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CMS Physician Quality Reporting System - *Incentive vs. Penalty*

Part I of II Part Series on CMS Physician Value Based Purchasing Initiatives

Judy Burleson, MHSA
American College of Radiology
Director, Metrics

Physician Quality Reporting System (PQRS)

WHAT is PQRS?

Program with incentives and penalties based on successful reporting of quality info (for covered Medicare Part B FFS services) by physicians to improve patient care and outcomes.

Who is eligible for participation?

Physicians and other eligible professionals (EPs) billing under Medicare Part B.

Brief History

- **2006:**
  - TRHCA: PQRI initial period July – December 2007 with 1.5 % incentive
  - 74 measures; 2 for Diagnostic Radiology, 2 Radiation Oncology, 6 Interventional Radiology
- **2008:**
  - MIPPA: Incentive payments increased to 2% for 2009 and 2010; initial phases of Physician Compare; (also authorized accreditation for advanced diagnostic imaging)
  - 134 measures, 1 new for IR, 5 new for RO
  - Registry reporting added
  - 15.1% participation across all specialties

Brief History

- **ACA 2010:**
  - Made program permanent → PQRS
  - Incentives through 2014; penalties beginning 2015
  - Informal review process
  - Improved feedback to physicians
  - CMS must begin integrating CQM reporting in MU/PQRS
  - Authorized PQRS MOC additional incentive
  - 2010 – no new DR measures, #11 revised/renumbered to #195, 1 new RO measure
  - 24% participation across all specialties

Future

- **American Taxpayer Relief Act of 2012:**
  - Provides for EP participation in a “qualified clinical data registry” as meeting requirement for satisfactorily reporting quality measure data, i.e. PQRS
- **Recent CMS RFI seeking input on how might use Clinical Quality Measures (CQM) data reported to:**
  - Specialty boards
  - Specialty societies
  - Regional healthcare quality organizations
  - Other non-federal reporting programs

For use in both PQRS and EHR Incentive Programs

PQRS Incentives and Penalties

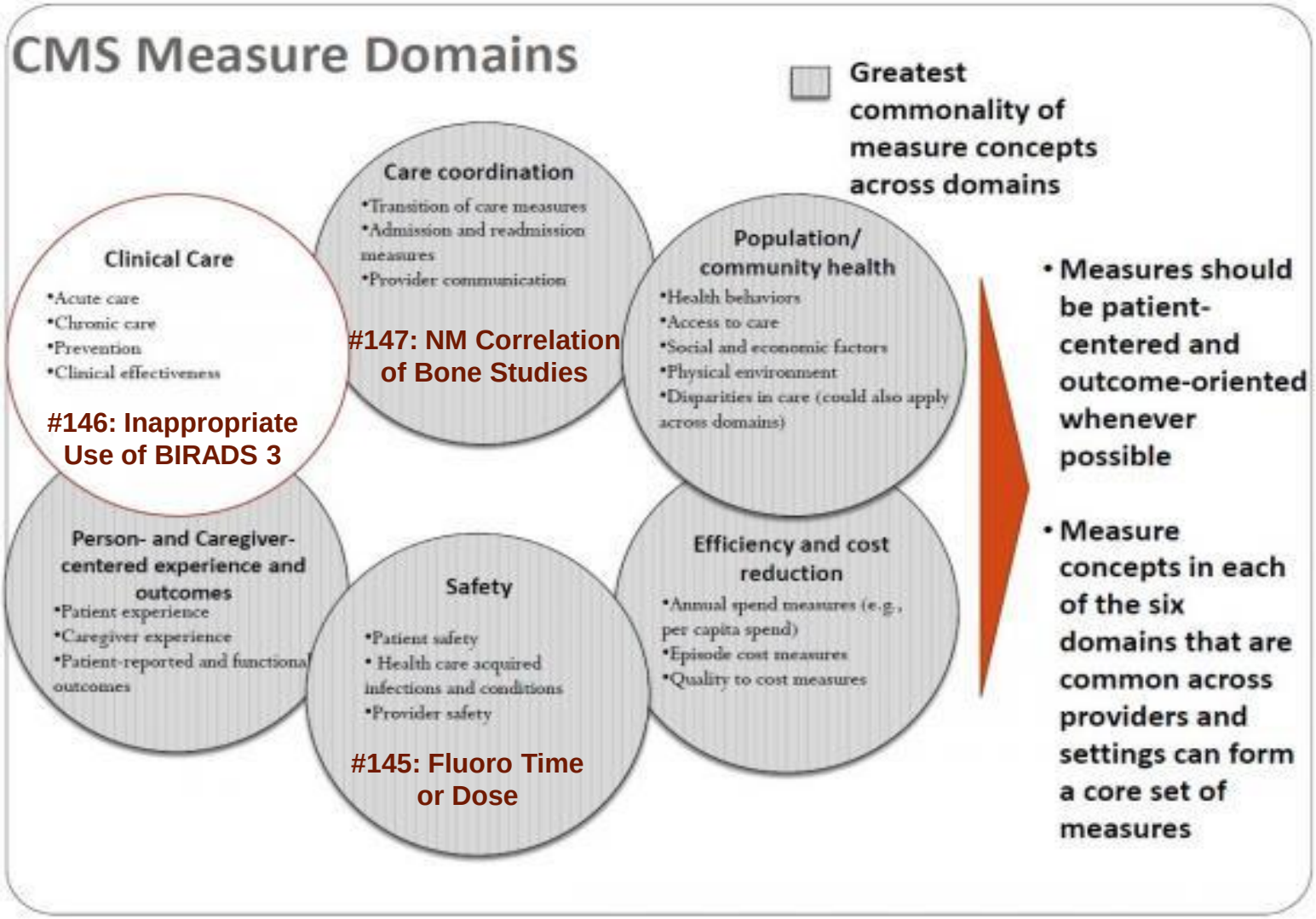
NEGATIVE payment adjustments are possible in 2015 based on 2013 reporting:

	PQRS Incentive/Penalty Amounts % of Total Allowable Medicare Part B FFS Charges		
	Satisfactory Participation in PQRS	Or PQRS+MOC	Not Participating in PQRS
2010	2.00%	N/A	0%
2011	1.00%	1.50%	0%
2012	0.50%	1.00%	0%
2013	0.50%	1.00%	0%
2014	0.50%	1.00%	0%
2015	*No PQRS Incentive Authorized* *Potential +% with Value Modifier*		-1.50% (CY13 reporting)
2016			-2.00% (CY14 reporting)
2017			-2.00% (CY15 reporting)

PQRS 2013 Highlights

- **2015 PQRS penalty based on 2013**
- **Addition of "administrative claims" reporting method to avoid 2015 penalty**
- **Group Practice Reporting Option (GPRO) expanded to registry based reporting of any PQRS measure**
- **Retirement of 15 measures including #10, reportable by diagnostic radiologists**

Framework for Measurement: National Quality Strategy Six Priorities



Which Measures Can Radiologists Report?*

DIAGNOSTIC: 8 measures

INTERVENTIONAL: 11 measures, 1 measures group

RADIATION ONCOLOGISTS: 11 measures, 1 measures group

UPCOMING: 5 measures in 2014:Optimizing Patient Exposure to Ionizing Radiation (primarily CT)

*** Based on denominator CPT I codes typically billed.**

Measures Applicable to Diagnostic Radiology (DR) or Nuc Med (NM)

PQRS Measure #	Measure
145	Exposure Time Reported for Procedures Using Fluoroscopy
146	Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening
147	Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
195	Stenosis Measurement in Carotid Imaging Reports
225	Reminder System for Mammograms
265	Biopsy Follow-up
322	Cardiac Stress Imaging: Preoperative Evaluation in Low Risk Surgery Patients
323	Cardiac Stress Imaging: Routine Testing After Percutaneous Coronary Intervention (PCI)
324	Cardiac Stress Imaging: Testing in Asymptomatic, Low-Risk Patients

Measures and Measures Groups Applicable to Interventional Radiology (IR)

PQRS Measure #	Measure
1	Diabetes Mellitus: Hemoglobin A1c Poor Control
20	Timing of Antibiotics-Ordering Phys
21	Selection of Antibiotic
22	Discontinuation of Antibiotic
23	VTE Prophylaxis
24	Communication Following Fracture
40	Mgmt Following Fracture
76	CVC Technique/Sterile Barrier Technique
256	Surveillance after Endovascular Abdominal Aortic Aneurysm Repair (EVAR)
258	Rate of Open Repair of Small or Moderate Non-Ruptured AAA
259	Rate of Endovascular Aneurysm Repair (EVAR) of Small or Moderate Non-Ruptured AAA
Perioperative Measures GROUP	(Measures 20, 21, 22, 23)

Measures and Measures Groups Applicable to Radiation Oncology (RO)

PQRS Measure #	Measure
71	Hormonal Therapy for Stage IC - IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer
72	Chemotherapy for AJCC Stage III Colon Cancer Patient
102	Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
104	Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients
110	Preventive Care and Screening: Influenza Immunization
130	Documentation of Current Medications in the Medical Record
143	Medical and Radiation – Pain Intensity Quantified
144	Medical and Radiation – Plan of Care for Pain
156	Radiation Dose Limits to Normal Tissues
194	Cancer Stage Documented
226	Tobacco Use: Screening and Cessation Intervention
Oncology Measures GROUP	(Measures 71, 72, 110, 130, 143, 144, 194, 226)

Now What? How Do I Get Started?

