Physician Quality Reporting System 2013 PQRS

Medicare Fee Schedule

- The 26.5% Sustainable Growth Rate Formula cut has been averted for this year.
- We still face a cut January 1, 2014.
- We also face a 2% sequestration cut March 1.
- I will keep you informed through my monthly updates.
- You can sign up at ChiroMedicare.net

Deadline Extended

- The deadline to change your participation status has been extended to February 15.
- If you are a non-par provider and want to become a par provider then complete and submit CMS form 460.
- If you are a par provider and want to become non-par then submit a letter to that effect to each MAC where you submit claims.

ABN

- If you use the ABN to voluntarily inform patients of their financial liability for non-covered services, they are not to choose an option.
- I will discuss this and much more in next month's webinar on the ABN.

Medicare Claim Reopening

- Medicare was able to review claims up to four years from the date of submission.
- But, they could only reopen the claim and collect money back to three years.
- The bill that extended the SGR pay cut extended that time back to five years.

Physician Quality Reporting System

- The Physician Quality Reporting System (Physician Quality Reporting or PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.
- Beginning in 2015, the program also applies a 1.5% payment adjustment to eligible professionals who do 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 2013 and 2014.
- The 2016 payment adjustment will be based on your 2014 reporting.
- To avoid the 2015 PQRS payment adjustment, individual eligible professionals and CMS-selected group practices participating in the PQRS Group Practice Reporting

Option (GPRO) will have to satisfactorily report data on quality measures for covered professionals services provided in 2013.

- 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 #321 Participation by a Hospital, Physician, or Other Clinician in a systematic Clinical Database Registry that Includes Consensus Endorsed Quality Measures.
- Measures consist of two major components:
    - A denominator that describes the eligible cases for a measure (the eligible patient population associated with a measure's numerator).
    - A numerator that describes the clinical action required by the measure for reporting and performance.
- Each component is defined by specific codes described in each measure specification along with reporting instructions and use of modifiersQuality-Data Codes (QDCs)
- QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure's numerator.
- Clinical actions can apply to more than one condition, and therefore, can also apply to more than one measure.
- 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
- Only 51 measures can be reported through EHR.
- Unfortunately none of those 51 measures are measures that chiropractors can report.
- Also, I have not found a Qualified Registry that applies to chiropractic.
- The 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, 2013 to December 31, 2013.
- There are 3 ways an individual eligible professional may meet the criteria for satisfactory reporting for the 2015 PQRS payment adjustment:
    - Meet the criteria for satisfactory reporting for the 2013 PQRS Incentive.
    - Report 1 valid measure or measures group using the claims, registry, or EHR-based reporting mechanisms.
    - Elect to be analyzed under the administrative claims-based reporting mechanism.

- Measure #124 Electronic Health Records has been retired.
- This is the measure that uses G8447 and G8448 numerators.
- There is no replacement.

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 each visit occurring during the reporting period for patients seen during the reporting period.
- There is no diagnosis associated with this measure.
- **Pain Assessment** A clinical assessment of pain through discussions with the patient and use of a standardized tool(s) for the presence and characteristics of pain which may include location, intensity, quality, 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** Proposed outline of treatment to be conducted as a result of pain assessment. Follow-up ***must*** include a planned reassessment of pain and may include documentation of future appointments, education, referrals, pharmacological intervention, or notification of other care providers as applicable.
- **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.
- The numerators are now in groups of two.
- You choose which group is appropriate.
- Then choose one of the two options within the group.

- Numerator Quality-Data Coding Options for Reporting Satisfactorily:
    - **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.
    - **OR**
    - **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
    - **OR**
    - **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.

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 indicating the appropriate numerator code; however, the assessment is required to be current as defined for patients seen during the reporting period.
- Documentation of a current functional outcomes assessment must include identification of the standardized tool used.
- Indicate the questionnaire utilized in the patient's chart.
- 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.
- **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)
    - Physical Mobility Scale (PMS)
- **Functional Outcome Assessment** Questionnaires designed to measure a patient's limitations in performing the usual human tasks of living. Functional questionnaires seek to quantify symptoms, functional and behavior directly, rather than to infer them from less relevant physiological tests.
- **Current** 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 or planned activities, including 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 upon one or more of the patient's health care problems. Care plans may include order sets as actionable elements, usually supporting a single session or phase and 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.
- 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.
- The numerators are now in groups.
- You choose which group is appropriate.
- Then choose one of the options from within the group.
- Numerator Quality-Data Coding Options for Reporting Satisfactorily:
    - **Functional Outcome Assessment and Care Plan Documented**
        - **G8539:** Documentation of a current functional outcome assessment using a standardized tool **AND** documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment. **OR**
        - **G8542:** Documentation of a current functional outcome assessment using a standardized tool; no functional deficiencies identified, care plan not required. **OR**
        - **G8942:** Documented functional outcomes assessment and care plan within the previous 30 days.
    - **OR**
    - **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**
    - **Functional Outcome Assessment not Documented, Reason not Given.**
        - **G8541:** Functional outcome assessment using a standardized tool not documented, reason not given. **OR**

