CMS PQRS Compliance White Paper

What is PQRS?

PQRS stands for Physician Quality Reporting System. It is a pay-for-performance program set up by the Centers for Medicare and Medicaid (CMS) that started in 2007. It started as a voluntary program, with incentives given to physicians who report quality clinical data to CMS for their Medicare Part B Fee for Service patients. Starting in 2014, eligible providers must report PQRS data in order to avoid reimbursement reductions. There are many ways to report to PQRS. Common reporting tools typically utilized by orthopaedic practices are: Clinical Data Registry and Claims-Based Reporting.

Who is an Eligible Provider?

MD/DO
Podiatrists
Dentist
Chiropractor
Physical Therapist
Occupational Therapist
Physician Assistant
Nurse Practitioners

Incentives for Reporting

CMS no longer offers incentives for PQRS reporting.

Penalties for Not Reporting – 2015

The penalty for not reporting 2015 PQRS is 4% for solo providers and groups with 2-9 providers (2% value modifier penalty + 2% PQRS penalty).

The penalty for not reporting 2015 PQRS is 6% for groups with ten or more providers (4% value modifier penalty + 2% PQRS penalty).

- Quality-tiering is mandatory for all providers. However, solo providers and groups with 2-9 providers have the potential to receive only a bonus or no adjustment. Groups with 10 or more providers could receive either a bonus, no adjustment, or a penalty depending on their quality tiering calculation.
- CMS will increase the maximum downward adjustment under the quality-tiering methodology for groups with ten or more EPs to -4.0%. CMS will also increase the maximum upward adjustment under the quality-tiering methodology in the CY 2017 payment adjustment period to +4.0x ('x' represents the upward payment adjustment factor) (CMS Fact Sheets).

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%	+0.0x

http://www.mdinteractive.com/2015-PQRS* Groups and solo practitioners eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where `x' represents the upward payment adjustment factor.

- "In CY 2017, CMS will apply a maximum downward adjustment of -2.0% for groups with two to nine EPs and solo practitioners, if the group or solo practitioner does not meet the quality reporting requirements for the PQRS. The maximum upward adjustment for groups of two to nine EPs and solo practitioners will be +2.0x ('x' represents the upward payment adjustment factor) if classified as high quality/low cost. Groups of two to nine EPs and solo practitioners will be held harmless from downward adjustments under the quality-tiering methodology for the CY 2017 payment adjustment period." (CMS Fact Sheets)

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%	+0.0x

* Groups and solo practitioners eligible for an additional +1.0x if reporting measures and average beneficiary risk score is in the top 25 percent of all beneficiary risk scores, where `x' represents the upward payment adjustment factor

What is the Value Based Modifier?

The value-based payment modifier applies to all physicians. The value modifier uses PQRS quality data and Medicare cost data to determine a provider's overall value score. It rewards high-performing providers with increased payments and reduces payments to low-performing providers.

CMS began applying a value based modifier (VM) in 2015 based on 2013 PQRS reporting. Both cost and quality data composites are to be included in calculating payments for physicians. All physicians who participate in Fee-For-Service Medicare will be impacted by CMS' emphasis on reporting quality data through PQRS and by 2017 will be affected by the value modifier. Click here for more on the value-based payment modifier

Steps to Successful PQRS Reporting

Step 1. Decide whether you plan to report Measures Groups or individual measures.
Step 2. For individual measure reporting, identify enough measures to meet the reporting requirements.
Step 3. Set-up a tracking method to collect the needed data.
The tracking system can be through your EMR system or a manual system.
Step 4. Collect data on more patients than absolutely required in case some of the patient data is not in compliance when reported.
Step 5. Set up an arrangement with a registry or some other system to report your data.
Step 6. Stay on schedule and report your data in a timely manner.

PQRS 2015 Reporting Requirements

Changes for 2015

A summary of the changes to the 2015 PQRS reporting requirements are listed below. This list is not intended to be all inclusive list. Refer to the CMS PQRS webpage for additional information.

