CitiusTech

Physician Quality Reporting System(PQRS) - 2016

Description : This document gives overview and understanding of PQRS 2016, the measure classifications, reporting methods and performance calculation methodology. It also describes how PQRS and MU reporting can be achieved together.

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Keywords : PQRS, PQRS reporting methods, PQRS and MACRA, PQRS incentives & adjustments, CEHRT, GPRO

Agenda

- **PQRS Overview**
  - **Program Overview**
  - **Participation & Eligibility**
  - **Incentive Payments and Adjustments**
- Measure Classification
- Reporting Methods
- Illustrative Measure Calculation
- PQRS and MACRA
- Glossary
- References

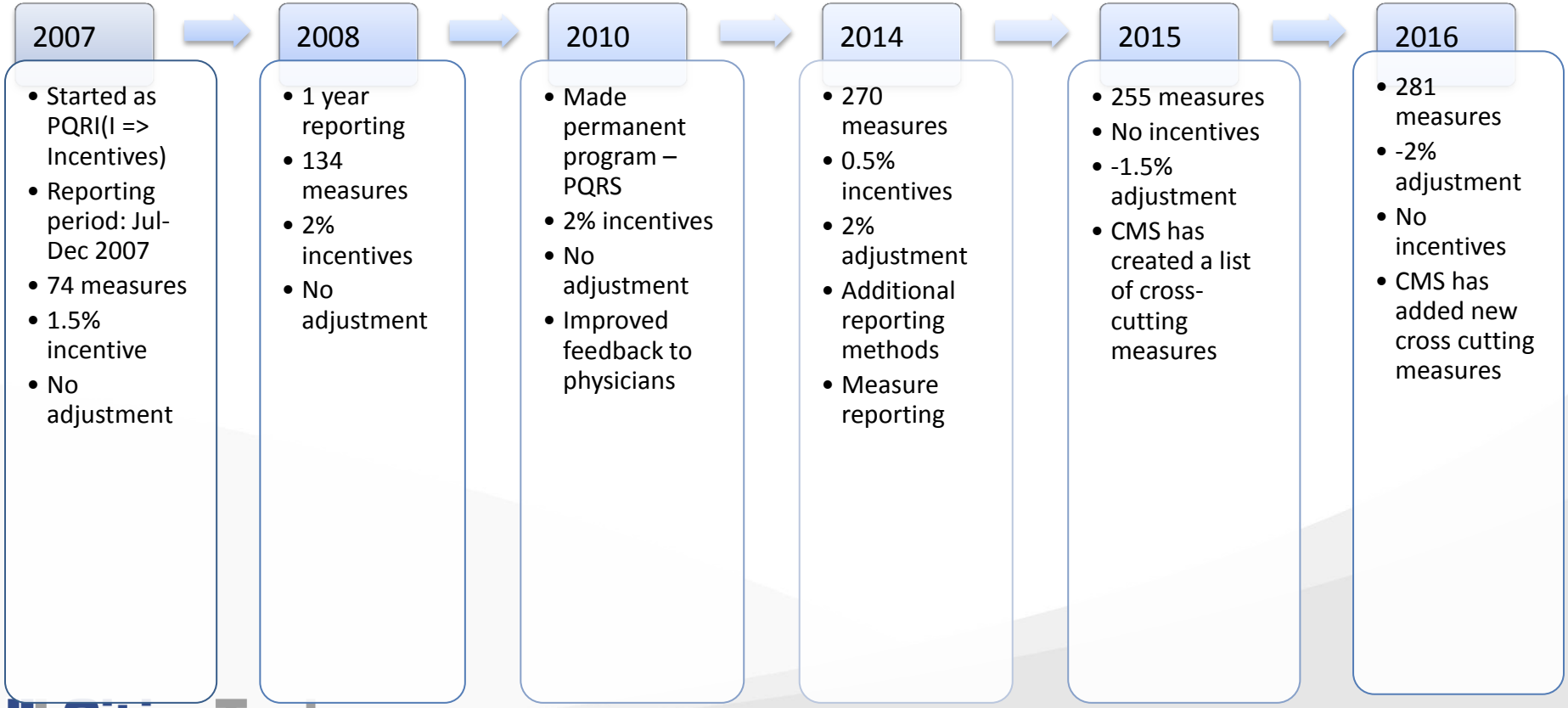
Overview (1/2)

Questions Answered

- What is PQRS?
- Why report using PQRS?
- What is the eligibility criteria to report using PQRS?
- What if one fails to report using PQRS?

Overview (2/2)

- Governed by CMS, PQRS is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by Eligible Professionals (EPs) or Group practice
- Provides incentives to EPs who satisfactorily report data on quality measures
- Reporting is done on yearly basis



Participation & Eligibility

- **Eligible Professionals(EP)**
  - Identified by NPI and TIN
  - Should belong to list of eligible professionals (click here)
  - Professional who don't bill Medicare at NPI level cannot be EP
- **Group Practice (GPRO)**
  - Two or more EPs together identified by a single NPI and TIN
  - Should belong to list of eligible professionals (click here)
  - An EP who is a member of a group practice participating in PQRS GPRO is not eligible to separately earn a PQRS incentive payment as an individual EP under that same TIN

Once registered to participate in the GPRO, this is the only PQRS reporting method available to the group and all individual NPIs who bill Medicare under the group's TIN. **If an organization or EP changes TINs, the participation** under the old TIN **does not carry over** to the new TIN, nor is it combined for final analysis.

Incentive Payments & Adjustments

- **Incentive Payments**
  - The EPs/ Group Practices who report and meet the criteria for satisfactory reporting are eligible for incentive payments
- **Adjustments**
  - The EPs/ Group Practices who do not report or meet the criteria for satisfactory reporting are subject to adjustments

PQRS Incentive/Penalty Amounts
% of Total Allowable Medicare Part B FFS Charges

Year	Satisfactory Participation	No Participation
2012	0.50%	0%
2013	0.50%	0%
2014	0.50%	0%
2015	**Incentive is not authorized**	**-1.50%(Year 2013)**
2016		**-2.00%(Year 2014)**
2017		**-2.00%(Year 2015)**
2018		**-2.00%(Year 2016)**

