

# Physician Quality Reporting System 2015 (PQRS)

By

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## Changes to Provider Enrollment

- Medicare has implemented a change to Medicare provider enrollment that was put in place in the Affordable Care Act.
- Medicare can now deny enrollment or revoke enrollment in the following circumstances;
- If the provider, supplier, or owner thereof was previously the owner of a provider or supplier that had a Medicare debt that existed when the latter's enrollment was voluntarily terminated, involuntarily terminated or revoked.
- If, within the preceding 10 years, the provider or supplier, or any owner or managing employee thereof, was convicted of a federal or state felony offense that CMS determines to be detrimental to the best interests of the Medicare program and its beneficiaries.
- If the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

## The -59 Modifier

- The -59 modifier is used to indicate that a procedure is distinct and separate from another procedure.
- Medicare has introduced a modifier subset to be used when the -59 modifier would otherwise be used.
- At this time, this subset is not to be used when billing other third party payers.
- This change will take place January 5, 2015.
- You should check you Local Coverage Determination.
- The new codes are:
- XE - separate encounter, a service that is distinct because it occurred during a separate encounter
- XS - separate structure, a service that is distinct because it was performed on a separate organ/ structure
- XP - separate practitioner, a service that is distinct because it was performed by a different practitioner
- XU - unusual non-overlapping service, the use of a service that is distinct because it does not overlap usual components of the main service.

**NOTE:** All of this material is taken from the 2015 Physician Quality Reporting System (PQRS) Measure Specifications Manual for Claims and Registry Reporting of Individual Measures and the Federal Register, Volume 79, Number 214, Thursday, November 13, 2014.

## 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.
- 2015 brings a major change to the PQRS.
- Starting this year, there will be no incentive to participate other than the avoidance of payment cuts.

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- In the past we have told you that failure to participate in the PQRS would result in fee cuts.
- That day is here.
- If you did not participate in the PQRS in 2013, you will have a 1.5% cut in your Medicare fees in 2015.
- If you did not participate in 2014, that cut will be increased to 2% in 2016.

NOTE	PROCEDURE	MOD	PAR AMOUNT	NON-PAR AMOUNT	LIMITING CHARGE	EHR LIMITING CHARGE**	PQRS LIMITING CHARGE***	<del>EHR/2014 eRx LIMITING CHARGE**</del>	EHR + PQRS LIMITING CHARGE****	<del>EHR/2014 eRx + PQRS LIMITING CHARGE****</del>
#	98925		22.92	21.77	25.04	24.78	24.66	24.53	24.41	24.16
	98926		43.27	41.11	47.28	46.81	46.56	46.33	46.10	45.64
#	98926		34.61	32.88	37.81	37.43	37.25	37.05	36.87	36.50
	98927		56.57	53.74	61.80	61.18	60.87	60.57	60.26	59.66
#	98927		45.98	43.68	50.23	49.73	49.47	49.23	48.98	48.50
	98928		69.72	66.23	76.16	75.41	75.03	74.65	74.28	73.53
#	98928		58.17	55.26	63.55	62.92	62.59	62.27	61.97	61.34
	98929		83.16	79.00	90.85	89.94	89.49	89.03	88.60	87.70
#	98929		69.69	66.21	76.14	75.38	75.00	74.62	74.26	73.51
	98940		26.91	25.56	29.39	29.10	28.96	28.81	28.66	28.37
#	98940		21.78	20.69	23.79	23.55	23.44	23.32	23.20	22.98
	98941		39.24	37.28	42.87	42.45	42.23	42.01	41.81	41.38
#	98941		33.79	32.10	36.92	36.55	36.36	36.18	36.00	35.64

- Starting in 2017, all physicians that participate in Fee-for-Service Medicare will be affected by the Value-Based Modifier.
- Failure to participate in PQRS in 2015 will result in the doctor being assigned the lowest level Value-Based Modifier in 2017.
- To avoid the 2017 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 2015.
- Chiropractors are listed as eligible professionals.
- We have two measures that we can report.
  - Measure #131 Pain Assessment and Follow-Up.
  - Measure #182 Functional Outcome Assessment.
- 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 modifiers.
- Quality-Data Codes (QDCs)

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- 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 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.
- 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, 2015 to December 31, 2015.
- There is one way an individual eligible professional may meet the criteria for satisfactory reporting for the 2017 PQRS payment adjustment:
- Meet the criteria for satisfactory reporting for the 2015 PQRS Incentive

### **PQRS 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.
- 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 presence of pain.
  - For example:

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- “Patient referred to pain management specialist for back pain”
- “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.”
- CPT codes and patient demographics are used to identify patients who are included in the measure’s denominator.
- G-codes are used to report the numerator of the measure.
- When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code.
- 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 if one or more of the following reason(s) exists:
    - 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.

- 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 in groups of two.
- You choose which group is appropriate.
- Then choose one of the two options within the group.
- **NUMERATOR NOTE:** The standardized tool used to assess the patient’s pain must be documented in the medical record (exception: A provider may use a fraction such as 5/10 for Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity)
- 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.
  - **Patient not Eligible for Pain Assessment for Documented Reasons**
    - **G8442:** Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool. **OR**
    - **G8939:** Pain assessment documented as positive, 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:** Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given.

### **PQRS 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 on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified 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,

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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.
- CPT codes and patient demographics are used to identify patients that are included in the measure's denominator.
- Quality-data codes (G-codes) are used to report the numerator of the measure.
- When reporting the measure via claims, submit the listed CPT codes, and the appropriate numerator G-code.
- Definitions
  - **Standardized Tool** – An assessment tool that has been appropriately normalized and validated.
  - 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)
    - Disabilities of the Arm, Shoulder and Hand (DASH)
    - Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL)
  - **Functional Outcome Assessment** – Patient completed questionnaires designed to measure a patient's physical 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 utilizing a standardized tool and a care plan if indicated within the previous 30 days.
  - **Functional Outcome Deficiencies** – 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.
  - **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) is documented:
    - Patient refuses to participate.
    - Patient unable to complete questionnaire.

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- 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.
- The numerators are 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 are:
- **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:** Functional Outcome Assessment NOT documented as being performed, documentation 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 positive functional outcome assessment using a standardized tool; care plan **not** documented, reason not given.
- Outcome Assessment Protocol
  - 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.

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- 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.
  
- 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 may 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.
- See example on next page.
- **Note:** This example is provided by Medicare and does not contain chiropractic specific codes.

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- By participating in the PQRS you will avoid a 2% cut in your fees starting in 2017.
- You will also be establishing your Value Based Modifier (VBM).
- The VBM will be effective for chiropractors in 2017 and will be based on your 2015 PQRS participation.
- 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.
- 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.