Prevent Medicare Penalties: 2016 PQRS for PM&R Providers

Marvel J Hammer
RN CPC CCS-P ASC-PM CPCO
**What Is PQRS?**

- **Physician Quality Reporting System**
  - Formerly known as Physician Quality Reporting Initiative (PQRI)
  - A quality reporting program that uses negative payment adjustments to promote reporting of quality information by individual eligible professionals and group practices
  - CMS partnered with outside agencies to develop the quality measures

- PQRS gives participating EPs the opportunity to
  - Assess the quality of care they are providing to their patients, helping to ensure that patients get the right care at the right time
  - Quantify how often they are meeting a particular quality metric
  - Compare their performance on a given measure with their peers
Medicare PQRS Incentive Program

- Only Medicare Part B covered services qualify
  - **Includes** Medicare Part B *primary* claims, Medicare Part B *secondary* Payer claims and *Railroad* Medicare Part B claims
  - **NOT** eligible for this incentive: Medicare Advantage, Tri-Care or Medicaid plans

- Private insurance plans may have separate Quality Incentive plans not associated with Medicare PQRS

May 2016
Why Participate in PQRS?

- The “carrots” are gone… PQRS participation in 2016 determines if adjustment penalties will be applied to your 2018 Medicare payments:

<table>
<thead>
<tr>
<th>Year</th>
<th>Reporting Year</th>
<th>Adjustment Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>2014</td>
<td>-2.0%</td>
</tr>
<tr>
<td>2017</td>
<td>2015</td>
<td>-2.0%</td>
</tr>
<tr>
<td>2018</td>
<td>2016</td>
<td>-2.0%</td>
</tr>
</tbody>
</table>

- PQRS participation included in CMS Physician Compare data [http://www.medicare.gov/physiciancompare/search.html](http://www.medicare.gov/physiciancompare/search.html)

- Value-based modifier incentive / payment adjustment linked to PQRS participation – potentially additional 2-4% penalty
Who Can Report as a PQRS Eligible Professionals (EP)?

- **Physicians**
  - MD / DO
  - Podiatrist
  - Optometrist
  - Oral Surgeon
  - Dentist
  - Chiropractor

- **Therapists**
  - Physical Therapist
  - Occupational Therapist
  - Qualified Speech-Language Therapist

- **Practitioners**
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - CRNA / AA
  - Certified Nurse Midwife
  - Clinical Social Worker
  - Clinical Psychologist
  - Registered Dietician
  - Nutrition Professional
  - Audiologist

May 2016
To Get Started…

1. Determine eligibility to report 2016 PQRS
2. Decide how to participate in 2016 PQRS: Individual versus Group (must register by 6/30/16)
3. Choose reporting method:
   - Claims Based Reporting
   - Registry Reporting
   - EHR Reporting
   - Qualified Clinical Data Registry Reporting
   - Group Practice Reporting Option
3. Select individual measures or measures group
4. Perform, document & report measures

http://tinyurl.com/2016PQRS-ImplementationGuide
2016 PQRS: Choosing How To Participate – Individual Eligible Professional (EP)

- PQRS reporting analysis is based on each individual NPI / Tax ID (TIN) combination
  - Individual EP reporting in multiple Tax IDs: PQRS payment adjustment would be applied to each unsuccessful NPI/TIN reporting

- Individual EP within a group practice that report as individuals are free to choose which PQRS measures / measures group to report
  - NO requirement to register to participate as an individual EP
  - Analysis is based on the individual/rendering NPI – not group NPI
2016 PQRS: Choosing How To Participate – Individual Eligible Professional (EP)

- Individual EP can successfully report PQRS under 1 TIN and have penalty adjustment applied for not successfully report under different TIN
- Potential for some individual EP in a group practice to successfully report while other EP in same group may be subject to penalty
- For EP in solo practices, participating in PQRS as an individual is the **only** option
- 2016 PQRS reporting options: Individual measures, Measures Groups
- 2016 PQRS reporting methods: Claims-based, Qualified Registry, EHR, Qualified Clinical Data Registry
2016 PQRS: Choosing How To Participate – Group Reporting Option (GPRO)

- Group practice: single Tax Identification Number (TIN) with **2 or more** individual EPs who have reassigned their billing rights to the TIN
  - PQRS reporting analyzed at the group or TIN level rather than individual NPI
  - **Deadline** for 2016: Group practices choosing PQRS GPRO must self-nominate / register between April 1, - June 30, 2016 via the Web [www.qualitynet.org](http://www.qualitynet.org)
  - Group practice will determine its size based on the number of EPs (NPIs) billing under the TIN at the time of registration: 2-24 EPs, 25-99 EPs, and 100 or > EPs
  - During registration, group practices must also indicate their reporting method for the 12-month period
2016 PQRS: Choosing How To Participate – Group Reporting Option (GPRO)

- Once a group practice (TIN) registers to participate in the GRPO, this is the **only** PQRS participation available to the group & all individual EPs who bill Medicare under the group’s TIN for 2016
  - Groups who register for the 2016 PQRS GPRO will **not** be able to withdraw its registration

- Benefit of reporting as GPRO: less administrative burden
  - Billing and reporting staff may report one set of quality measures data on behalf of all EP within a group practice, reducing the need to keep track of individual EP’s reporting efforts separately
2016 PQRS: Choosing How To Participate – Group Reporting Option (GPRO)

- PQRS for Groups (GPROs) are analyzed at the TIN level under the TIN submitted at the time of the final self-nomination / registration
  - If a group is unsuccessful at preventing a PQRS payment adjustment, all NPIs under the TIN during the unsuccessful reporting period will receive the payment adjustment

- 2016 PQRS reporting options: Individual measures
  - Measures Groups not an option for GPRO reporting

- 2016 PQRS reporting methods: Qualified Registry, Qualified Clinical Data Registry, EHR, GPRO Web-Interface (25+ EPs), CMS-certified survey vendor for CAHPS in combination with one of other methods
  - CAHPS: Consumer Assessment of Healthcare Providers & Systems

What Are the Methods to Report PQRS Measures?