- **Decide to participate *individually* or as a *group***
- **Choose a reporting *mechanism***
- **Choose a reporting *period***
- **Choose *quality measures* that best apply to your practice for reporting (259 total have been finalized for PQRS 2013)**
  - **Individual Measures**
  - **Measures Groups**

Individual vs. Group PQRS Reporting

- **Individuals** are assessed at the TIN/NPI level
  - No requirement to register (except for administrative claims-based reporting mechanism to avoid the 2015 PQRS payment adjustment)
  - Only option for physicians in solo practices
  - Individuals within a group practice may choose which PQRS measures they wish to report

Individual vs. Group PQRS Reporting

- **Group Practices** evaluated at the TIN level using the Group Practice Reporting Option (GPRO)
  - Group is defined as a single Tax Identification Number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider Identifier (NPI), who have reassigned their Medicare billing rights to the TIN
- **Benefits of Participating as a GPRO:**
  - Staff may report one set of quality measures data on behalf of all physicians within the group, reducing tracking burden
  - Avoid penalty for physicians within group who cannot report any measure
  - Groups must self-nominate to CMS by Oct. 15, 2013

Choose Reporting Mechanism

- **Claims**
  - **Individual EPs:** individual measures or measures groups
  - **GPRO:** cannot report through claims
- **Registry**
  - **Individual EPs:** individual measures or measures groups
  - **GPRO:** individual measures ONLY
  - Must report at least 3 measures
  - Cost involved with registry reporting

Q. What is a measures group?

A. Specified group of 4 or more clinically related measures.

ACR™ American College of Radiology PQRI*wizard*sm

Choose Reporting Mechanism

EHR-Based

- **Individual EPs:**
  - Must be able to report 3 measures specified for EHRs; IRs and ROs may be able to report 3
  - Qualified direct EHR – submit directly from your EHR to CMS
  - Qualified EHR data submission vendor – submit on your behalf like registry vendor
  - Cannot report 0% performance rate
- **GPRO** may use CEHRT in 2014
  - Either direct EHR or EHR data submission vendor

Choose Reporting Mechanism

- **Administrative Claims-Based Reporting**
  - **Individual EPs or GPRO:**
    - Set of primary care measures that CMS will calculate from claims; do not need to submit quality data
    - Radiologists may elect this option even if measures do not apply; 0% rate is ok
    - Cannot obtain PQRS incentive under this option
    - In 2013 ONLY to avoid 2015 payment adjustment
    - Under this option must elect to be analyzed (by October 15) on CMS web portal to be available beginning July 15
    - If a GPRO selects this option, individuals in that group can qualify for incentive as an individual EP by reporting traditional PQRS measures.

