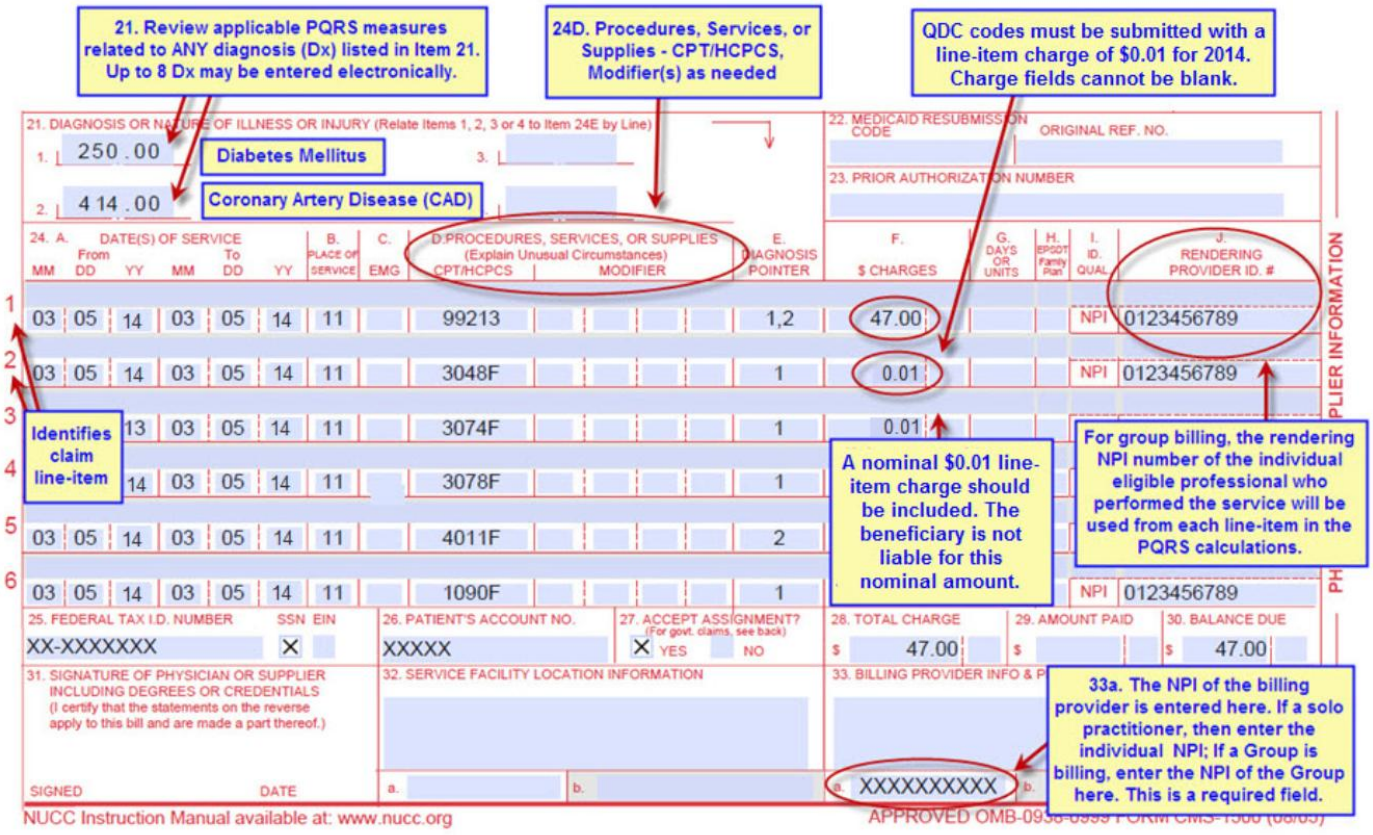
BP Classification	Systolic BP mmHg	Diastolic BP mmHg	Recommended Follow-Up *(must include all indicated actions for each BP Classification)*
Normal BP Reading	< 120	AND < 80	• No Follow-Up required
Pre-Hypertensive BP Reading	≥ 120 AND ≤ 139	OR ≥ 80 AND ≤ 89	• Rescreen BP within a minimum of 1 year *AND* Recommend Lifestyle Modifications OR • Referral to Alternative/Primary Care Provider
First Hypertensive BP Reading	≥ 140	OR ≥ 90	• Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks *AND* Recommend Lifestyle Modifications OR • Referral to Alternative/Primary Care Provider
Second Hypertensive BP Reading	≥ 140	OR ≥ 90	• Recommend Lifestyle Modifications *AND* 1 or more of the Second Hypertensive Reading Interventions (see definitions) OR • Referral to Alternative/Primary Care Provider

    - **Not Eligible** – A patient is **not** eligible if one or more of the following reason(s) are documented:
        - Patient has an active diagnosis of hypertension.
        - Patient refuses to participate (either BP measurement or follow-up).
        - 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. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated.
- For chiropractors, the denominator is one of the codes 98940, 98941, or 98942.
- This is to be reported on **one** patient encounter for patients aged 18 years and over.
    - **G8783:** Normal blood pressure reading documented, follow-up not required. **OR**
    - **G8950:** Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented.
    - **G8784:** Blood pressure reading not documented, documentation the patient is not eligible. **OR**
    - **G8951:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, documentation the patient is not eligible.
    - **G8785:** Blood pressure reading not documented, reason not given. **OR**
    - **G8952:** Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given.
- Blood Pressure protocol based on guidelines in PQRS.
    - Take patient's blood pressure.
    - If systolic is not over 120 and the diastolic is not over 80, patient is within normal range and no further action is required.
    - If systolic is between 120 and 139 and/or diastolic is between 80 and 89, patient is pre-hypertensive and you should recommend lifestyle modifications.

- If systolic is over 140 and/or diastolic is over 90, a follow-up test is required. Re-screen before four weeks and recommend lifestyle modifications.
- Re-test patient's blood pressure.
- If systolic is over 140 and/or diastolic is over 90, a follow-up test is required. Refer to primary care physician for BP management.

Physician Quality Reporting System

- These measures are to be reported when filing the claim.
- When filing electronically you may, depending on the software, be able to automate the process.
- When filing paper claims you should place the correct codes as illustrated in the following slide.
- It is important to place an entry in the charge field.



- All of the G-codes are not payable codes.
- You should watch for a code N365 on the remittance advisories.
- N365 reads: "This procedure code is not payable. It is for reporting/information purposes only."
- This code will indicate that the reporting code passed into the national database.

Summary

- Reporting the PQRS measures is essential for two reasons.
- To ensure that you are paid the maximum amount available from Medicare
- To build as accurate of a performance database as possible for chiropractic procedures and for yourself.