- There are two new measures groups. Five Measures Groups were dropped. http://www.mdinteractive.com/files/uploaded/file/2015_PQRS_Measures_Groups__2014-26183.pdf

A Measures Group is composed of 6-10 individual measures and they are created and approved by CMS. Measures Groups are not editable to include or omit specific individual measures. The following Measures Groups are available:

New Measures Groups in 2015:

- Acute Otitis External (AOE) (2+)
- Sinusitis (18+)

2014 Measures Groups which are continued in 2015:

- Asthma (5-64)
- CABG (18+)
- CAD (Coronary Artery Disease) (18+)
- Chronic Obstructive Pulmonary Disorder (COPD) (18+)
- CKD (Chronic Kidney Disease) (18+)
- Dementia (All ages)
- Diabetes (18-75)
- General Surgery (18+)
- Heart Failure (18+)
- Hepatitis C (18+)
- HIV/Aids (13+)
- Irritable Bowel Disease (IBD) (18+)
- Oncology (18+)
- Optimizing Patient Exposure to Ionizing Radiation (OPEIR) (18-75)
- Parkinson's (18+)
- Preventive Care (50+)
- RA (Rheumatoid Arthritis) (18+)
- Sleep Apnea (18+)
- Total Knee Replacement (TKR) – All ages

Orthopaedic Measures Groups deleted in 2015:

- Back Pain (18-79)
- Perioperative Care Measure Group – All ages

- Eligible providers with 2+ providers must either 1) register to report as a Group Practice Reporting Option (GPRO) OR 2) at least ½ of the eligible professionals under their tax ID must report successfully. Must register for PQRS GPRO between April 1, 2015 and June 30, 2015.

- Individual measure reporting requires reporting on 9 measures across 3 domains at a 50% reporting rate in order to avoid the payment adjustment. In addition, CMS is requiring that eligible professionals who see at least one Medicare patient in a face-to-face encounter report measures from a newly proposed cross-cutting measures set in addition to any other measures that the eligible professional is required to report. Please reference the 2015 PQRS List of Face-To-Face Encounter Codes for the billable codes that identify face-to-face encounters for the purposes of 2015 PQRS reporting. This includes general office visits, outpatient visits, and surgical procedure codes

- Eligible providers who report 1-8 measures will be subject to the Measure-Applicability Validation (MAV) process. Refer to the CMS webpage for more information on MAV. 2015 PQRS Measure-

Applicability Validation (MAV) Process for Registry-Based Reporting of Individual Measures – provides guidance for those eligible professionals who satisfactorily submit via a Qualified Registry for fewer than nine PQRS measures or for fewer than three NQS domains, and how the MAV process will determine whether they should have submitted additional measures. This also includes the process flow depicting the MAV process.

- Groups with 100+ providers are required to have all CAHPS for PQRS survey measures reported on its behalf via a CMS certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the qualified registry.

Reporting Options for 2015 Services:

1 Report Using Measures Group.

There is only 1 remaining Measures Group that applies to orthopaedic practice:

- Total Knee Replacement (TKR) – All ages

Must Report on 20 patients – 11 of whom must be eligible traditional Medicare Part B patients. The remaining 9 patients can be any type of insurance. The same patient can be reported on by more than one eligible professional billing under the same tax ID number if they were seen by multiple eligible professionals billing during the reporting period.

Because there is a Measures Group for Total Knee Replacement, TKR cannot be reported as an individual measure.

Or

2 Report Using Individual Measures

Report on a minimum of 9 individual measures across 3 domains for 50% of patients for which the measure applies. There are six domains:

1) Effective Clinical Care
2) Person and Caregiver-Centered Experience and Outcomes
3) Population/Community Health
4) Patient Safety
5) Communication and Care Coordination
6) Efficiency and Cost Reductions

Each individual measure is within a domain. For the criteria of when and how often an individual measure can be reported for a particular patient, consult the CMS "2015 Physician Quality Reporting System: Implementation Guide."

2015 CMS-Approved Individual Measures – changes reflected for 2015

Some suggested individual measures to consider for orthopaedic practices:

21	Perioperative Care: Selection of Prophylactic Antibiotic –First or Second Generation Cephalosporin
22	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)
23	Perioperative Care: Venous Thromboembolism Prophylaxis – when indicated in all patients
24	Osteoporosis: Communication with the Physician Managing On-Going Care Post Fracture of Hip,
39	Screening or therapy for Osteoporosis for Women Aged 65 years and older
40	Osteoporosis: Management following Fracture of Hip, Spine, or Distal Radius for Men and Women aged 50 years and older
41	Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older
108	Rheumatoid Arthritis: Disease Modifying Anti-Rheumactic Drug Therapy
109	Osteoarthritis: Function and Pain Assessment
110	Preventive Care Screening: Influenza Immunization