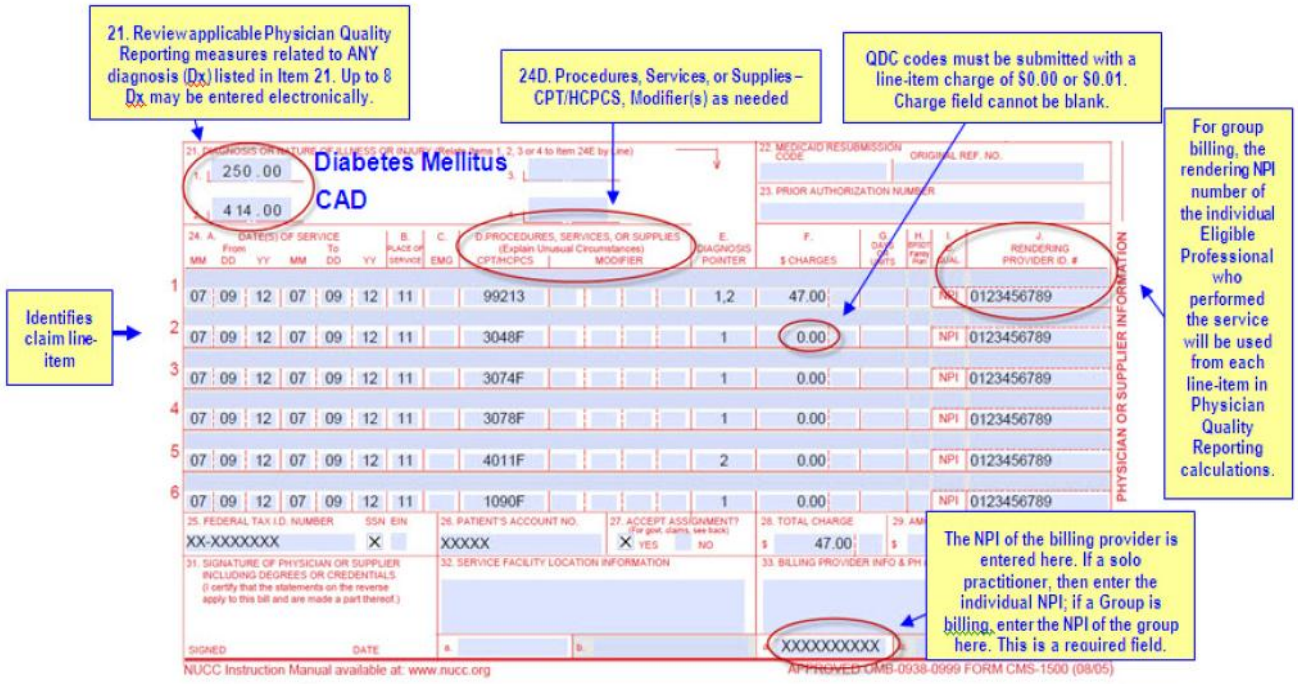
        - **G8543:** Documentation of a current functional outcome assessment using a standardized tool; care plan not documented, reason not given.
- A recent unpublished review of the literature found more than 50 references to the use of functional health status assessment tools in evaluating chiropractic spinal manipulation.
- Among those most commonly identified were the Oswestry Pain Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), and Neck Disability Index (NDI).
- While there is a strong scientific basis for the use of outcome assessment in evaluating the impact of chiropractic manipulative procedures, these tools have not yet been widely incorporated into the clinical setting as a quality benchmark.