- **Claims-Based Reporting**
  - Individual EP reporting as individual *only*, no Group EP reporting
  - No enrollment or registry requirement to begin reporting
  - Simply report appropriate PQRS denominator and numerator code(s) on the same claim as payable service
  - Can be sent either via electronic or paper 1500 claim form
  - 12 month period only
  - Individual measures: \( \geq 50\% \) of PQRS measure applicable Medicare Part B patients
  - Measures group: **NOT** a reporting option
PQRS Claims-Based Reporting

- CMS **strongly encourages** claims-based billing of all 2016 QDCs with a **$0.01** charge
  - **Cannot** hold beneficiary responsible for nominal amount
  - The submitted charge field **cannot** be left blank

- Entire claims with a zero charge will be **denied** - total charge for claim **cannot** be zero

- EP will receive a Remittance Advice (RA) associated with the PQRS claim which contains a PQRS QDC line item:
  - Billed with $0.01: claims adjustment reason code CO 246 **N620** – “This non-payable code is for required reporting only”

- Check to see if QDC is being received by MAC/contractor
  - The N620 claims adjustment reason code does **NOT** indicate whether the QDC was correct or that PQRS quotas were met; but rather only that the QDCs were **received**

Successful PQRS Claims-Based Reporting

- Claims for 2016 PQRS program **must** reach the NCH database by **February 24, 2017** to be included in the analysis

- Claims may **NOT** be resubmitted for the sole purpose of adding or correcting QDCs
  - If you forget to report the PQRS code for the measure, **CANNOT** add code to claim that has already been processed!
    - **Only** exception is if claim for corresponding PQRS denominator service was denied for any reason, i.e. not processed for payment
  - Claims that are resubmitted **only** to add the PQRS QDC (numerator) code will **NOT** be included in the analysis
Are the Methods to Report PQRS Measures?

- **Registry-Based Reporting**
  - Collects clinical data submitted from EP and submits PQRS individual measures or measures groups to CMS on behalf of participants
  - Provides CMS with EP’s calculated reporting and performance rates at the end of the reporting period
  - **12-month reporting period only** (Jan 1 – Dec 31, 2016)
  - Individual measures: at least 50% of applicable Medicare Part B patients (same as claims-based requirements)
  - Measures group: ≥ 20 patient sample, a majority (at least 11 out of 20) must be Medicare Part B patients
Registry-Based Reporting Options

☑ Not all registries report all individual measures and/or measures groups – best to check!

▪ Must use a CMS qualified PQRS registry - often specialty or membership societies
  – Responsible for providing instructions on how to submit the selected 2016 measures / measures group in 1st quarter of 2017

▪ CMS Qualified 2016 Registry list: 

▪ After selecting a qualified registry, it is important that you provide the correct/accurate NPI/TIN combination for incentive payment purposes
  – Individual EPs: report the TIN & individual rendering NPI to which Medicare Part B charges are billed, not group NPI

May 2016

http://tinyurl.com/2016PQRS-RegistrySimple
Are the Methods to Report PQRS Measures?

- **Electronic Health Record-Based Reporting;** 2 methods:
  - **Direct** EHR-based: EPs submit PQRS quality measure data directly from the CEHRT to CMS
  - Qualified EHR **Data Submission Vendor;** PQRS quality measure data extracted from CEHRT to DSM vendor who submits to CMS on behalf of the EP or Group practice
  - **Must** use technology that is Certified EHR technology (CEHRT)

- ✓ Best to check PQRS individual measures list as not all are allowed to be reported via EHR-based reporting

http://tinyurl.com/2016PQRS-EHRSimple
http://tinyurl.com/2016PQRS-Group-EHRreporting

May 2016
Electronic Health Record-Based Reporting Options

- Reporting PQRS via CEHRT is aligned with the Medicare EHR Incentive Program (Meaningful Use)
  - **2 for 1:** report your clinical quality measures (CQM) electronically through the PQRS EHR reporting option portal - can fulfill the CQM requirements for both PQRS and Meaningful Use
  - Recommend working with your EHR vendor

http://tinyurl.com/eCQM-Specifications

http://tinyurl.com/eCQMs-2016Reporting
What Are the Methods to Report PQRS Measures?

- **Qualified Clinical Data Registry (QCDR)**
  - **New** for 2016: reporting option for not only Individual EPs, but **also** GPRO reporting
  - A CMS-approved entity (such as a registry, certification board, collaborative, etc.) that collects medical and/or clinical data for the purpose of patient and disease tracking to foster improvement in the quality of care furnished to patients
    - Data submitted covers quality measures **across** multiple payers & is **not** limited to Medicare beneficiaries
    - Different from a qualified registry – **not** limited to measures within PQRS

http://tinyurl.com/2016PQRS-QCDRSimple
**Qualified Clinical Data Registry (QCDR)**

- May submit measures from **one or more** of the following categories with a **maximum** of **30** non-PQRS measures allowed:
  - Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG CAHPS)
  - National Quality Forum (NQF)-endorsed measures
  - Current 2016 PQRS individual measures
  - Measures used by boards or specialty societies
  - Measures used in regional quality collaborations

- **Must** report on at least **2** outcome measures

- CMS Qualified 2016 Qualified Clinical Data Registry list not released yet: [http://tinyurl.com/CMS-PQRS-QCDR](http://tinyurl.com/CMS-PQRS-QCDR)
Are the Methods to Report PQRS Measures?

- **Group Practice Reporting Options (GPRO)**
  - **GPRO Web** interface:
    - **2-24 EPs/group**: cannot report through this option
    - **25+ EPs/group**: report designated measures on 1st consecutive 248 designated Medicare patients; if less, report 100% of assigned
  - **Qualified Registry**: 2-99 EP groups: same as individual EP reporting requirements
  - **Qualified Clinical Data Registry**: 2-99 EP groups: same as individual EP reporting requirements
  - **Direct EHR or EHR Data Submission Vendor**: 2+EP groups: same as individual EP reporting requirements.

http://tinyurl.com/PQRS-GPRO-WebInterface
FYI: If an individual EP or a GPRO organization changes TINs during reporting period, the participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis.
What Are Quality Measures?

- Indicators of the quality of care provided by eligible professionals

- Tools that help CMS measure or quantify …
  - Health care processes, outcomes, patient perceptions and organizational structure
  And/or
  - Systems that are associated with the ability to provide high-quality health care and/or that relate to one or more quality goals for health care

- These goals include: effective, safe, efficient, patient-centered, equitable and timely care
How Should You Determine Which Individual Measures Or Measures Group to Report?