Note: 2018 onwards PQRS will be merged into MACRA/MIPS

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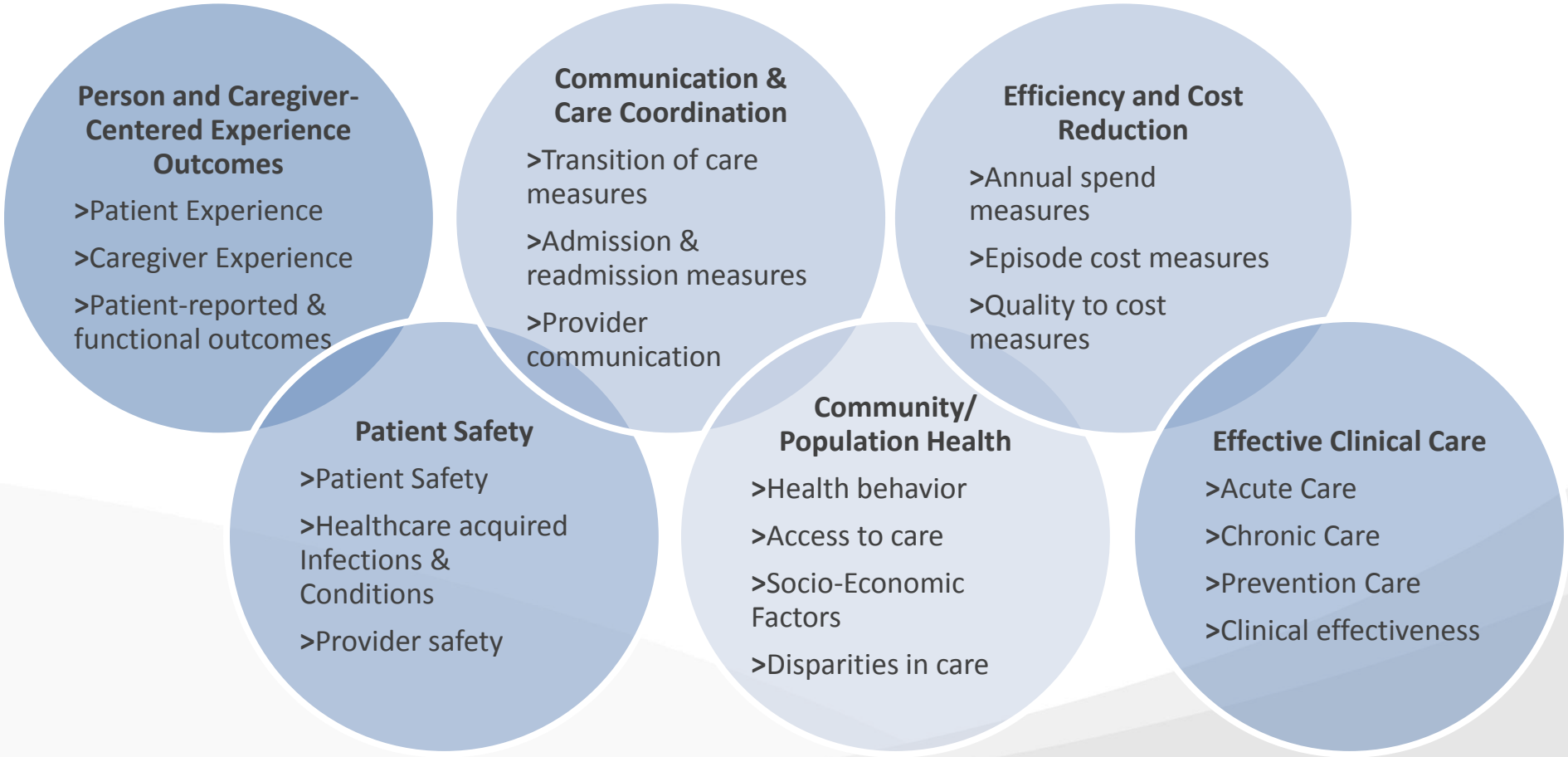
PQRS Measure Classification

Questions Answered

- What are NQS domains?
- How are the measures classified?
- What are the changes between PQRS 2015 and 2016 measures?

National Quality Strategy(NQS) domains

- Measures are divided in six different domains and most of the reporting methods require to select at least 3 of the **6 available domains** and at least 3 measures from at least 3 of the selected domains



PQRS Measure Classification (1/2)

- PQRS measures fall in two categories:
  - Individual Measures
  - Group Measures
- Individual Measures
  - Each measure can be reported individually. Minimum 9 measures falling in 3 domains need to be chosen.
- Group Measures
  - Group of 4 to 9 measures which are reported as a group belonging to the same category(Example: CKD)
- 281 PQRS measures are available in 2016, including:
  - 68 outcome-based measures
  - 23 cross-cutting measures

PQRS Measure Classification (2/2)

Proposed New Measures

- 46 for individual reporting
- 3 new Measures Groups (Cardiovascular Prevention, Diabetic Retinopathy, Multiple Chronic Condition)
- 1 for GPRO Web Interface
- National Quality Strategy (NQS) domains covered
  - 2 Person and Caregiver-Centred Experience and Outcomes
  - 4 Community/Population Health
  - 20 Effective Clinical Care
  - 4 Communication and Care Coordination
  - 10 Patient Safety
  - 6 Efficiency and Cost Reduction

Proposed Measures for Removal

- 12 to be removed from Claims or Registry
- 1 measure which was part of Measures Group only

Changes to Existing Measures

- 4 measures are changing in NQS Domains

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Reporting Methods

Questions Answered

- How to report measures in PQRS?
- What is the reporting criteria for each of the reporting methods?
- What kind of reporting method is apt for any EP or GPRO?
- What is QDC and how it is represented through CPTII codes?

Reporting Methods

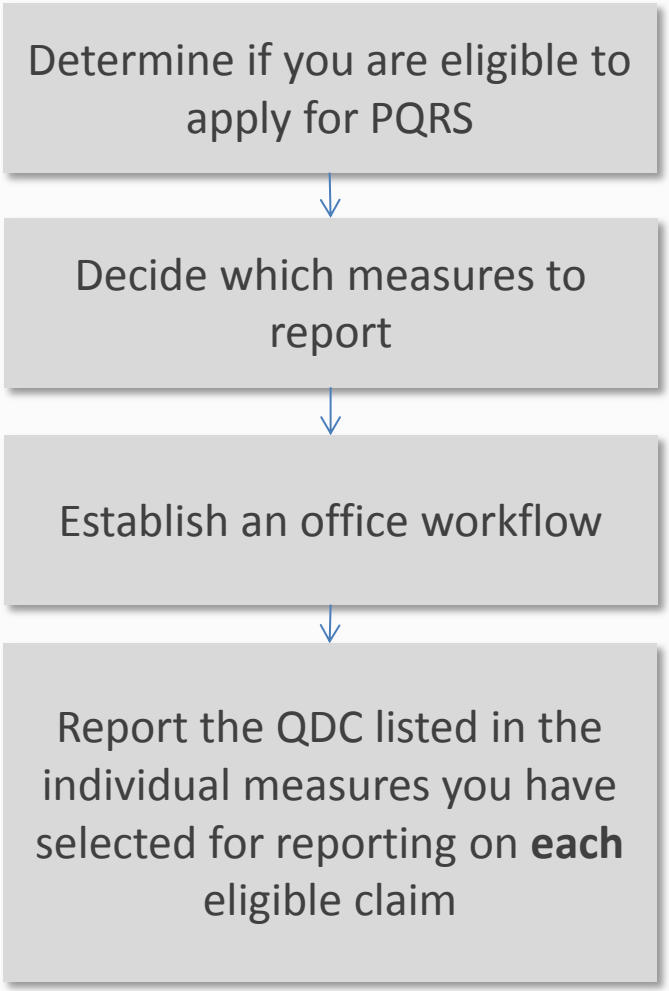
Reporting Method	Applicability		Source
	EP	GPRO	
Claim based reporting	✓	✗	Routine Billing Process
Qualified PQRS registry	✓	✓	Clinical data from EP/GP
QCDR	✓	✗	Clinical data from an EP
Direct EHR using CEHRT	✓	✓	Structured EHR Data
Web-Interface	✗	✓	Clinical data from a GP
CG CAHPS CMS- certified survey vendor	✗	✓	CMS-certified survey vendor