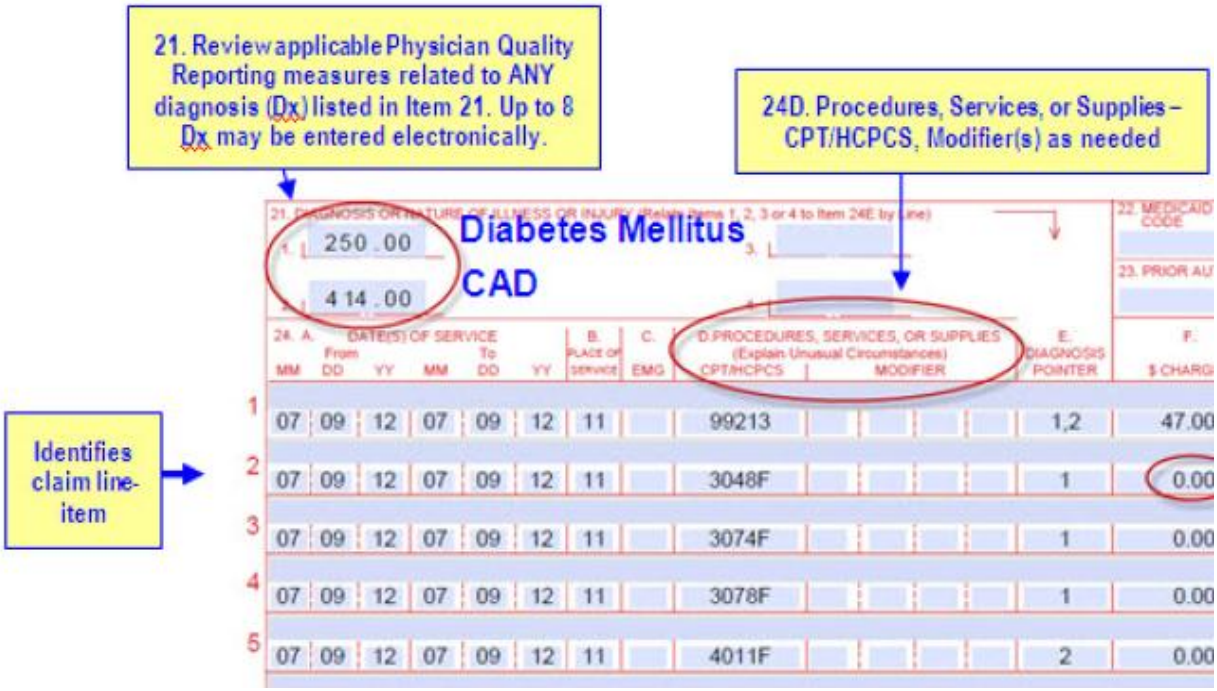
Measure # 321 Participation by a Hospital, Physician, or Other Clinician in a Systematic Clinical Database Registry that Includes Consensus Endorsed Quality Measures.

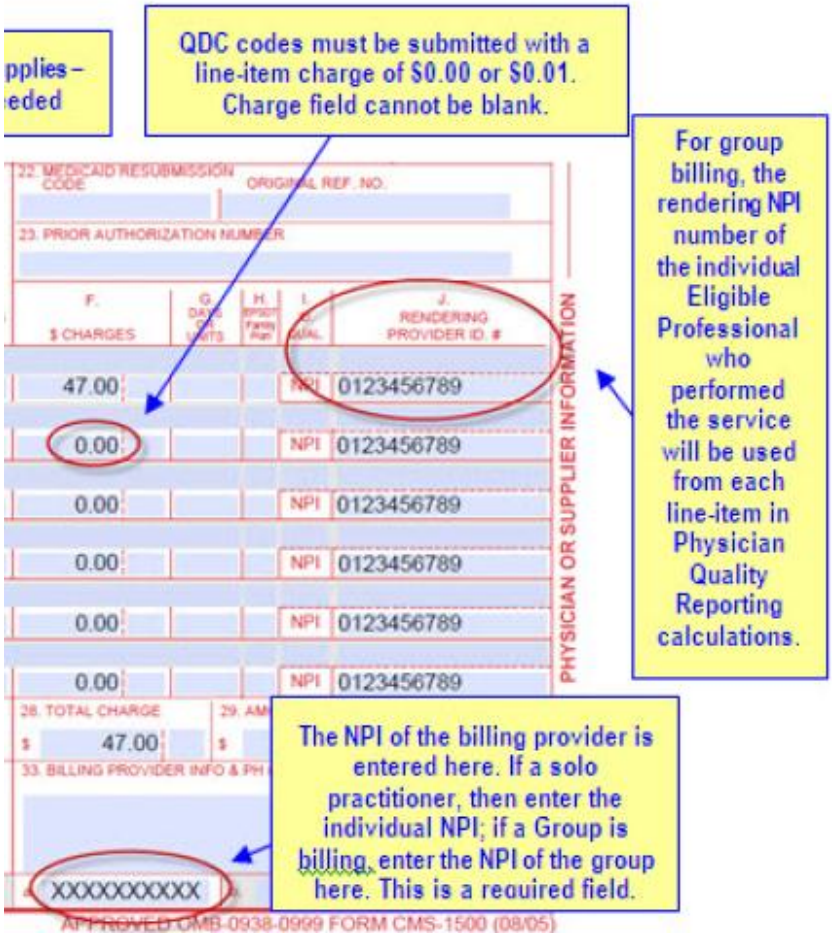
- This measure indicates the doctors participation in a Clinical Database Registry.
- Participation in a systematic qualified clinical database registry involves:
    - Physician or other clinician submits standardized data elements to registry.
    - Data elements are applicable to consensus endorsed quality measures.
    - Registry measures shall include at least two (2) representative NQF consensus endorsed measures for registry's clinical topic(s) and report on all patients eligible for the selected measures.
    - Registry provides calculated measures results, benchmarking, and quality improvement information to individual physicians and clinicians.
    - Registry must receive data from more than 5 separate practices and may not be located (warehoused) at an individual group's practice.
    - Participation in a national or state-wide registry is encouraged for this measure.
    - Registry may provide feedback directly to the provider's local registry if one exists.
- This measure is to be reported **once per patient seen during the reporting period**, with no penalty for over reporting.
- There is no diagnosis associated with this measure.
- **Qualified Registry** Qualified is defined as receiving data from more than five hospitals and providing calculated measures, results, benchmarks, and quality improvement information to the participant (and to designated third parties).
- **Clinician Reported Patient Data to Qualified Database Registry**
    - **G8954:** Complete and appropriate patient data were reported to a qualified clinical database registry.
- There is currently no Qualified Clinical Database Registry for chiropractors.
- We cannot report this measure at this time even though we are eligible to do so.