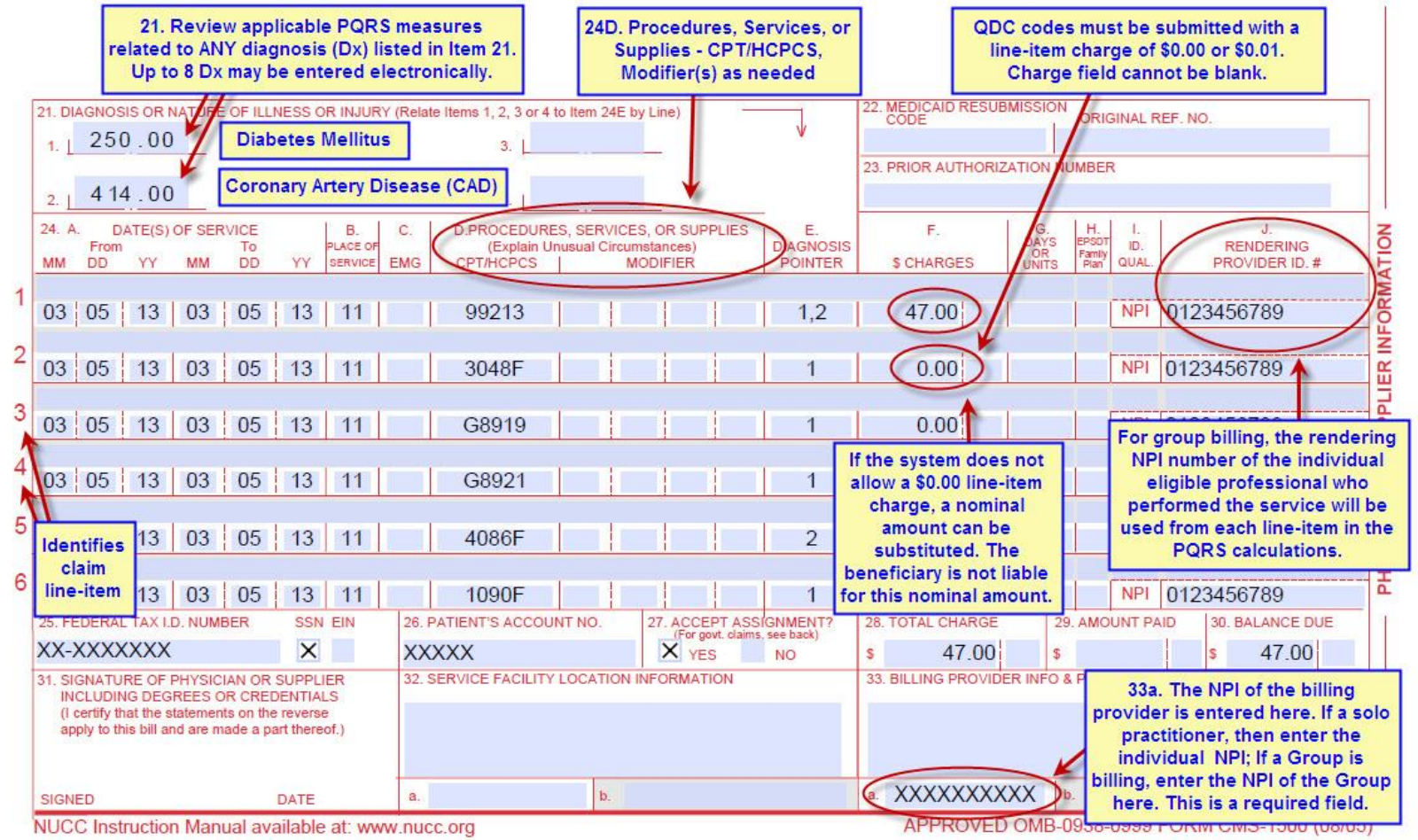
Reporting Periods Available

- **Individual EPs reporting a measures group through registry may use 6 month reporting period (July 1 – December 31) for PQRS incentive. Option only available to IRs and ROs in 2013**
- **All other (individual EP or GPRO) must report 12 month period for PQRS and MOC additional incentive**

How to Report: Claims Based

- **Benefits of claims based reporting include:**
  - Readily accessible to all eligible professionals as part of routine billing processes
  - No need to contact registry or qualified EHR vendor for submission of data
  - Simple to select measures and begin reporting (add respective Quality Data Code [QDC] to claim)
- **How:**
  - Develop internal process to flag cases that should include QDC on claim
  - Submit QDC on original claims for Part B reimbursement for procedures relevant to measures
  - Include the individual's NPI on claim
  - Claims data, including QDC, sent to Claims History File (NCH)

CMS-1500 Claim PQRS Example – Individual NPI



The patient was seen for an **office visit (99213)**. The provider is reporting several measures related to diabetes, coronary artery disease (CAD), and urinary incontinence (#'s 2, 3, 6 48):

- Note: All diagnoses listed in Item 21 will be used for PQRS analysis.
- NPI placement: Item 24J must contain the NPI of the individual provider who rendered the service when a group is billing.
- If billing software limits the line items on a claim, you may add a nominal amount such as a penny to one of the QDC line items on that second claim. PQRS analysis will subsequently join both claims based on the same beneficiary, for the same date-of-service, for the same TIN/NPI and analyze as one claim.

Downloaded from: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2013_PQRS_sampleCMS1500claim_12-19-2012.pdf

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Reporting Less than 3 Measures? Measure Applicability Validation Will Apply

At close of reporting year, applied to EPs using claims based reporting who submit QDCs for **1-2 PQRS measures for at least 50 percent of their patients or encounters eligible for each measure and who do not submit any QDCs for any other measure**

STEP 1: Clinical Relation Test

If one measure in a cluster of measures related to a particular clinical topic or eligible professional service is applicable to an eligible professional's practice, then other closely-related measures may also be applicable

Step 2: Minimum Threshold Test

If there is an additional measure(s) that could have been submitted identified during the clinical relation test, an EP will not be held accountable for reporting that measure unless more than a "threshold" number of patients or encounters was met (will not be less than 15 patients for the 12-month PQRS reporting in 2013)

Measure Applicability Validation

Diagnostic Imaging Cluster	
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy
146	Radiology: Inappropriate Use of “Probably Benign” in Mammography Screening
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy
225	Radiology: Reminder System for Mammograms
Note: Measure 195 Stenosis Measurement in Carotid Imaging Report is excluded from MAV	
Other clusters:	
• **Cancer Care 2 – Colon Cancer** • **Cancer Care 3 – Radiation Oncology/Prostate Cancer** • **Breast Cancer** • **Surgical Care**	

Measure Applicability Validation Example

Dr. Alexander accurately reported QDCs on Measures #146 and #225 for 50% of his patient (cases) in 2013.

STEP 1: Clinical Relation Test
CMS will analyze Dr. Alexander's claims to see if he could have reported Measures #145 or #147 because they are also in the "Diagnostic Imaging Cluster".

Step 2: Minimum Threshold Test
CMS found 3 claims submitted by Dr. Alexander with denominator codes in Measure #145 (Fluoro Time/Dose). Since the "threshold" for accountable reporting is less than 15 patients for the 12 month reporting period, Dr. Alexander would not be held responsible for reporting #145. He will be considered incentive eligible and will receive a PQRS bonus for CY2013 reporting.

Cluster vs. Measures Groups

WAIT!

- Earlier you talked about groups of measures
- Now you are talking about clusters of measures

What is the difference?