Claims Based Reporting Method (1/5)

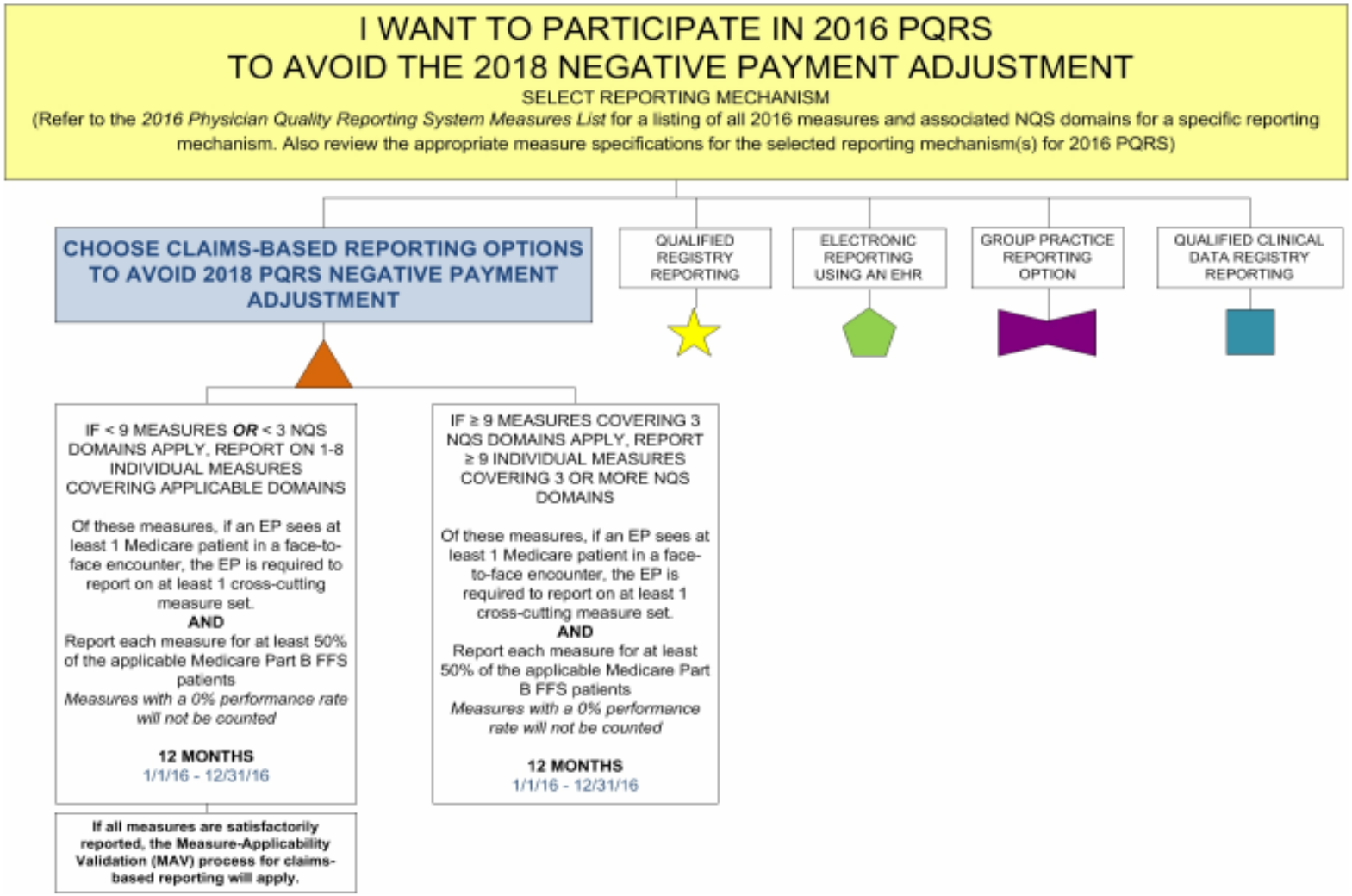
CRITERIA

- Applicable only for EPs
- Report on at least 9 measures covering 3 NQS domains for at least 50% of the EP's Medicare Part B FFS patients. EPs that see 1 Medicare patient in a face-to-face encounter must also report on 1 crosscutting measure.
- EPs that submit quality data for less than 9 PQRS measures for at least 50% of their patients or encounters eligible for each measure, OR that submit data for 9 or more PQRS measures covering less than 3 domains for at least 50% of their patients or encounters eligible for each measure will be subject to MAV.
- EPs that see 1 Medicare patient (face-toface encounter), but do not report on 1 cross-cutting measure will be subject to MAV.
- Measures with a 0% performance rate will not be counted.

REPORTING WORKFLOW



Claims Based Reporting Method (2/5)