- Review the measures list
- Consider important factors - at a minimum, the following factors should be considered when selecting measures for reporting:
  - Clinical conditions usually treated
  - Types of care typically provided – e.g., preventive, chronic, acute
  - Settings where care is usually delivered – e.g., office, emergency department (ED), surgical suite
  - Quality improvement goals for 2016
  - Other quality reporting programs in use or being considered
- Review measure specifications
NEW! 2016 PQRS Individual Measure Web-based Tool

https://pqrs.cms.gov/#/home
2016 PQRS Specialty Measure Sets

- Can be used as a guide for EPs to choose individual measures applicable to their specialty; they are not required measures - only suggested measure for specific specialties

  - Cardiology
  - Dermatology
  - Emergency Medicine
  - Gastroenterology
  - General Practice/Family Practice
  - General Surgery
  - Hospitalist
  - Internal Medicine
  - Mental Health
  - Multiple Chronic Conditions
  - Obstetrics/Gynecology
  - Oncology/Hematology
  - Ophthalmology
  - Pathology
  - Physical Therapy/Occupational Therapy
  - Radiology
  - Urology

http://tinyurl.com/PQRS-SpecialtyMeasureSets
PQRS Individual Quality Measures

- 2016 – 233 quality measures
  - Includes 36 new measures; 10 measures removed
  - 106 are reportable **ONLY** through registry method
  - 33 are reportable **ONLY** through EHR method

☑ Best to check: Each measure has different specifications, codes & reporting options

---

<table>
<thead>
<tr>
<th>Measure Title</th>
<th>Measure Number</th>
<th>Measure Description</th>
<th>NQF Domain</th>
<th>Measure Type</th>
<th>Reporting Method(s)</th>
<th>Use in Other Reporting Program(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Documentation of Current Medications in the Medical Record</td>
<td>60y5 0419 130</td>
<td>Percentage of visits for patients aged 16 years and older for which the eligible professional attempts to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include all known prescriptions, over-the-counter, herbal, and vitamin/mineral/dietary (nutritional) supplements and must contain the medications’ name, dosage, frequency and route of administration.</td>
<td>X</td>
<td>Process</td>
<td>X X X X X</td>
<td>X X X X X</td>
</tr>
</tbody>
</table>

http://tinyurl.com/PQRSMeasureCodes
How to Report PQRS Measures: Denominator

- **Key Question**: “Does this patient visit / service meet the PQRS measure criteria for the EP to report?”

- Describes **eligible cases** for a measure (the eligible patient population associated with a measure’s numerator)
  - ICD-10-CM, CPT Category I & HCPCS codes
    - **G44.85** Primary stabbing headache
    - **M81.0** Age-related osteoporosis without current pathologic ...
    - **99201-99205** New patient visit…
    - **77002** Fluoroscopic guidance for needle placement …
    - **G0444** Annual depression screening
  - Patient demographics (age, gender, etc.) & place of service
    - Patients aged 18 – 79 years
How to Report PQRS Measures: Numerator

- The specific **clinical action** required by the measure for reporting and performance (i.e., patients who received a particular service or obtained a particular outcome that is being measured)
  - Pain assessment, Functional status assessment

- **Quality Data Code** (QDC): specified CPT Category II codes with or without modifiers and/or HCPCS G-codes that describe the clinical action required by the measure’s numerator

  - **4004F** Patient screened for tobacco use and received tobacco cessation intervention (counseling, pharmacotherapy, or both) if identified as a tobacco user
  - **G8417** BMI is documented above normal parameters and a follow-up plan is documented
PQRS Measures

- Each measure has a **Reporting Frequency** requirement: number of times QDCs specified for a quality measure must be submitted on claims during the reporting period
  - “How often do you need to report the measure?”
    - Report only one-time per EP
    - Report three times per year
    - Report once for each procedure performed
    - Report for each acute episode / each visit

- Some measures have a **Performance Timeframe** – designated timeframe within which the action described in a performance measure should be completed; may or may not coincide with measure’s data reporting frequency requirement
  - Perform within 12 months or annually
  - Perform within 4 hours of…
Does Medicare Calculate a PQRS Individual Measure Reporting Performance?

- The PQRS individual measure final reporting rate calculation represents the percentage of the eligible population (denominator) that received a particular process of care or a particular outcome (numerator)

**Numerator Codes**
- G8417
- G4818
- G4819
- G4820
- G4821
- G4822
- G8938

**Denominator Codes**
- 99201
- 99202
- 99203
- 99204
- 99205
- 99212
- 99213
- 99214
- 99215

- Note the difference if the PQRS individual measure requires the EP to report only once per the 12 month reporting period or EACH time one of the denominator codes is reported for each Medicare Part B beneficiary that meets the requirements
What Are Performance Measure Modifiers?

- CPT II modifiers developed exclusively for use **only** with CPT Category II codes; **cannot** be used with HCPCS G-codes
- Can only report a **maximum** of 1 modifier; **cannot** combine performance measure modifiers
- Some PQRS measures have more than one allowable exclusions
- Certain PQRS measures **have no** applicable exclusions, i.e. no modifiers can be reported
- ✓ Best to check the PQRS individual measure specifications to determine appropriate exclusion modifiers
PQRS Performance Measure

- **Performed**: no modifier necessary
- **Not Performed**: Exclusion Modifiers: Documented Reason
  - **Medical**: -1P modifier
  - **Patient**: -2P modifier
  - **System**: -3P modifier
  - **Reason Not Specified**: -8P modifier
2016 PQRS Individual Claims Registry Measure Specifications

- ZIP file with separate PDF for each PQRS individual measure
- 2016 PQRS Measure Flows have been incorporated within each 2016 Individual Measure Specification PDF

http://tinyurl.com/2016-PQRS-IndMeasSpec
National Quality Strategy (NQS)

- The Affordable Care Act sought to increase access to high-quality, affordable care for all Americans; it required the Secretary of HHS to establish a National Strategy for Quality Improvement in Health Care (National Quality Strategy) that set priorities to guide effort and include a strategic plan for how to achieve it
  - Set of 3 overarching aims were developed to establish framework within which specific priorities could be identified and implemented
    - Better Care
    - Healthy People/Healthy Communities
    - Affordable Care
  - To advance these aims, the NQS will focus initially on 6 priority domains …
National Quality Strategy Domains