Physician Quality Reporting System

- Both measure #131 and #182 specifically list the Oswestry Disability Index (which is another name for the Oswestry Low Back Disability Index) and the Roland Morris Questionnaire as acceptable standardized tools.
- You should be able to use the following to satisfy the requirements for both measure #131 and #182:
    - Revised Oswestry Low Back Pain Disability Questionnaire.
    - Neck Disability Index.
    - Rowland-Morris Questionnaire.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 slides.
- It is important to place an entry in the charge field.




21. Review applicable Physician Quality Reporting measures related to ANY diagnosis (Dx) listed in Item 21. Up to 8 Dx may be entered electronically.
24D. Procedures, Services, or Supplies – CPT/HCPCS, Modifier(s) as needed
250.00
Diabetes Mellitus
414.00
CAD
Identifies claim line-item
24. A. DATE(S) OF SERVICE
B. PLACE OF SERVICE
C. EMG
D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)
CPT/HCPCS
MODIFIER
E. DIAGNOSIS POINTER
F. $ CHARGE
1 07 09 12 07 09 12 11 99213 1,2 47.00
2 07 09 12 07 09 12 11 3048F 1 0.00
3 07 09 12 07 09 12 11 3074F 1 0.00
4 07 09 12 07 09 12 11 3078F 1 0.00
5 07 09 12 07 09 12 11 4011F 2 0.00


QDC codes must be submitted with a line-item charge of $0.00 or $0.01. Charge field cannot be blank.
For group billing, the rendering NPI number of the individual Eligible Professional who performed the service will be used from each line-item in Physician Quality Reporting calculations.
22. MEDICAID RESUBMISSION CODE
ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER
F. $ CHARGES
J. RENDERING PROVIDER ID. #
47.00 NPI 0123456789
0.00 NPI 0123456789
0.00 NPI 0123456789
0.00 NPI 0123456789
0.00 NPI 0123456789
0.00 NPI 0123456789
PHYSICIAN OR SUPPLIER INFORMATION
28. TOTAL CHARGE
$ 47.00
33. BILLING PROVIDER INFO & PH
XXXXXXXXXX
The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; if a Group is billing, enter the NPI of the group here. This is a required field.
APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

- By participating in the PQRS, you will avoid a 1.5% cut in your fees starting in 2015.
- You will also be helping chiropractic.
- The future of Medicare is a pay-for-performance model that will pay the doctor based on how well the patient improves within anticipated guidelines.
- Measure #131 Pain Assessment and Measure # 182 Functional Outcome Assessment will provide the data to develop these guidelines for chiropractic.
- The more data the more accurate the guidelines.
- All of the G-codes are not payable codes.
- You should watch for a code N365 on the remittance advisories.
- 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.
- Accurately reporting the PQRS measures will prove beneficial to both you and the profession.