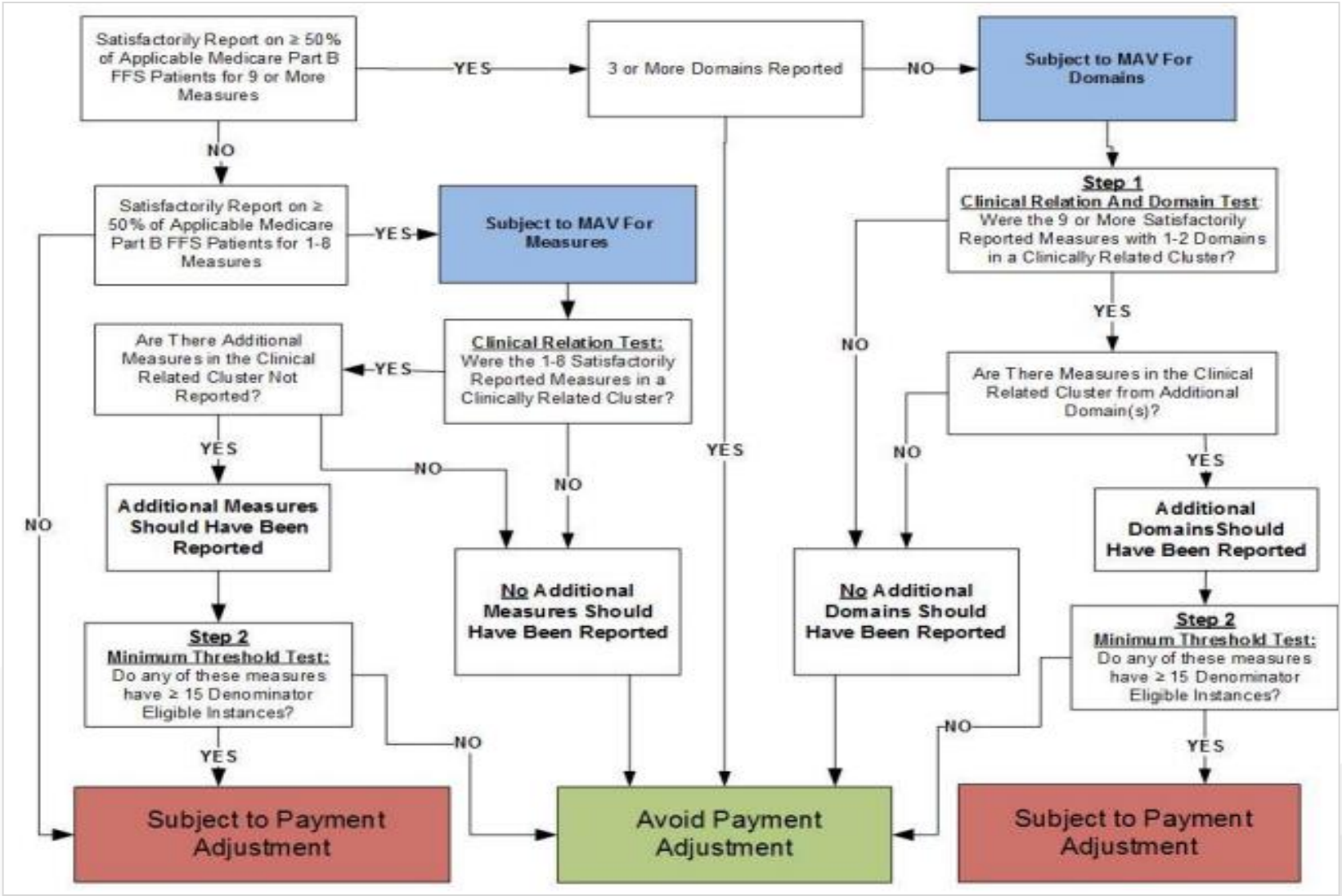
Source: http://www.cms.gov

Claims Based Reporting Method (3/5)

Measure Applicability Validation(MAV)

- EPs who submit quality data for only 1 to 8 PQRS measures for at least 50% of their patients or encounters eligible for each measure, OR they submit data for 9 or more PQRS measures across less than 3 domains for at least 50% of their patients or encounters eligible for each measure will be subject to Measure-Applicability Validation (MAV).
- EPs who see 1 Medicare patient (face-to-face encounter), but do not report on 1 cross-cutting measure will be subject to MAV.
- EPs who fail MAV will be subject to the 2018 PQRS Payment Adjustment
- CMS will apply a **two-step validation** process to operationalize MAV
  - Clinical/Domain Relation test
  - Minimum threshold test.

Claims Based Reporting Method (4/5)



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Claims Based Reporting Method (5/5)

Quality Data Code and CPT II format

- Quality-data codes(QDCs) are used to report the numerator of the measure using CPT format
- Submission of QDCs is compulsory only for Claims Based reporting method
- CPT II codes consist of five alphanumeric characters in a string ending with the letter “F”
- CPT II code modifiers fall into two categories; exclusion modifiers and the 8P reporting modifier
- 8P is used to facilitate reporting an eligible case when the action is not performed and the reason is not specified. It can give credit for satisfactory reporting but not for performance
- The claims are reported using a CMS-1500 claim form for up to 4 diagnosis or by electronic claim up to 12 diagnosis in their respective headers

Exclusion Modifier	Reason Type	Reasons
1P	Medical	• Not indicated (absence of organ/limb, already received/performed, other) • Contraindicated (patient allergy history, potential adverse drug interaction, other) • Other medical reasons
2P	Patient	• Patient declined • Economic, social, or religious reasons • Other patient reasons
3P	System	• Resources to perform the services not available (e.g., equipment, supplies) • Insurance coverage or payer-related limitations • Other reasons attributable to health care delivery system

Qualified PQRS Registry Reporting Method (1/2)

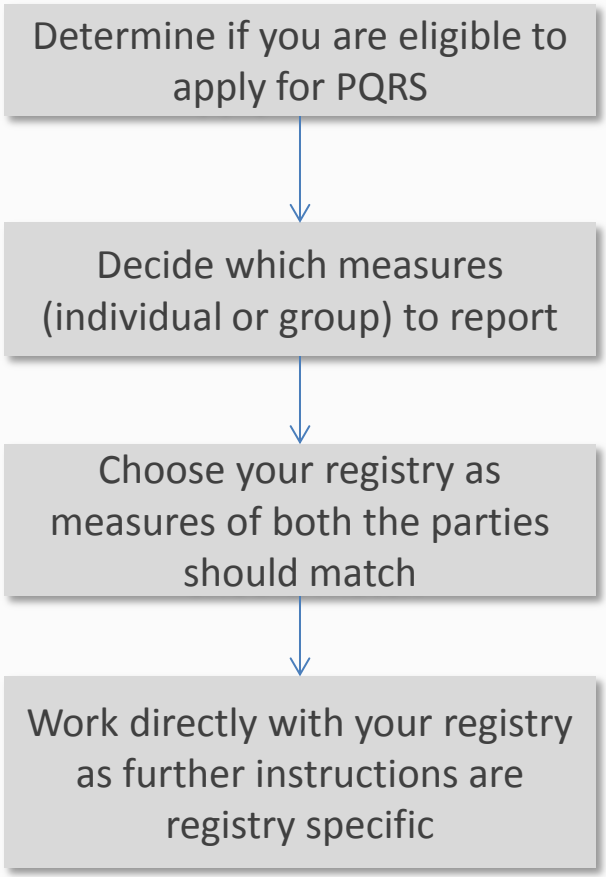
CRITERIA

- Report on at least 9 measures covering 3 NQS domains for at least 50 percent of the Medicare Part B FFS patients (VALID FOR EPs & GPRO)