- **Patient Safety**: making care safer by reducing harm caused in the delivery of care
- **Person and Caregiver-Centered Experience and Outcomes**: Ensuring that each person and family is engaged as partners in their care
- **Communication and Care Coordination**: Promoting effective communication and coordination of care
- **Effective Clinical Care**: Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease
- **Community/Population Health**: Working with communities to promote wide use of best practices to enable healthy living
- **Efficiency and Cost Reduction**: Making quality care more affordable for individuals, families, employers and governments by developing and spreading new health care delivery models
2016 PQRS Cross-Cutting Measures

- Part of Medicare’s mission to obtain “a better picture of the overall quality of care furnished by EP, particularly for the purpose of having PQRS reporting being used to assess quality performance under the Value-Based modifier”

- To satisfactorily report 2016 PQRS via claims and registry reporting of individual measures, EP or group practice is required to report 1 cross-cutting measure if they have at least 1 Medicare patient with a face-to-face encounter.
  - Face-to-face encounter: instance in which the EP billed for services that are associated with face-to-face encounters under the Physician Fee Schedule; includes office visits, surgical procedure codes (not telehealth visits); Cross-cutting Measures List: http://tinyurl.com/CMS-PQRS-CrossCut

- Not in addition to regular 9 individual measure reporting
2016 Successfully Reporting: PQRS Individual Measures to Avoid 2018 PQRS Penalty Adjustment

- Report at least 9 measures covering at least 3 NQS domains AND report each measure for at least 50% of the EP’s measure applicable Medicare Part B patients seen during the 12 month reporting period (Jan 1 – Dec 31, 2016)
  - Claims-based & Registry Reporting: of the measures reported, if the EP sees at least 1 Medicare patient in a face-to-face encounter, the EP will report on at least 1 measure contained in the cross-cutting measure set
- Note 50% threshold reporting requirement; if an EP reports on less than 50% ➔ 2018 penalty applies
What happens if you can’t find 9 applicable individual measures to report OR the 9 individual measures are from only 1 or 2 NQS domains?
Measure Applicability Validation (MAV)

- A measure-applicability validation (MAV) process will apply for those EP that report less than 9 individual measures and/or covering less than 3 NQS domains

- **Only** applies to PQRS individual measures reported via claims or registry reporting method

- In order for MAV to be applied, EP ....
  - **Must** satisfactorily report on at least 50% of their eligible patients / encounters for each individual measure reported
  - **Must** report at least 1 cross-cutting measure if applicable
  - **Cannot** have 0% performance on individual measure(s) reported

- MAV does **not** apply to PQRS Measure groups or individual measures reported via Electronic Health Record, a Qualified Clinical Data Registry or Group Practice Reporting Option Web Interface

[http://tinyurl.com/CMS-PQRS-Analysis-Payment](http://tinyurl.com/CMS-PQRS-Analysis-Payment)
Are PQRS Measures Groups?

- A group of measures covering patients with a specific condition or preventive service that is addressed by at least six measures that share a common patient / visit clinical condition or focus

- **Only** the defined PQRS measures groups can be utilized when reporting the measures group options
  - All other individual measures that are included in PQRS but not defined as included in a measures group cannot be grouped together by EP to define a measures group
  - Some measures groups include performance measures that can only be reported as a group
PQRS Measures Groups

- 2016: 25 measures groups
  - Includes 3 new measures groups, 0 deleted for 2016
  - **Only** reportable by individual EP, **no** GPRO reporting option
  - **ONLY** can report by qualified PQRS registry; **no** claims-based, QCDR or EHR method reporting options
  - Each of the applicable measures in a measures group **must** be reported for each patient

- Only one 2016 reporting period for EPs to report PQRS measures groups: **12**-month (Jan 1 – Dec 31, 2016)

- Measure applicability validation process **not** an option
PQRS Measures Groups

☑️ Best to check: Measures Group specifications may be different from those of the individual measures that form the group; use the **correct** specifications manual!

http://tinyurl.com/PQRS-2016MeasuresGroupSpec

<table>
<thead>
<tr>
<th>Overview</th>
<th>Dementia Measures Group</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>Care Plan</td>
<td>225</td>
</tr>
<tr>
<td>134</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan</td>
<td>227</td>
</tr>
<tr>
<td>280</td>
<td>Dementia: Staging of Dementia</td>
<td>228</td>
</tr>
<tr>
<td>281</td>
<td>Dementia: Cognitive Assessment</td>
<td>230</td>
</tr>
<tr>
<td>282</td>
<td>Dementia: Functional Status Assessment</td>
<td>231</td>
</tr>
<tr>
<td>283</td>
<td>Dementia: Neuropsychiatric Symptom Assessment</td>
<td>232</td>
</tr>
<tr>
<td>284</td>
<td>Dementia: Management of Neuropsychiatric Symptoms</td>
<td>233</td>
</tr>
<tr>
<td>286</td>
<td>Dementia: Counseling Regarding Safety Concerns</td>
<td>234</td>
</tr>
<tr>
<td>287</td>
<td>Dementia: Counseling Regarding Risks of Driving</td>
<td>235</td>
</tr>
<tr>
<td>288</td>
<td>Dementia: Caregiver Education and Support</td>
<td>236</td>
</tr>
</tbody>
</table>

- Reminder: can **only** report measures group via qualified registry, can **not** report via claims
2016 PQRS Measures Group Flow Documents

- ZIP file with separate PDF for each PQRS measures group
- Unlike the 2016 Individual measures, the 2016 PQRS Measures Group Flow documents are separate PDF from 2016 PQRS Measures Group Specification file

http://tinyurl.com/PQRS-2016MeasureGrpFlow
2016 Successfully Reporting: PQRS Measures Group to Avoid 2018 Penalty Adjustment

- Report at least 1 measures group AND report each measures group for at least 20 patients, a majority (at least 11 of 20) of which are required to be Medicare Part B patients
  - If the minimum number of patients does not meet the measures group ≥ 20 patient sample criteria, the EP does not prevent the 2018 penalty
- If an EP does not have the minimum number of patients for inclusion in the required patient sample for the reporting period, EP should report either another measures group OR select reporting of individual measures that are applicable to the EP’s practice
Successfully Report PQRS

- Clinical measure(s) which you are reporting **must** be documented in the medical record