- **Measures group:**
  - An identified group of clinically-related measures for reporting through claims-based and/or registry-based submission. Denominators for the measures are similar patient population
  - 22 measures groups in 2013 PQRS, e.g. Chronic Kidney Disease, Oncology, Preventive Care, Perioperative Care, Back Pain, Dementia
  - IRs may be able to report Perioperative group; ROs may report Oncology group
- **Cluster:**
  - Only for purpose of determining satisfactory reporting; can't report a measure cluster
  - Measures are closely-related based on clinical topic or services that may be applicable to an eligible professional's practice; denominator population may be entirely different

How to Report: Registry Based

- **Benefits of registry reporting include:**
  - Can submit data throughout year or at end of year
  - Ongoing, timely feedback
  - Success rate historically higher (2011 claims requirement lowered, may see claims reporting success jump)

- **How:**
  - Begin with same basic internal process as with claims – must develop flow from radiologist to staff for indicating quality cases
  - Registry may allow online data entry or file submission of quality data
  - Can report individual measures (3+) or measures groups (individual EPs)

Sample Reporting for Measure #145:

Radiology: Exposure Time Reported for Procedures Using Fluoroscopy

Measure Description:

Percentage of final reports for procedures using fluoroscopy that include documentation of radiation exposure or exposure time.

Document the exposure amount (if known) or exposure time.

Rationale:

Exposure to radiation during procedures using fluoroscopy poses risks to patients including deterministic risk of various types of skin injury and stochastic risk of malignant disease. The risk of radiation-related complications in any individual patient cannot be predicted unless that patient's exposure level is known.

Measure #145 Denominator Codes

Denominator

Patients undergoing a procedure using fluoroscopy:

0234T, 0235T, 0238T, 0075T, 0080T, 25606, 25651, 26608, 26650, 26676, 26706, 26727, 27096, 27235, 27244, 27245, 27509, 27756, 27759, 28406, 28436, 28456, 28476, 36147, 36221, 36222, 36223, 36224, 36225, 36226, 36251, 36252, 36253, 36254, 36598, 37182, 37183, 37184, 37187, 37188, 37210, 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37234, 37235, 43260, 43261, 43262, 43263, 43264, 43265, 43267, 43268, 43269, 43271, 43272, 43752, 44500, 49440, 49441, 49442, 49446, 49450, 49451, 49452, 49460, 49465, 50382, 50384, 50385, 50386, 50387, 50389, 50590, 61623, 62263, 62264, 62280, 62281, 62282, 63610, 64610, 64620, 70010, 70015, 70170, 70332, 70370, 70371, 70373, 70390, 71023, 71034, 72240, 72255, 72265, 72270, 72275, 72285, 72291, 72295, 73040, 73085, 73115, 73525, 73580, 73615, 74190, 74210, 74220, 74230, 74235, 74240, 74241, 74245, 74246, 74247, 74249, 74250, 74251, 74260, 74270, 74280, 74283, 74290, 74291, 74300, 74305, 74320, 74327, 74328, 74329, 74330, 74340, 74355, 74360, 74363, 74425, 74430, 74440, 74445, 74450, 74455, 74470, 74475, 74480, 74485, 74740, 74742, 75600, 75605, 75625, 75630, 75658, 75705, 75710, 75716, 75726, 75731, 75733, 75736, 75741, 75743, 75746, 75756, 75791, 75801, 75803, 75805, 75807, 75809, 75810, 75825, 75827, 75831, 75833, 75840, 75842, 75860, 75870, 75872, 75880, 75885, 75887, 75889, 75891, 75893, 75894, 75896, 75898, 75901, 75902, 75952, 75953, 75954, 75956, 75957, 75958, 75959, 75960, 75962, 75966, 75970, 75978, 75980, 75982, 75984, 76000, 76001, 76080, 76120, 76496, 76499, 77001, 77002, 77003, 92611, 93565, 93566, 93567, 93568, G0106, G0120, G0275, G0278

Measure #145 Numerator Coding

Numerator

Report for those patients in the denominator:

CPT II 6045F:
Radiation exposure or exposure time in final report for procedure using fluoroscopy is documented

CPT II 6045F–8P:
Radiation exposure or exposure time in final report for procedure using fluoroscopy is not documented