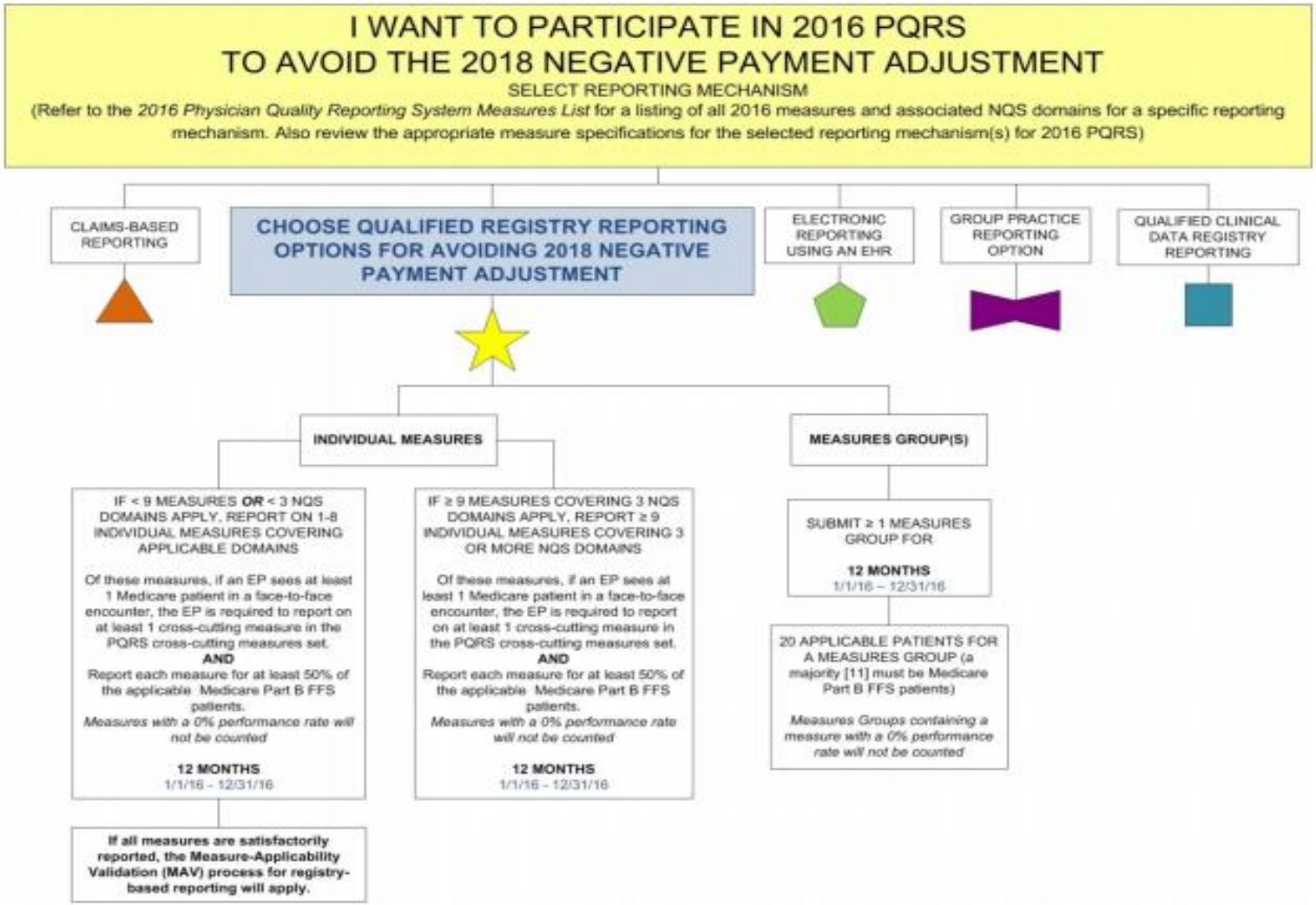
OR

- Report at least 1 measures group on a 20-patient sample, a majority of which (at least 11 out of 20) must be Medicare Part B FFS patients (VALID ONLY FOR EPs)
- An EP can report via Measure groups as well
- For reporting measures, the data format and data submission method is specified by the respective registries

REPORTING WORKFLOW



Qualified PQRS Registry Reporting Method (2/2)



Source: http://www.cms.gov

Qualified Clinical Data Registry Reporting (1/2)

- Data submitted to CMS via a QCDR **covers quality measures across multiple payers and is not limited to Medicare beneficiaries**

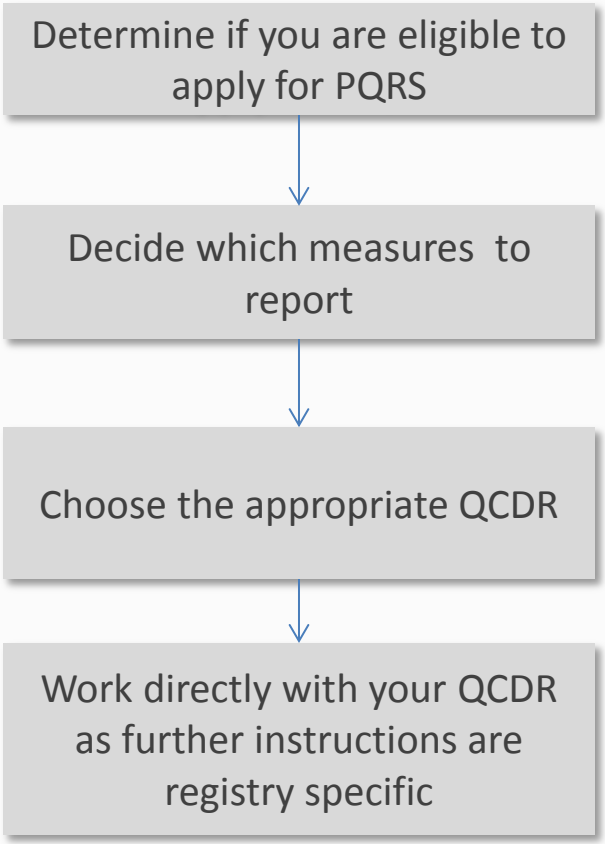
CRITERIA for individual EPs

- Report at least 9 measures available for reporting under a QCDR covering at least 3 NQS domains and includes at least 2 outcome measures for at least 50% of the EP's applicable patients seen during the 2016 participation period.
- If 2 outcome measures are not available, report at least 1 outcome measure and at least 1 of the following other type of measure: resource use, patient experience of care etc.