- PQRS is a **reporting** program; reporting of non-performance of measures potentially will count toward the prevention of payment adjustment (whether the clinical action is reported as completed or not completed via a performance measure exclusion modifier) …

- **Reminder**: 0% performance rate on an individual measure will **not** be counted toward 2016 PQRS requirements
  - Measures groups containing a measure with 0% performance rate will **not** be counted as satisfactorily reporting the measures group
  - Reporting that the EP **did not** perform the measure 100% of the time is **not** accepted!
PQRS Participation Reports

- Each year following data analysis, CMS releases PQRS feedback reports
  - Effective July 2015, CMS changed PQRS report access to the Enterprise Identity Management System (EIDM); CMS moved prior IACS users & data over to EIDM
    - Look at bottom left hand corner of page – “Physician Value”

- Reports are available for every TIN under which at least 1 EP submitted at least 1 valid PQRS measure via claims-based reporting a minimum of once during reporting period
PQRS Participation Reports

- Historically, final reports are not released until 4-6 months after end of reporting period with no method to monitor PQRS reporting during the actual reporting period.

- **Interim Feedback** Dashboard reports
  - Available to those EP using **claims-based** reporting; qualified PQRS registries & EHR vendors are also required to provide interim feedback reports, if technically feasible.
  - Allows organizations and EP to log-in and access their interim PQRS reported data on a **quarterly basis** in order to monitor the status of claims-based individual measures reporting.
Where To Get PQRS Help?

- Contact the **QualityNet Help Desk** for help with program questions ranging from “How do I get started?” to accessing feedback reports
  - 866-288-8912  
  - Or e-mail: Qnetsupport@hcqis.org
- Medicare PQRS Reporting Made Simple:
  - Registry: [http://tinyurl.com/2016PQRS-RegistrySimple](http://tinyurl.com/2016PQRS-RegistrySimple)
Transitioning from Volume to Value

Value-based Payment Modifier

http://tinyurl.com/Medicare-VBPM

- CMS Physician Value Help Desk for Value Modifier questions
  - 888-734-6433, press option 3 (8:00 a.m. – 8:00 p.m. EST M-F)
Value-Based Payment Modifier

- CMS is moving toward physician payment that rewards value rather than volume.
  - CMS set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018.

- The Affordable Care Act (ACA) required HHS to establish a budget-neutral Value-Based Payment Modifier (VM)
  - Based upon quality of care compared to the cost of care furnished to Medicare beneficiaries
  - Providers practicing high-quality, low-cost medicine will earn a positive VM, while providers determined to provide low-quality and high-cost care will receive a negative VM
Are VM Payment Adjustments Applied?

- CMS divides TINs subject to VM into two categories based on their registration and participation in the PQRS basis performance period:
  - **Category 1**: includes TINs that met the criteria as a group to avoid the corresponding PQRS payment adjustment OR at least 50% of EPs in the TIN met the criteria to avoid the corresponding PQRS payment adjustment as individuals
  - **Category 2**: includes TINs subject **do not** meet the criteria for inclusion in Category 1, including all non-PQRS reporters

- FYI: any VM payment adjustment is in **addition to** any PQRS negative payment adjustment!
How Does VM Work?

1. PQRS-reported quality information along with CMS-calculated outcomes & cost measures are analyzed.

2. Each group practice receives two composite scores: a quality and a cost composite.

3. CMS classifies each score into “high”, “average” or “low” based on whether the score is at least 1 standard deviation above/below the national mean score, which IDs statistically significant outliers.

4. “Quality Tiering” Analysis: CMS assigns outliers to their respective quality and cost “tiers” to determine whether the score will earn the practice a bonus, penalty or no adjustment to their payment based on their performance in these categories.
Value-Based Payment Modifier

- Medicare **adjusts** eligible provider payments using quality outcomes data from the Physician Quality Reporting System (PQRS) and cost data from Medicare claims for fee-for-service patients
  - This is a pay for value (i.e., quality relative to cost) program – higher value gets higher pay; lower value gets lower pay, based on quality tiering

- Quality and Resource Use Reports (QRUR) provide the quality-related feedback

- VM is **separate** from PQRS and EHR Meaningful Use programs
Is Subject to the VM?

- **Jan 1, 2017**: VM will be applied to Medicare PFS physician payments for physician *solo practitioners* and physicians in groups of **2 or more** EPs as identified by their TIN.
  - **2015** was the performance basis period for the 2017 VM

- **Jan 1, 2018**: VM will be applied to Medicare PFS payments for physician *and non-physician* EPs who are solo practitioners or in groups of 2 or more EPs as identified by their TIN.
  - **2016** is the performance basis period for the 2018 VM
Quality Resource and Use Reports (QRURs)

- Confidential feedback reports provided to physicians and groups of physicians under the Medicare Physician Feedback Program
  - Provide information about the resources used and the quality of care furnished to their Medicare fee-for-service (FFS) patients
  - Can be used to compare with other physicians and groups of physicians caring for Medicare patients
  - Contain quality of care and cost performance rates on measures that will be used to compute the VM
  - Provide meaningful and actionable information to providers so they can improve the care they deliver
Quality Resource and Use Reports (QRURs)

- **2012 QRURs**: made available in September 2013 based on care provided in 2012 to group practices that had at least 25 EPs.

- **2013 QRURs**: made available September 2014, based on care provided in 2013 to all groups as well as solo physicians who met specific criteria.

- **2014 QRURs**: made available in September 2015 to every group practice and solo practitioner nationwide; groups and solo practitioners are identified in the QRURs by their TIN;
  - Also available for groups / solo practitioners that participated in the Medicare Shared Savings Program, the Pioneer ACO Model, or the Comprehensive Primary Care initiative in 2014 as well as those TINs consisting only of non-physician EPs.

http://tinyurl.com/CMS-2014-QRUR
VBPM & QRUR Resources

- CMS “How to obtain a QRUR” website: http://tinyurl.com/CMS-ObtainQRUR
- An Enterprise Identity Management System (EIDM) account is required – same registration necessary in order to access PQRS reports http://portal.cms.gov
VM Implementation

- **2018** VM phased in to apply to **all** EPs, including non-physician practitioners (PAs, NPs, CNSs, CRNAs)
  - **2016 PQRS** reporting used to determine the EP’s 2018 VM score
  - TINs that consist of non-physician EPs only will be held harmless from downward adjustments
  - All other TINs will be subject to upward, neutral or downward adjustments

