The Physician Quality Reporting System 2016

By
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Chiropractic Training from CMS

- In April of last year Congress repealed the SGR formula.
- As part of that law, CMS was to provide training by January 1 to help chiropractors to improve Medicare documentation.
- On December 23 they uploaded a video to fulfill that requirement.
- You can find it here: https://www.youtube.com/watch?v=tMiw1X9KvDA&feature=youtu.be
- After you have viewed the video please send me your opinion of the training to chiromedicare@gmail.com. I especially want to know if you feel that this training will help you to document Medicare visits better.

Physician Quality Reporting System

- All of this material is taken from the 2016 Physician Quality Reporting System (PQRS) Measure Specification and Measure Flow Guide for Claims and Registry Reporting of Individual Measures, the specification sheet for Measure #131 and the specification sheet for Measure #182.
- 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 brought a major change to the PQRS.
- Starting last year, there is no incentive to participate other than the avoidance of payment cuts.
- 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% this year.
- 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.
- While the final percentages have yet to be set for 2017, the lowest level Value-Based Modifier for 2016 is a 2% cut.
- This may very well change by 2017.
- To avoid the 2018 PQRS payment adjustment, individual eligible professionals must:
- Report on at least 9 individual measures covering 3 National Quality Strategy (NQS) domains for at least 50% of denominator eligible Medicare Part B FFS patients.
- If you report less than 9 measures covering 3 domains, you will be subject to the Measure-Applicability Validation (MAV) Process.

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- 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.
- Since chiropractors only have 2 measures that we can report, we need to report both of those measures on 50% of our Medicare patients.
- 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)
- 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.
- The satisfactory reporting requirements are:
- Report on at least 9 individual measures covering 3 National Quality Strategy (NQS) domains for at least 50% of denominator eligible Medicare Part B FFS patients.
- Measures with a 0% performance rate will not be counted.
- An EP that sees at least 1 Medicare patient in a face-to-face encounter must report a minimum of 1 cross-cutting measure.
- Both measures #131 and #182 are cross-cutting measures.
- Measures with a 0 percent performance rate will not be counted.
- The reporting period is January 1, 2016 to December 31, 2016.

Measure #131Pain 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.
- It is to be reported on all visits that bill the code 98940, 98941, or 98942.

- The documented follow up plan must be related to the presence of pain.
- For example:
- "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."
- **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.
- **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)

- **Performance Met:**
  - **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.
- **Other Performance Exclusion:**
  - **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, documentation the patient not eligible.
- **Performance Not Met:**
  - **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.

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, 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** – A tool that has been 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 reason(s) is documented:
    - 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.

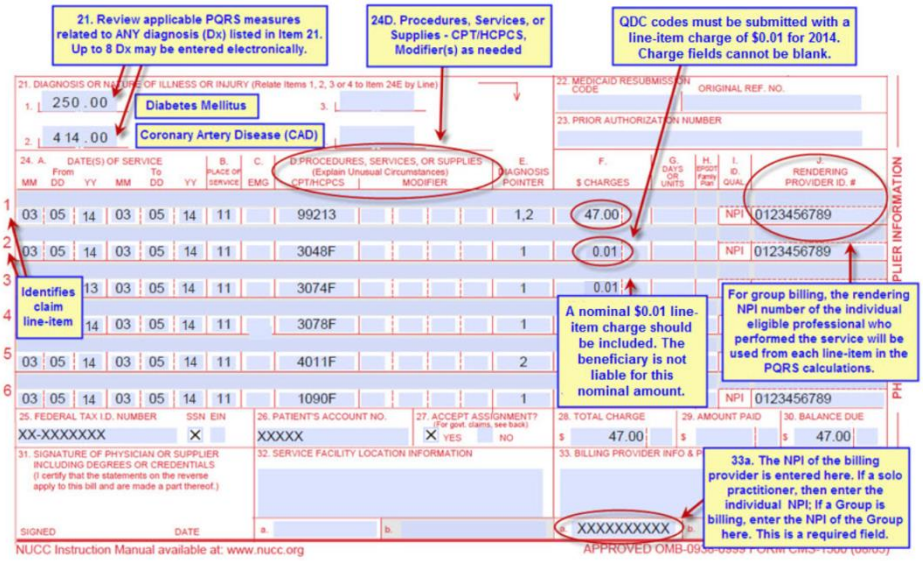
- **Performance Met:**
    - **G8539:** Functional outcome assessment documented as positive using a standardized tool **AND** a care plan based on identified deficiencies on the date of the functional outcome assessment, is documented. **OR**
    - **G8542:** Functional outcome assessment using a standardized 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.
- **Other Performance Exclusion:**
    - **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.
- **Performance Not Met:**
    - **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.

- 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.

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 slides.
- It is important to place an entry in the charge field.



- 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 N620 on the remittance advisories.
- N620 reads: "This procedure code is not payable. It is for reporting/information purposes only" and replaces code N365.
- This code will indicate that the reporting code passed into the national database.
- If you report the G-codes with a $0.00 dollar amount you will receive a N620 code on the remittance advisory.
- If you report the G-codes with a $0.01 dollar amount you will receive both a N620 and a CO260 code on the remittance advisory.