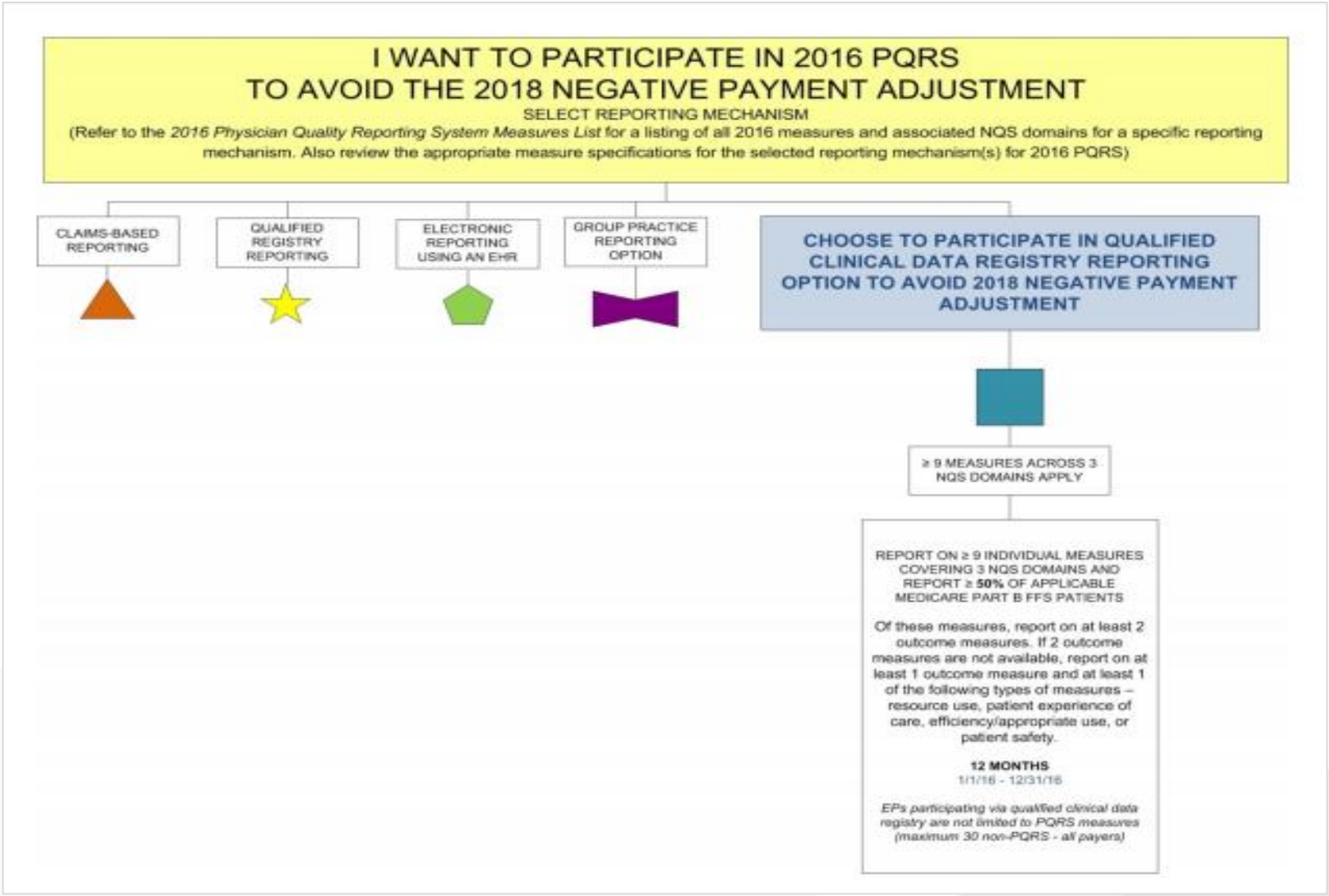
CRITERIA for PQRS Group Practices (Without CAHPS for PQRS)

- 2 – 99 EPs participating via GPRO
- Same as above
- Same as above

REPORTING WORKFLOW



Qualified Clinical Data Registry Reporting (2/2)



Source: http://www.cms.gov

Direct EHR (CEHRT) (1/3)

- Direct EHR Vendor (also known as EHR Direct)
  - Certified EHR product and version for EPs or group practices which is utilized to directly submit their PQRS measures data to CMS in the CMS-specified format(s) on their own behalf
- CRITERIA
  - For the EPs or Group practices who are submitting through Direct EHR, Enterprise Identity Management (EIDM) account registration is required
  - Report at least 9 measures covering 3 NQS domains
  - In case of absence of data related to 9 measures, they must report the measures for which there is Medicare patient data available
  - Reporting of at least 1 measure for which there is Medicare patient data is must

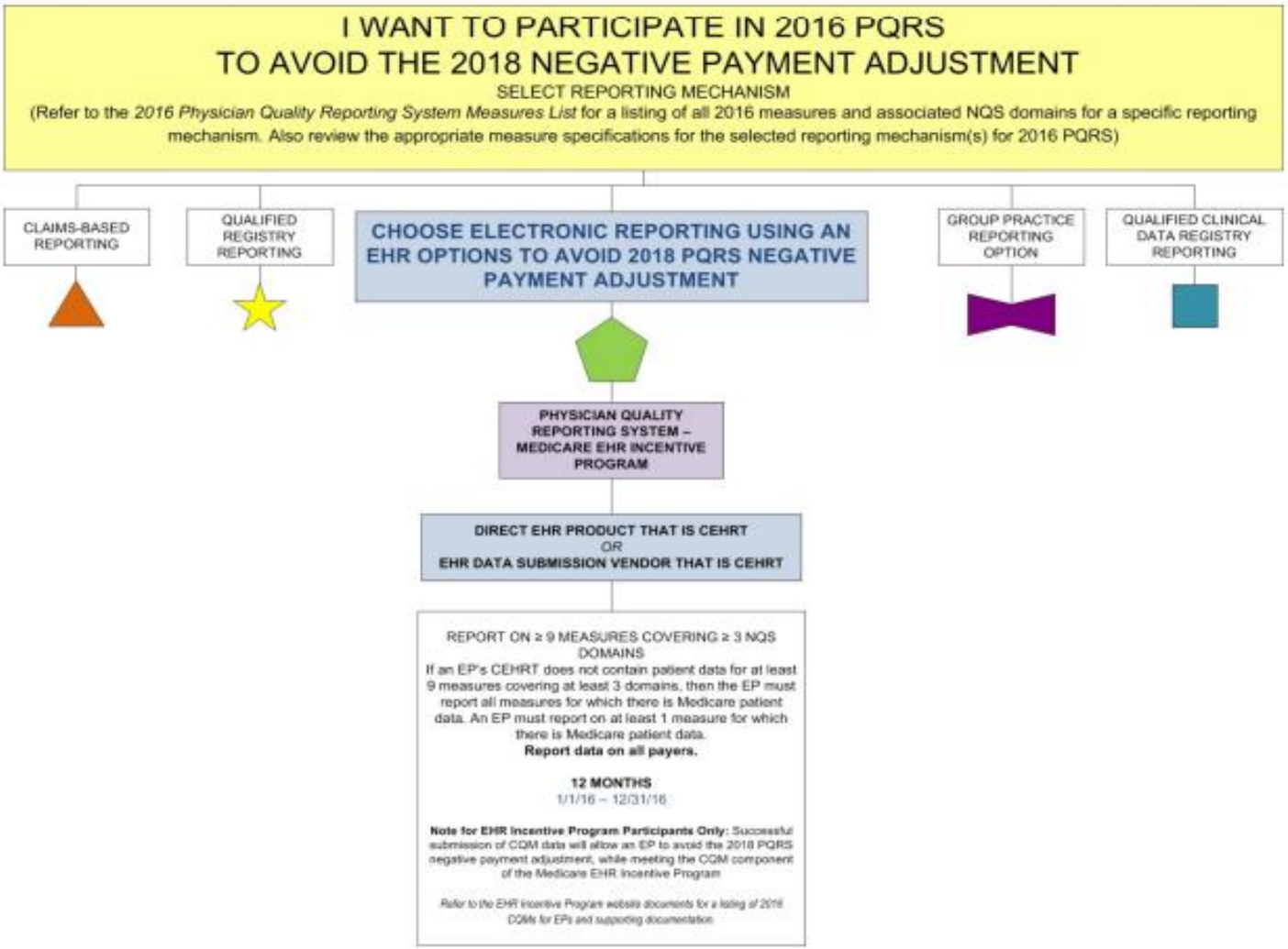
Data submitted to CMS via a Direct EHR vendor EHR product must be transmitted using the Quality Data Model (QDM)-based Quality Reporting Documentation Architecture (QRDA) Category I or QRDA Category III formats.