- **Reminder**: the VM payment adjustment is **separate** from the PQRS and other Medicare sponsored programs payment adjustments
For 2018 VM, **all physicians & NPPs**

**Category 1 / 2016 PQRS Reporters**

- Mandatory Quality Tiering calculation

**Physicians & NPPs:**
- **Solo** or in groups of **2-9** EPs
- **Upward, neutral or downward** adjustment based on quality tiering

**Category 2 / 2016 Non-PQRS Reporters**

- **-2% VM adjustment:**
  - groups of 2-9 EP or solo practitioners

**Physicians & NPPS:**
- Groups of **10+** EPs
- **Upward, neutral or downward** adjustment based on quality tiering

**NPPs only:**
- **Solo** or in **Groups**
- **Upward or no** adjustment based on quality tiering
### 2018 VM / 2016 PQRS:
Physician & NPP Groups with 10+ EP

<table>
<thead>
<tr>
<th>Cost / Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low</strong> Cost</td>
<td>+ 0.0%</td>
<td>+ <strong>2.0x</strong></td>
<td>+ <strong>4.0x</strong></td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>+ 0.0%</td>
<td>+2.0x*</td>
</tr>
<tr>
<td><strong>High</strong> Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>+ 0.0%</td>
</tr>
</tbody>
</table>

- Under quality-tiering, successful 2016 PQRS reporters: potential upward adjustment is up to +4x; payment at risk is -4%
- * the “x” in the upward adjustment represents the payment redistribution adjustment factor
- **Automatic** downward 4% adjustment for NOT successfully reporting PQRS in 2016
### 2018 VM / 2016 PQRS: Physician & NPP Groups with 2-9 EP & Solo Practitioners

<table>
<thead>
<tr>
<th>Cost / Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+ 0.0%</td>
<td>+ 1.0x*</td>
<td>+ 2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-1.0%</td>
<td>+ 0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>+ 0.0%</td>
</tr>
</tbody>
</table>

- Under quality-tiering, successful 2016 PQRS reporters: potential upward adjustment is up to **+2x**; payment at risk is **-2%**
- * the “x” in the upward adjustment represents a payment redistribution adjustment factor
- **Automatic** downward **2%** adjustment for **NOT** successfully reporting PQRS in 2016
2018 VM / 2016 PQRS: PAs, NPs, CNSs, & CRNAs who are Solo Practitioners or in Groups of NPP EPs Only

<table>
<thead>
<tr>
<th>Cost / Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>+ 0.0%</td>
<td>+ 1.0x*</td>
<td>+ 2.0x*</td>
</tr>
<tr>
<td>Average Cost</td>
<td>+0.0%</td>
<td>+ 0.0%</td>
<td>+1.0x*</td>
</tr>
<tr>
<td>High Cost</td>
<td>+0.0%</td>
<td>+0.0%</td>
<td>+ 0.0%</td>
</tr>
</tbody>
</table>

- Under quality-tiering, successful 2016 PQRS reporters: earn only an upward or neutral adjustment in 2018; no downward adjustment
- Reminder: automatic negative 2% payment adjustment for NOT successfully reporting PQRS in 2016
Actions for all Group Practices or Solo Practitioners in 2016 for the 2018 VM

- Be sure to satisfactorily report quality data under PQRS for 2016
  - Decide how to participate in the 2016 PQRS program – individual versus group reporting
  - Choose a PQRS reporting mechanism and become familiar with the measures and data submission timeframes

- Download your 2014 Annual QRUR report, which shows 2016 VM information
  - Watch for announcements about availability of the 2015 Mid-Year QRUR & 2015 Annual QRUR
  - Review quality measure benchmarks under the VM, understand what is required for above avg. performance
What Happens Next Year In 2017?

- 2016 is the last year for participation in the individual Medicare PQRS, VM and EHR programs
  
  - Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) creates a new framework for rewarding health care providers for giving better care, not just more care as well as combines the existing quality reporting programs into one new system
  
  - Merit-based Incentive Payment System (MIPS) – will incorporate penalties and bonuses, which will be based on performance scores that are above or below annual thresholds; maximum penalties top out at 4% in 2019 and reach up to 9% in 2022 and beyond
  
  - Alternate Payment Models (APMs) – Accountable Care Organizations, Patient Centered Medical Homes and bundled payment models
Merit-Based Incentive Program

- New program that combines parts of the current Physician Quality Reporting System, Value Modifier and Medicare Electronic Health Record Incentive programs based on:
  - Quality
  - Resource use
  - Clinical practice improvement
  - Meaningful use of certified EHR technology

- Starting in 2017, MIPS will annually measure Medicare Part B providers in four performance categories to derive a MIPS score which can have a positive or negative effect on the provider’s Medicare reimbursement