126 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Neurological Evaluation
127 Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy – Evaluation of Footwear
128 Preventive Care and Screening: BMI
131 Pain Assessment and Follow-up
145 Radiology: Exposure Time Reported for Procedures Using Fluoroscopy
147 Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
154 Falls: Risk Assessment
155 Falls: Plan of Care
163 Diabetes: Foot Exam
178 Rheumatoid Arthritis: Functional Status Assessment
182 Functional Outcome Assessment
222 Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Elbow, Wrist or Hand Impairments
223 Functional Deficit: Change in Risk-Adjusted Functional Status for Patients with Neck, Cranium, Mandible, Thoracic Spine, Ribs, or Other General Orthopedic Impairments
226 Preventive Care and Screening: Tobacco Use: Screening and Cessation
236 Controlling High Blood Pressure
342 Pain Brought Under Control Within 48 Hours
358 Patient-Centered Surgical Risk Assessment and Communication

Will Your EMR System Automatically do Your PQRS Reporting?

No. You cannot assume that your EMR system will automatically do your PRQS reporting. Some EMR companies have the capability, but will charge extra to add this service. Some EMR companies require that the data collection be done in a certain way – e.g., have to be collecting beginning in January of each year. You must check with your EMR company to see how they can help you with the PQRS reporting compliance. Claims-based reporting must be done throughout the year. Registry reporting can be done at the end of the year.

Are there any Orthopaedic-Specific Clinical Data Registries that CMS has approved?

Not to our knowledge. Currently there are no CMS-approved registries that just collect orthopaedic data. However, some registries collect orthopaedic data along with other medical specialties. Some registries that have been recommended by COA members and orthopaedic EMR companies include:

Covisint: http://www.pqrs.covisint.com

Covisint is offering COA members a 25% discount. The regular cost is $299 per provider on whom you are reporting. The COA discounted rate is $224 per provider. Enter the COA discount code: "COAPQRS" at the end of your submission when you are entering your payment information. Questions: Contact Melissa Blom – Phone: 866-823-3958 melissa.blom@covisint.com

IMPORTANT NOTE: COA is not endorsing Covisint, but merely providing the information as a starting point for our members. Should you decide to use a registry for PQRS compliance, you must evaluate each company to see if they are appropriate for reporting data from your practice.

How can a Registry Help in Reporting Data

1. Registries use a web-based portal, so orthopaedic practices just need access to the Internet to submit data.
2. No need to have an EMR system to be able to submit data to the registry. However, if you do have an EMR system, registries can extract data directly from your EMR system and place the data in a report that can be successfully submitted to CMS for Medicare Part B billing. This can be an extra charge to your reporting costs.
3. Allows you to do annual reporting of the data.
4. Typically takes a couple of days to identify eligible patients on whom you want to submit data and to enter the data.
5. Have support staff to help ensure submission compliance.
6. Provide data accuracy safeguards and will identify submission errors.

Claims-Based Reporting

1. Requires the practice to identify a person who has comprehensive knowledge of the PQRS reporting criteria and who will really take charge of the project.
2. Requires more staff time and reporting throughout the year.
3. No internal checks and balances to help ensure successful reporting.

Tips in reporting data:

1. NPI numbers – must report using the physician's individual NPI number – not the group NPI number
2. Must report your Tax ID number
3. If you make an error or either your NPI or Tax ID Number, CMS currently will not let you correct the number once the data is submitted, so double-check your numbers.
4. You can submit through a registry even if you are not using the other services that the firm offers.
5. Higher probability of meeting the reporting criteria and receiving your incentive payment.
6. The registry will take care of submitting your data, once CMS opens up the submission which is expected to happen in March 31, 2016 for 2015 reporting.

Additional Resources:

CMS also recommends contacting QualityNet Help Desk – Available Monday – Friday for help in PQRS reporting. QualityNet is available - 7:00 AM–7:00 PM CST
Phone: 1-866-288-8912
Email: Qnetsupport@sdps.org

2015 Medicare Physician Fee Schedule (MPFS) Final Rule (National Provider Call 12/2/2014)
MD Interactive: http://www.mdinteractive.com/2015-PQRS

CMS – 2016 Physician Quality Reporting System (PQRS) Payment Adjustment Fact Sheet

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