Direct EHR (CEHRT) (2/3)

Step 1	Determine if you are eligible to participate
Step 2	Determine which measures apply to your practice
Step 3	Choose an ONC-Certified EHR Product
Step 4	Document all patient care and visit-related information in your EHR system
Step 5	Register for EIDM
Step 6	Work with your EHR vendor to create the required reporting files from your EHR system so they can be uploaded through the Portal using EIDM
Step 7	Participate in testing
Step 8	Ensure submission

Only for Direct EHR

Direct EHR (CEHRT) (3/3)



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Web-Interface Reporting Method

- **Applicable for GPRO with group practice size of 25+**

GPRO Reporting via Web-Interface	
EPs count	Reporting Criteria
25 to 99 EPs	▪ Report on all measures included in the Web Interface ▪ Populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure ▪ If the pool of eligible assigned beneficiaries is less than 248, then report on 100 percent of assigned beneficiaries
100+ Eps	▪ Report on all measures included in the Web Interface ▪ Populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure ▪ If the pool of eligible assigned beneficiaries is less than 248, then report on 100 percent of assigned beneficiaries

- Data submitted to CMS via a Web-Interface must also report all CAHPS summary survey modules via a CMS-certified survey vendor (CAHPS for PQRS). CMS will not bear the cost of administering

CG CAHPS CMS-Certified Survey Vendor (1/2)

- Applicable for GPRO with group practice size of 25+
- The CG CAHPS summary survey modules will be considered the equivalent of 3 individual measures and 1 NQS domain
- Group practices that register for this method of reporting will need to report on at least 6 additional measures covering at least 2 additional NQS domains via qualified registry, direct EHR product or EHR data submission vendor
- Assignment of beneficiaries to a group practice using the 2014 CMS-certified survey vendor reporting method focuses on assigning beneficiaries to a group based on whether the group provided the plurality of primary care services

Summary Survey Modules
Getting Timely Care, Appointments, and Information
How Well Providers Communicate
Patient's Rating of Provider
Access to Specialists
Health Promotion & Education
Shared Decision Making
Health Status/Functional Status
Courteous and Helpful Office Staff
Care Coordination
Between Visit Communication
Helping You to Take Medication as Directed
Stewardship of Patient Resources

CG CAHPS CMS-Certified Survey Vendor (2/2)

GPRO Reporting via CG CAHPS CMS-Certified Survey Vendor	
EPs count	Reporting Criteria
25 to 99 Eps	▪ Report all 12 CAHPS for PQRS summary survey modules via a CMS-certified survey vendor AND ▪ Report at least 6 measures covering at least 2 of the NQS domains using a qualified registry, a CEHRT direct product, or a CEHRT data submission vendor OR ▪ Report all 22 GPRO Web Interface measures
100 + EPs	▪ Report all 12 CAHPS for PQRS summary survey modules via a CMS-certified survey vendor AND ▪ Report all 22 GPRO Web Interface measures

- CMS **WILL** bear the cost of administering the CAHPS for PQRS summary survey modules to patients, regardless of reporting option (i.e. web interface, qualified registry, or certified EHR technology)

Agenda

- PQRS Overview
- Measure Classification
- Reporting Methods
- **Illustrative Measure Calculation**
- PQRS and MACRA
- Glossary
- References

Illustrative Measure Calculation

Questions Answered

- How to select a measure for reporting?
- How are measures described?
- How are CQM for PQRS measures defined?
- What are the keywords used in CQM?
- How is EP/GPRO performance for any measure calculated?

Measures Selection Parameters

- Quality measures are developed by provider associations, quality groups, and CMS and are used to assign a quantity, based on a standard set by the developers, to the quality of care provided by the EP or group practice
- When selecting measures for reporting, eligible professionals should consider factors such as:
  - Clinical conditions commonly treated
  - Types of care delivered frequently – e.g., preventive, chronic, acute
  - Settings where care is often delivered – e.g. office, emergency department (ED), surgical suite
  - Quality improvement goals
  - Other quality reporting programs in use or being considered

Example : NQF#0018/PQRS#236 (1/3)

Description

- Percentage of patients 18 through 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period

Reporting Period & Frequency

- Once per reporting period (12 months)

Exemptions

- Blood pressure readings from the patient's home (including readings directly from monitoring devices)
- Taken during an outpatient visit which was for the sole purpose of having a diagnostic test or surgical procedure performed (e.g., sigmoidoscopy, removal of a mole)
- Readings taken on the same day of a major diagnostic or surgical procedure (e.g., stress test, administration of IV contrast for a radiology procedure, endoscopy) are exempted

Example : NQF#0018/PQRS#236 (2/3)

Reporting via Claims

- ICD-10-CM diagnosis codes, CPT or HCPCS code and patient demographics are used to identify patients who are included in the measure's denominator
- Quality-data codes(QDCs) are used to report the numerator of the measure
- While reporting, submit the listed ICD-9-CM/ ICD-10-CM diagnosis codes, CPT or HCPCS codes and the appropriate quality-data code

Reporting via Registry

- ICD-10-CM diagnosis codes, CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator
- The listed numerator options are used to report the numerator of the measure
- While reporting, the QDCs need not be submitted

Example : NQF#0018/PQRS#236 (3/3)

DENOMINATOR

- Patients 18 through 85 years of age who had a diagnosis of essential hypertension within the first six months of the measurement period or any time prior to the measurement period

NUMERATOR

- Patients whose most recent blood pressure is adequately controlled (systolic blood pressure < 140 mmHg and diastolic blood pressure < 90 mmHg) during the measurement period

- The reporting modifier allowed for this measure is: 8P- reason not otherwise specified

Performance Calculation (1/4)

- 4 factors which determine PQRS measure calculation:
  - Eligibility for a measure.
  - Performance in meeting the measure.
  - Reporting rate
  - Performance rate.
- Eligibility

  The criteria are generally specific to:
  - Time frame (in the last year, two years etc.)
  - Age range
  - Procedure (CPT) code
  - Diagnosis (ICD-9) code
  - Place of service
  - Other disease-specific factors.