<table>
<thead>
<tr>
<th>Proposed 2017 MIPS (0 – 100 points)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality (50%)</strong> (replaces PQRS measures)</td>
</tr>
</tbody>
</table>
Potential 2016 PQRS Individual Measures for PM&R Providers
<table>
<thead>
<tr>
<th>National Quality Strategy Domain</th>
<th>PQRS #</th>
<th>Individual Measure Description</th>
<th>Reporting Options</th>
<th>Reporting Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication &amp; Care Coordination</td>
<td>24</td>
<td>Communication with the Physician or Other Clinician Managing On-going Care Post-Fracture for Men and Women …</td>
<td>C, R</td>
<td>Each occurrence</td>
</tr>
<tr>
<td></td>
<td>46</td>
<td>Medication Reconciliation After Inpatient Facility Discharge</td>
<td>C, R</td>
<td>Within 30 days after inpatient discharge</td>
</tr>
<tr>
<td></td>
<td>47</td>
<td>(Advanced) Care Plan</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>131</td>
<td>Pain Assessment &amp; Follow-Up</td>
<td>C, R</td>
<td>Each visit</td>
</tr>
<tr>
<td></td>
<td>155*</td>
<td>Falls: Plan of Care</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td>National Quality Strategy Domain</td>
<td>PQRS #</td>
<td>Individual Measure Description</td>
<td>Reporting Options</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>Communication &amp; Care Coordination (continued)</td>
<td>325</td>
<td>Adult Major Depressive Disorder: Coordination of Care of Patients w/ Spec Comorbid Conditions</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>374</td>
<td>Closing the Referral Loop: Receipt of Specialist Report</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>411 New</td>
<td>Depression Remission at Six Months</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td>Community / Population Health</td>
<td>110</td>
<td>Influenza Immunization</td>
<td>C, R, EHR, GPRO Web Interface</td>
<td>2 time periods: once each</td>
</tr>
<tr>
<td></td>
<td>111</td>
<td>Pneumonia Vaccination for Older Adults</td>
<td>C, R, EHR, GPRO Web Interface</td>
<td>Once / year</td>
</tr>
<tr>
<td>National Quality Strategy Domain</td>
<td>PQRS #</td>
<td>Individual Measure Description</td>
<td>Reporting Options</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
<td>---------------------------------</td>
<td>-------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Community / Population Health (continued)</td>
<td>128</td>
<td>Body Mass Index (BMI) Screening &amp; Follow-up</td>
<td>C, R, EHR, GPRO Web Interface</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>134</td>
<td>Screening for Clinical Depression &amp; Follow-Up Plan</td>
<td>C, R, EHR, GPRO Web Interface</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>226</td>
<td>Tobacco Use: Screening &amp; Cessation Intervention</td>
<td>C, R, EHR, GPRO Web Interface</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>317</td>
<td>Screening for High Blood Pressure &amp; Follow-up Documented</td>
<td>C, R, EHR, GPRO Web Interface</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>431</td>
<td>Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
<td>X-Cutting</td>
<td>Once / Year</td>
</tr>
<tr>
<td>National Quality Strategy Domain</td>
<td>PQRS #</td>
<td>Individual Measure Description</td>
<td>Reporting Options</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
<td>--------------------------------</td>
<td>--------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Effective Clinical Care</td>
<td>9</td>
<td>Anti-Depressant Medication Management</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>32</td>
<td>Stroke &amp; Stroke Rehabilitation: Discharged on Antithrombotic Therapy</td>
<td>C, R</td>
<td>At each discharge from hospital</td>
</tr>
<tr>
<td></td>
<td>39</td>
<td>Screening or Therapy for Osteoporosis for Women Aged 65 – 85 years old</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>41</td>
<td>Osteoporosis: Pharmacologic Therapy for Men and Women Aged 50 Years and Older</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>48</td>
<td>Urinary Incontinence: Assessment of Presence or Absence of Women &gt; 65</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td>National Quality Strategy Domain</td>
<td>PQRS #</td>
<td>Individual Measure Description</td>
<td>Reporting Options</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------</td>
<td>---------------------------------</td>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Effective Clinical Care (continued)</td>
<td>107</td>
<td>Adult Major Depressive Disorder: Suicide Risk Assessment</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>127</td>
<td>Diabetes: Foot &amp; Ankle: Peripheral Neuropathy Neurological Evaluation</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>128</td>
<td>Diabetes: Foot &amp; Ankle: Ulcer Prevention – Footwear Eval</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>163</td>
<td>Diabetes – Foot Exam</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>178</td>
<td>Rheumatoid Arthritis: Functional Status Assessment</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>236</td>
<td>Controlling High Blood Pressure</td>
<td>C, R, EHR, GPRO Web Interface</td>
<td>Once / year</td>
</tr>
<tr>
<td>National Quality Strategy Domain</td>
<td>PQRS #</td>
<td>Individual Measure Description</td>
<td>Reporting Options</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
<td>--------------------------------</td>
<td>--------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Effective Clinical Care (continued)</td>
<td>281</td>
<td>Dementia – Cognitive Assessment</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>367</td>
<td>… &amp; Major Depression: Appraisal for Alcohol &amp; Chemical Substance Use</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>370</td>
<td>Depression Remission at 12 months</td>
<td>R, EHR, GPRO Web Interface</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>371</td>
<td>Depression: Utilization of PHQ-9 Tool</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>408 New</td>
<td>Opioid Therapy Follow-up Evaluation</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>412 New</td>
<td>Documentation of Signed Opioid Treatment Agreement</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td>National Quality Strategy Domain</td>
<td>PQRS #</td>
<td>Individual Measure Description</td>
<td>Reporting Options</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>----------------------------------</td>
</tr>
<tr>
<td>Effective Clinical Care (continued)</td>
<td><strong>414</strong> New</td>
<td>Evaluation or Interview for Risk of Opioid Misuse</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td><strong>418</strong> New</td>
<td>Osteoporosis Management in Women Who Had a Fracture</td>
<td>C, R</td>
<td>Each occurrence of a fracture</td>
</tr>
<tr>
<td></td>
<td><strong>435</strong> New</td>
<td>Quality of Life Assessment for Patients with Primary Headache Disorders</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td>Patient Safety</td>
<td><strong>130</strong></td>
<td>Documentation of Current Medications in the Medical Record</td>
<td>C, R, EHR, GPRO Web Interface</td>
<td>Each visit</td>
</tr>
<tr>
<td></td>
<td><strong>145</strong></td>
<td>Radiology: Exposure Time Reported for Procedures Using Fluoroscopy</td>
<td>C, R</td>
<td>Each time</td>
</tr>
<tr>
<td>National Quality Strategy Domain</td>
<td>PQRS #</td>
<td>Individual Measure Description</td>
<td>Reporting Options</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
<td>---------------------------------</td>
<td>-------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Patient Safety (continued)</td>
<td>154</td>
<td>Falls: Risk Assessment (partnered with #155)</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>181</td>
<td>Elder Maltreatment Screen &amp; Follow-up Plan</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>238</td>
<td>Use of High-Risk Medications in the Elderly</td>
<td>R, EHR</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>318</td>
<td>Falls: Screening for Fall Risk</td>
<td>EHR, GPRO Web Interface</td>
<td></td>
</tr>
<tr>
<td>Efficiency &amp; Cost Reduction</td>
<td>312</td>
<td>Use of Imaging Studies for Low Back Pain</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>419</td>
<td>Overuse of Neuroimaging for Patients with Primary Headache &amp; a Normal Neurological Examination</td>
<td>C, R</td>
<td>Each Visit</td>
</tr>
<tr>
<td>National Quality Strategy Domain</td>
<td>PQRS #</td>
<td>Individual Measure Description</td>
<td>Reporting Options</td>
<td>Reporting Frequency</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Person &amp; Caregiver-Centered Experience &amp; Outcomes</td>
<td>50</td>
<td>Plan of Care for Urinary Incontinence in Women Aged 65 and Older</td>
<td>C, R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>109</td>
<td>Osteoarthritis: Function and Pain Assessment</td>
<td>C, R</td>
<td>Each visit</td>
</tr>
<tr>
<td></td>
<td>342</td>
<td>Pain Brought Under Control Within 48 Hours After Admission to Palliative Care</td>
<td>R</td>
<td>Once / year</td>
</tr>
<tr>
<td></td>
<td>375</td>
<td>Functional Status Assessment for Knee Replacement</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>376</td>
<td>Functional Status Assessment for Hip Replacement</td>
<td>EHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>377</td>
<td>Functional Status Assessment for Complex Chronic Conditions</td>
<td>EHR</td>
<td></td>
</tr>
</tbody>
</table>
Potential 2016 PQRS Measure Groups for PM&R Providers
# Individual Measure Description