CPTII Modifiers Denote Exclusions

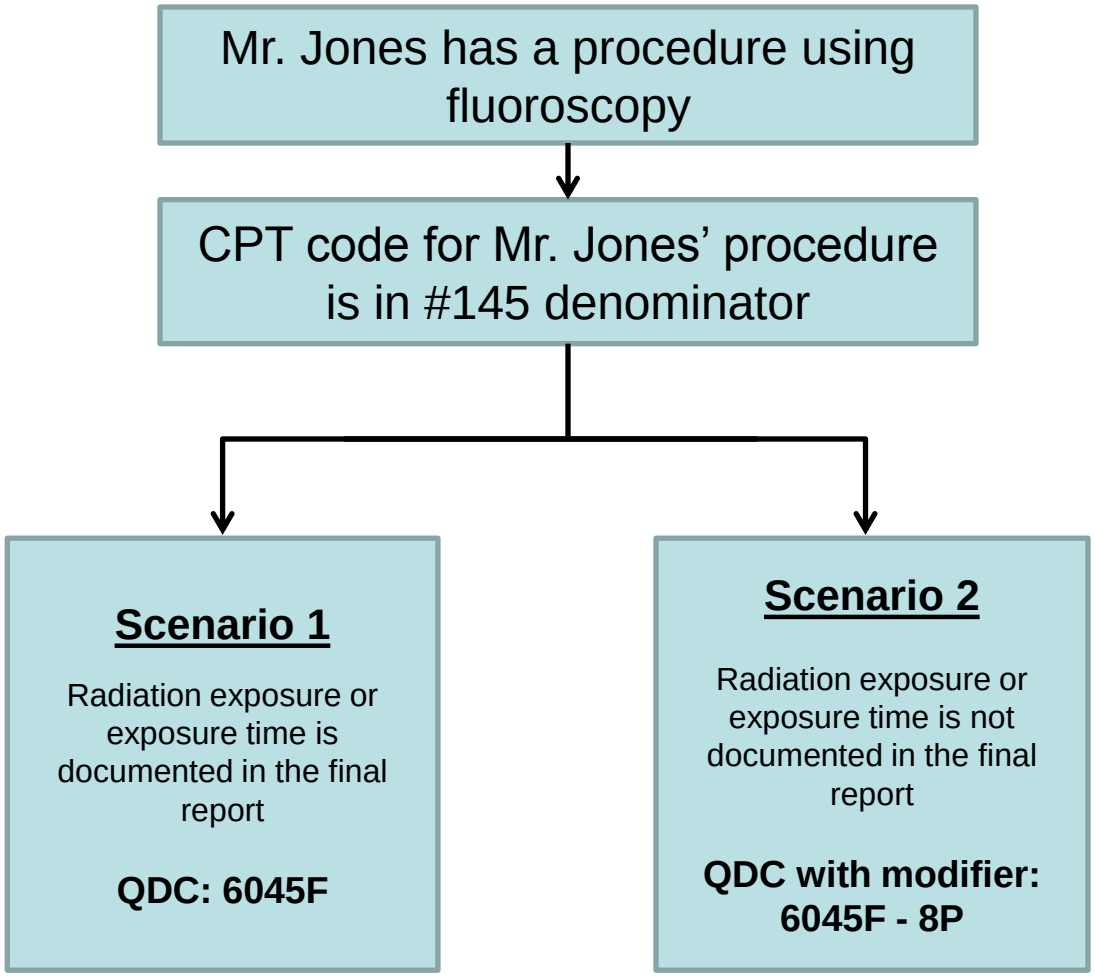
Specified Reason

1P: Medical Reason
2P: Patient Reason
3P: System Reason

Reason NOT Specified

8P: No specification

Satisfactory Reporting on Measure #145:

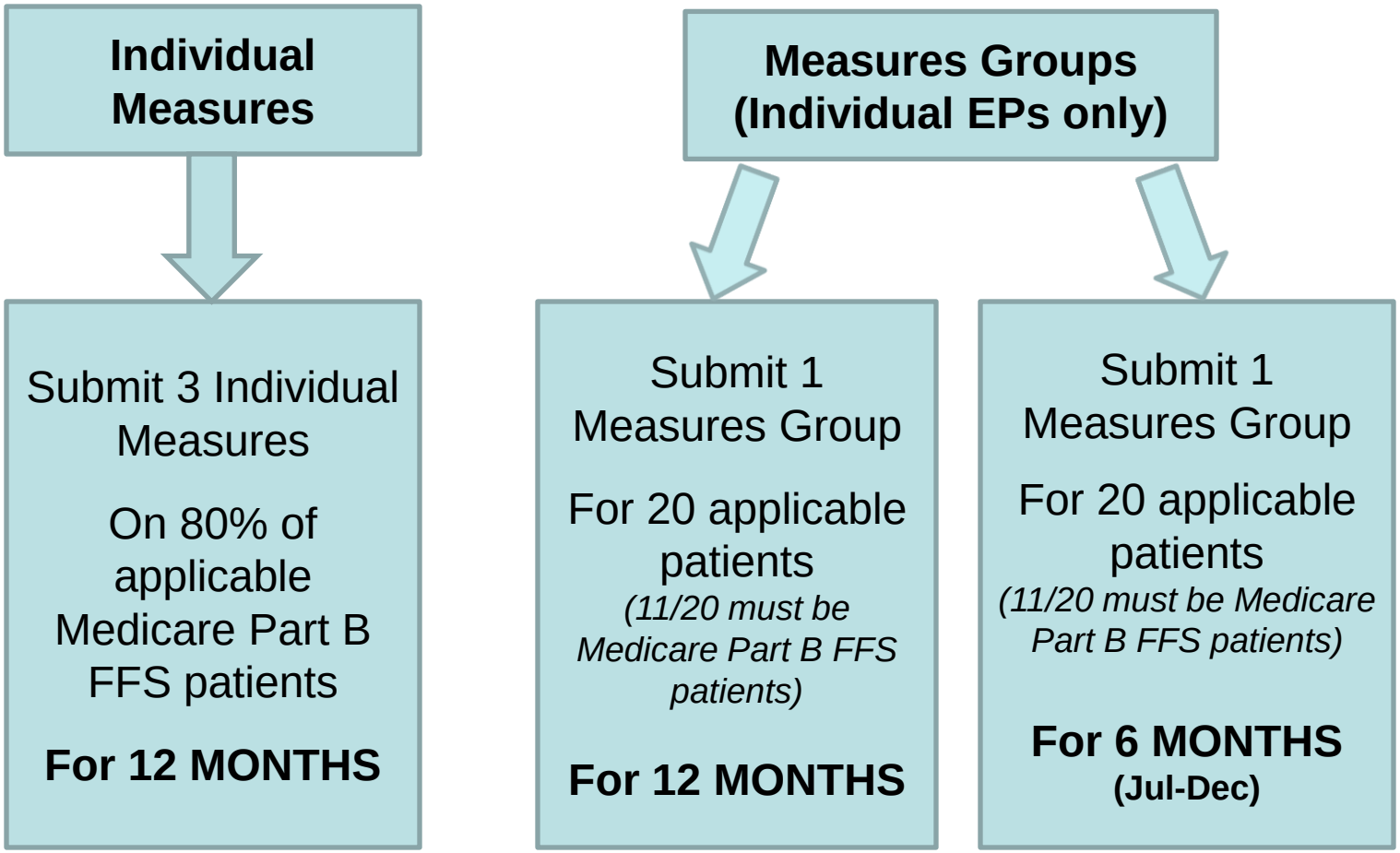


Satisfactory Reporting for Incentive Payment with CLAIMS – Individual EP

<3 Measures Apply	3+ Measures Apply	1 Measures Group
Report on <3 Individual Measures (may be subject to *MAV analysis*) for 50% of applicable Medicare Part B FFS patients **For 12 MONTHS**	Report on 3 Individual Measures for 50% of applicable Medicare Part B FFS patients **For 12 MONTHS**	Report on 1 Measures Group for 20 applicable patients Medicare Part B FFS patients **For 12 MONTHS**

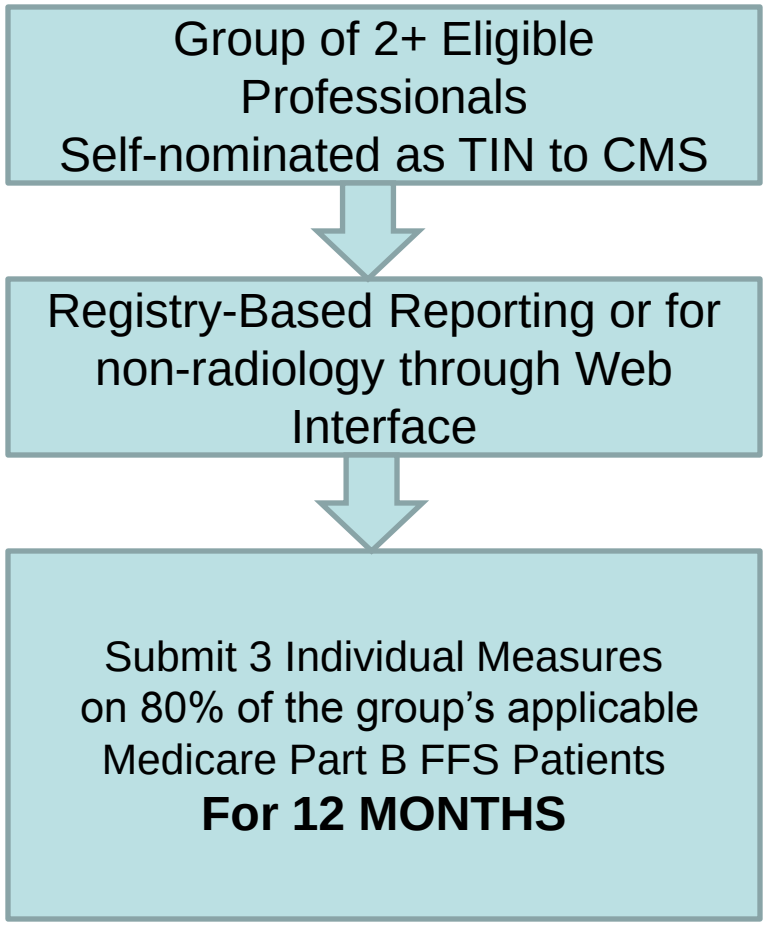
Measures with a 0% performance rate will not be considered satisfactorily reported for incentive eligibility.

Satisfactory Reporting for Incentive Payment with a REGISTRY – Individual EP



Measures with a 0% performance rate will not be counted.

Successful Reporting for Incentive Payment through Group Practice Reporting (GPRO)



Measures with a 0% performance rate will not be counted.