Performance Calculation (2/4)

- Performance

  The performance is described as

  - Met: Performance criteria met or quality action performed
  - Not Met: Performance criteria not met or quality action not performed.
  - Excluded: There is a medical, patient or system reason documented in the patient record for not meeting the performance criteria (not all measures allow exclusions)
- Reporting rate
  - The Reporting Rate is the number of patients reported (Performance Met (A) + Performance Not Met (B) + Performance Exclusions(C))
    divided by the total number of Eligible Patients (D) expressed in percent.
  - RR=(A + B+ C)/D*100
  - In order to qualify for an incentive payment, you must have a Reporting Rate of 50% or above.

Performance Calculation (3/4)

- Performance rate
  - The number of patients who meet the performance criteria (or for whom the quality action was performed) (A) divided by the number of patients reported (E) minus the number excluded (C).
  - PR=A/(E-C)
- Example
  - Patient data that is eligible for this measure includes all patients in your practice who are aged 18 or older with a diagnosis of CAD (410.00, 410.01, 410.02 etc.) and a CPT code of 99201, 99202, 99203 etc.
  - The performance criteria is the number of eligible patients who were prescribed aspirin or clopidogrel.
  - Patients who could not be prescribed aspirin or clopidogrel for medical, patient or system reasons (e.g. allergy, patient declined or lack of drug availability) are excluded from the measure.

Performance Calculation (4/4)

- Sample Calculation
  - There are 75 patients in your practice who meet eligibility criteria. D=75
  - 67 of the eligible patients were given aspirin. (A=67)
  - 2 were not given aspirin or clopidogrel and there was no documentation as to why. (B=2)
  - 5 of the 75 patients are allergic to aspirin and clopidogrel.(C=5)
  - 1 patient chart could not be found
- RR=(67+2+5)/75*100=98.66%
- PR=67/(74-5)*100=97.10%

Design of 2016 PQRS CQM (1/3)

Measure consists of following major components:

- Initial Patient Population (IPP)
- Denominator (D)
- Denominator Exclusions (DENEX)
- Numerator (N)
- Denominator Exceptions (Medical/Patient/System/Other reasons)

Design of 2014 PQRS CQM (2/3)

Colorectal Cancer Screening

- **Initial Patient Population =**
  - AND: "Patient Characteristic Birthdate: birth date" >= 50 year(s) starts before start of "Measurement Period"
  - AND: "Patient Characteristic Birthdate: birth date" < 75 year(s) starts before start of "Measurement Period"
  - AND:
    - OR: "Encounter, Performed: Office Visit"
    - OR: "Encounter, Performed: Face-to-Face Interaction"
    - OR: "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
    - OR: "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
- **Denominator =**
  - AND: "Initial Patient Population"
- **Denominator Exclusions =**
  - AND:
    - OR: "Diagnosis, Resolved: Malignant Neoplasm of Colon"
    - OR: "Diagnosis, Active: Malignant Neoplasm of Colon"
    - starts before or during "Measurement Period"
- **Numerator =**
  - AND:
    - OR: "Procedure, Performed: Colonoscopy" <= 9 year(s) ends before or during "Measurement Period"
    - OR: "Laboratory Test, Result: Fecal Occult Blood Test (FOBT) (result)" during "Measurement Period"
    - OR: "Procedure, Performed: Flexible Sigmoidoscopy" <= 4 year(s) ends before or during "Measurement Period"
- **Denominator Exceptions =**
  - None

Patient aged between 50 and 75 years on the first day of the measurement period with an encounter **AND NOT** suffering from Malignant Neoplasm of colon at any time in the patient's history qualifies for the Numerator.

Colonoscopy/Flexible Sigmoidoscopy/FOBT performed during the specified duration makes a patient Numerator compliant

Design of 2014 PQRS CQM (3/3)

Colorectal Cancer Screening

- **Initial Patient Population =**
  - AND: "Patient Characteristic Birthdate: birth date" >= 50 year(s) starts before start of "Measurement Period"
  - AND: "Patient Characteristic Birthdate: birth date" < 75 year(s) starts before start of "Measurement Period"
  - AND:
    - OR: "Encounter, Performed: Office Visit"
    - OR: "Encounter, Performed: Face-to-Face Interaction"
    - OR: "Encounter, Performed: Preventive Care Services - Established Office Visit, 18 and Up"
    - OR: "Encounter, Performed: Preventive Care Services-Initial Office Visit, 18 and Up"
- **Denominator =**
  - AND: "Initial Patient Population"
- **Denominator Exclusions =**
  - AND:
    - OR: "Diagnosis, Resolved: Malignant Neoplasm of Colon"
    - OR: "Diagnosis, Active: Malignant Neoplasm of Colon"
    - starts before or during "Measurement Period"
- **Numerator =**
  - AND:
    - OR: "Procedure, Performed: Colonoscopy" <= 9 year(s) ends before or during "Measurement Period"
    - OR: "Laboratory Test, Result: Fecal Occult Blood Test (FOBT) (result)" during "Measurement Period"
    - OR: "Procedure, Performed: Flexible Sigmoidoscopy" <= 4 year(s) ends before or during "Measurement Period"
- **Denominator Exceptions =**
  - None

The AND operator means all elements joined by the AND have to be true for consideration by the measure. The OR operator means any one element has to be true for consideration by the measure.

"AND NOT" or an "OR NOT" negates a QDM element with its associated attribute(s) or phrase.

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PQRS and MACRA (1/2)

Questions Answered

- How will PQRS transition to MACRA?
- What are the advantages of MACRA over PQRS?

PQRS and MACRA (2/2)

Timeline	Till CY 2018	Post 2018
Purpose	▪ Quality reporting system for EP and GPRO	▪ PQRS is component of MACRA applicable for both EP and GPRO
Reporting requirement	▪ Pay-for-reporting program ▪ Satisfactory reporting requirement	▪ Not a pay-for-reporting program ▪ Satisfactory reporting not required
Guiding Principles	▪ Overall evaluation of care quality (NQS Domains)	▪ Strive to evaluate care quality on multiple domains (NQS Domains)
Reporting time	▪ Calendar year	▪ Calendar year
Measures	▪ Report 9 measure which span across 3 out of 6 NQS domains ▪ Choose 9 measures out of set of 300 measures thus confusing EPs ▪ NQS domain is given more importance as compared to scope of EP	▪ Report 6 measures without any NQS domain requirement ▪ Limited set of measures thus providing more clarity to EPs ▪ Flexibility to determine the most meaningful measures and reporting mechanisms
Weightage of PQRS in score	▪ 100%	▪ 50% of CPS for first 2 years ▪ 30% of CPS post 2 years

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Glossary

Abbreviation	Definition
NPI	National Provider Identifier
TIN	Tax Identification Number
PFS	Physician Fee Schedule
FFS	Fee For Service
CEHRT	Certified Electronic Health Record Technology
QCDR	Qualified Clinical Data Registry
NQS	National Quality Strategy
DME	Durable Medical Equipment
QDC	Quality Data Codes
GPRO	Group Practice Reporting Option

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- **References**

References (1/2)

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THANK YOU