<table>
<thead>
<tr>
<th>PQRS #</th>
<th>Individual Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>47</td>
<td>(Advanced) Care Plan</td>
</tr>
<tr>
<td>134</td>
<td>Screening for Clinical Depression and Follow-up Plan</td>
</tr>
<tr>
<td>280</td>
<td>Dementia: Staging of Dementia</td>
</tr>
<tr>
<td>281</td>
<td>Dementia: Cognitive Assessment</td>
</tr>
<tr>
<td>282</td>
<td>Dementia: Functional Status Assessment</td>
</tr>
<tr>
<td>283</td>
<td>Dementia: Neuropsychiatric Symptom Assessment</td>
</tr>
<tr>
<td>284</td>
<td>Dementia: Management of Neuropsychiatric Symptoms</td>
</tr>
<tr>
<td>286</td>
<td>Dementia: Counseling Regarding Safety Concerns</td>
</tr>
<tr>
<td>287</td>
<td>Dementia: Counseling Regarding Risks of Driving</td>
</tr>
<tr>
<td>288</td>
<td>Dementia: Caregiver Education and Support</td>
</tr>
</tbody>
</table>

2016 PQRS: Measures Group – Registry Reporting Only
2016 PQRS: Measures Group – Registry Reporting Only

<table>
<thead>
<tr>
<th>PQRS #</th>
<th>Individual Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARKINSON’S MEASURES GROUP</td>
<td></td>
</tr>
<tr>
<td>47</td>
<td>(Advanced) Care Plan</td>
</tr>
<tr>
<td>289</td>
<td>Annual Parkinson’s Disease Diagnosis Review</td>
</tr>
<tr>
<td>290</td>
<td>Parkinson’s Disease: Psychiatric Disorders or Disturbances Assessment</td>
</tr>
<tr>
<td>291</td>
<td>Parkinson’s Disease: Cognitive Impairment or Dysfunction Assessment</td>
</tr>
<tr>
<td>292</td>
<td>Parkinson’s Disease: Querying about Sleep Disturbances</td>
</tr>
<tr>
<td>293</td>
<td>Parkinson’s Disease: Rehabilitative Therapy Options</td>
</tr>
<tr>
<td>294</td>
<td>Parkinson’s Disease Medical &amp; Surgical Treatment Options Reviewed</td>
</tr>
</tbody>
</table>
### 2016 PQRS: Measures Group – Registry Reporting Only

<table>
<thead>
<tr>
<th>PQRS #</th>
<th>Individual Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PREVENTIVE CARE MEASURES GROUP</strong></td>
<td></td>
</tr>
<tr>
<td>39</td>
<td>Screening for Osteoporosis for Women Aged 65-85 Years of Age</td>
</tr>
<tr>
<td>48</td>
<td>Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years of Age or Older</td>
</tr>
<tr>
<td>110</td>
<td>Influenza Immunization</td>
</tr>
<tr>
<td>111</td>
<td>Pneumonia Vaccination Status for Older Adults</td>
</tr>
<tr>
<td>112</td>
<td>Breast Cancer Screening</td>
</tr>
<tr>
<td>113</td>
<td>Colorectal Cancer Screening</td>
</tr>
<tr>
<td>128</td>
<td>Body Mass Index Screening &amp; Follow-up Plan</td>
</tr>
<tr>
<td>134</td>
<td>Screening for Clinical Depression and Follow-up Plan</td>
</tr>
<tr>
<td>226</td>
<td>Tobacco Use: Screening and Cessation Intervention</td>
</tr>
<tr>
<td>431</td>
<td>Unhealthy Alcohol Use: Screening &amp; Brief Counseling</td>
</tr>
</tbody>
</table>
## Individual Measure Description

<table>
<thead>
<tr>
<th>PQRS #</th>
<th>Individual Measure Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>047</td>
<td>Care Plan</td>
</tr>
<tr>
<td>110</td>
<td>Preventive Care and Screening: Influenza Immunization</td>
</tr>
<tr>
<td>128</td>
<td>Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan:</td>
</tr>
<tr>
<td>130</td>
<td>Documentation of Current Medications in the Medical Record:</td>
</tr>
<tr>
<td>131</td>
<td>Pain Assessment and Follow-Up:</td>
</tr>
<tr>
<td>134</td>
<td>Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan:</td>
</tr>
<tr>
<td>154</td>
<td>Falls: Risk Assessment:</td>
</tr>
<tr>
<td>155</td>
<td>Falls: Plan of Care:</td>
</tr>
<tr>
<td>238</td>
<td>Use of High-Risk Medications in the Elderly:</td>
</tr>
</tbody>
</table>

**2016 PQRS: New Measures Group – Registry Reporting Only**
2016 Multiple Chronic Conditions PQRS Measures Group

- Patient sample criteria for the Multiple Chronic Conditions Measures Group are patients:
  - Aged 66 years and older
  - With at least of the two conditions as listed in the Chronic Conditions Data Warehouse (CCW)
    - Accompanied by a specific encounter:
      (one of the following patient encounter codes)
      - 99487 Complex chronic care management services, …
      - 99490 Chronic care management services, …

http://tinyurl.com/CMS-CCWdata
Marvel J Hammer
RN CPC CCS-P ACS-PM CPCO

MJH Consulting
www.marvelhammer.com
Denver, CO
303-871-9484 (T)
marvelh@aol.com

May 2016