PQRS Maintenance of Certification Additional Incentive

- Additional incentive of 0.5%
- Began in 2011, currently authorized through 2014
- Must satisfactorily submit data to CMS on PQRS measures for a 12-month reporting period (incentive eligible) AND
- Participate in a qualified MOC program "**more frequently**" than required for continued certification
- Work with a CMS-qualified MOC entity (Board such as ABR or ABNM) to ensure successful completion of the MOC Program Incentive participation requirements

2013 Requirements* for “More Frequent” MOC Participation

- Valid and unrestricted medical license(s)
- 30 CME and 10 Self-Assessment CME (SA-CME)
- Attest to completion of 1 PQI project
  (Patient Experience of Care Survey is additionally required for each project)

* Differences in requirements exist for “Time-Limited” vs “Lifetime” certifications

MOC Participation Requirements

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http://www.theabr.org/

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3 Ways to Avoid PQRS Payment Adjustment in 2015

1. Meet the criteria for the 2013 PQRS Incentive

2. Report one applicable measure for one patient or, for Individual EPs ONLY, 1 measures group

3. Elect the Administrative Claims option
(must elect to be analyzed under this option by Oct 15, 2013)

2015 PQRS Payment Adjustment Analysis

- Individual EPs are analyzed for each TIN/NPI combination
- **PQRS payment adjustment may be applied to each unsuccessful TIN/NPI (as well as incentive to each successful TIN/NPI)**
- If an individual EP changes TINs, participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis
- GPROs are analyzed at the TIN level (TIN submitted at the time of self-nomination)
- **If a group does not successfully report, all NPIs under the TIN during the unsuccessful reporting period will receive the payment adjustment (or incentive if successful)**
- If an organization changes TINs, participation under the old TIN does not carry over to the new TIN, nor is it combined for final analysis

Bonus Payment and Feedback Reports

- **Interim Feedback Dashboard**
  - Allows participants to monitor status of claims-reported measures
  - Displays the most current data on a cumulative quarterly basis -- May, August, December, February
  - Provides detail at both TIN and NPI level
  - Reporting rates on # of eligible instances where quality data codes (QDCs) were reported accurately
  - Available through Individual Authorized Access to the CMS Computer System (IACS); must register
  - Does not provide final data analysis for bonus eligibility
- **Incentive analysis begins in March following report year**
  - Bonus paid in October timeframe to TIN/NPI combinations
  - Check comes from Carrier
  - Feedback reports include reporting rate and performance rate

What if I Don't Understand or Disagree with My PQRS Determination?

- CMS required by ACA to provide an Informal Review Process
- Allows EPs and GPRO participants to request a review of their incentive eligibility determination
- CMS will reanalyze the determination that the EP or GPRO participant did not satisfactorily submit data on quality measures under PQRS
- Request review through an online tool on the Quality Reporting Communication Support Page (to be announced)
- Review available for all reporting mechanisms
- Informal review decisions are final
- Review request deadline for 2013 is TBD but likely be Feb 2014

What is the Impact of PQRS 2013?

0.5% PQRS incentive still available in 2013 (with additional 0.5% for MOC)

-1.5% Penalty for any EP that does not participate (report at least 1 measure)

2013 PQRS participation is basis for Physician Value Based Payment Modifier (VM) for groups of 100+.

Upcoming ACR Webinar Summer 2013:
CMS Value Based Purchasing
Part II – Physician Value-Based Payment Modifier

CMS National Provider Call on June 5, 2013
1:30-2:30 ET
Getting Started with PQRS Reporting: Implications for the Value-based Payment Modifier
http://www.eventsvc.com/blhtechnologies

A recording of today's webinar will be available soon for on demand viewing at this webpage:
http://www.acr.org/Quality-Safety/Quality-Measurement/PQRS

PQRS Abbreviations

ABNM: American Board of Nuclear Medicine
ABR: American Board of Radiology
ACA: Affordable Care Act (aka PPACA: Patient Protection and Affordable Care Act)
CEHRT: Certified Electronic Health Record Technology
CME: Continuing Medical Education
CQM: Clinical Quality Measure
EP: Eligible Professional
GPRO: Group Practice Reporting Option
MIPPA: Medicare Improvements for Patients and Providers Act
MOC: Maintenance of Certification
MU: Meaningful Use (with EHR)
NPI: National Provider Identification (#)
PQI: Practice Quality Improvement (projects)
PQRS (Previously “PQRI”), Physician Quality Reporting System
QDC: Quality Data Code
SAM: Self-Assessment Module
TIN: Tax Identification Number

What Resources are Available?

- ACR Quality Measurement webpages http://www.acr.org/Quality-Safety/Quality-Measurement
- CMS Website
  - **PQRS:** http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html?redirect=/pqrs
  - **Value Modifier:** http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/ValueBasedPaymentModifier.html
- Judy Burleson jburleson@acr.org (703) 648-3787
- Colleen Tallant ctallant@acr.org (703) 390-9842
- P4Pquestions@acr.org

QUESTIONS????