PQRS for Neurologists

The Physician Quality Reporting System (PQRS) is designed to provide incentive payment to eligible professionals who meet the guidelines on reporting data on quality measures for covered professional services furnished on Medicare patients. There are over 300 measures in the 2013 program. PQRS has proven to be daunting to many Neurologists. Trying to understand the requirements and how to implement the measures is often confusing. It is also important to recognize that while PQRS may provide a reimbursement to Neurologists, those physicians who elect not to participate or are determined to be unsuccessful in reporting during the 2013 program year will receive a payment penalty starting in 2015. In addition CMS plans to publish the names of those practitioners who successfully participated in PQRS. There is also indication that CMS may also highlight the names of practitioners who do not participate in PQRS.

As is common with other CMS programs, PQRS has a defined vocabulary referred to as the "Glossary of Terms". The definitions of the terms can be found in the CMS *2013 Physician Quality Reporting System Implementation Guide*. In Appendix A: Glossary of Terms, there are 29 items defined. The following are some of the more important terms to help understand PQRS.

Glossary of Terms:

Eligible Professional (EP): Refers to the list of professionals eligible to participate in PQRS. Since this update is written for Neurologists, the text below will reference either Neurologists *or* Eligible Professional

Encounter: Encounters with patients during the reporting period which include: CPT Category 1 E/M service codes, CPT Category 1 procedure codes, or HCPCS codes specific for PQRS.

CPT Category 11 Codes: A set of supplemental CPT codes intended to be used for performance measurement. For PQRS, CPT Category 11 codes are

used to report quality measures on a claim for measurement calculation PQRS is reported using Category 11 CPT Codes

CPT Category 11 Codes are generally 4 numbers followed by "F" or 4 numbers preceded by "G"

e.g. 1200F for Seizure frequency and G8851 for adherence to positive airway pressure therapy

G-Codes for PQRS: Are a set of CMS defined temporary HCPCS codes used to report quality measures on a claim. G-Codes are maintained by CMS

Measure: Performance Measure is a quantitative tool (e.g., rate, ratio, index, percentage) that provides an indication of performance in relation to a specified process of outcome.

Measure Tags: Measure Tags are reporting frequencies or timeframe requirements. For example, "report each visit", "once during the reporting period", "report each episode".

The measure restrictions limit the frequency of reporting that may be necessary in certain circumstances. An example would be patients with a chronic illness for whom a particular process of care is provided only periodically

Measure Tags are found in the instructions for each measure specification

Eligible Cases: Eligible Cases are defined as a patient population that receive a particular process of care or achieve a particular outcome. The Eligible Cases are defined by demographic information, certain International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) Diagnosis, Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in the measures that are submitted by Individual Eligible Professionals as part of a claim for covered services under the Physician Fee Schedule.

Denominator Codes (Eligible Cases) and Numerator Quality- Data Codes:

Quality measures consist of a numerator and a denominator that permit the calculation of the percentage of a defined patient population that receive a particular process of care or achieve a particular outcome

Denominator: The denominator is associated with a given population that may be counted as Eligible Cases to meet a measure's inclusion requirements and defines the Eligible Cases for a measure. For Neurologists reporting PQRS, most denominator codes will usually be ICD-9 codes

Numerator: Describes the clinical action required by the measure for reporting and performance. The clinical action to be counted must meet a measure's requirements (i.e., patients who received the particular service or obtained outcome that is being measured). PQRS measure numerators are CPT Category 11 codes and G-codes.

When Quality Measures are calculated in terms of a numerator and denominator, the results are a percentage of a defined patient population that receives a particular process of care or achieves a particular outcome

Example of Numerator and Denominator:

Denominator: All patient visits with a diagnosis of Epilepsy

Numerator: Report the CPT Category 11, Seizure Type(s) and Current Seizure Frequency(ies) in development designated for this numerator 1200F

PQRS reports are issued to an individual National Provider Identifier (NPI) and payment is under the group Tax Identification Number (TIN)

More detailed information on these two major components of PQRS are described in the *2013 CMS Physician Quality Reporting System (Physician Quality Reporting) Implementation Guide* found on the CMS website

How can I avoid the payment penalty in 2015?

The easiest way for a Neurologist to avoid a 1.5% payment penalty in 2015 is to successfully report on at least one individual measure at each encounter for >50% of all eligible patients

For example: If using the documentation of seizure type and frequency, the Neurologist needs to report this measure for at least 50% of their epilepsy patients.

To satisfy CMS rules and **receive** the incentive

Individual Measures and Measures Groups:

If reporting via registry:

>80% on 3 or more individual measures

20 or more unique patients (>50% must be Medicare) for 1 or more measures group

If reporting via claims:

>50% on 3 or more individual measures for the 12 month reporting period

1 or more measures group of the 12 month reporting period for 20 or more unique patients

Group Practice Reporting Option (GPRO):

Report at least 3 Measures and report each measure for at least 80% of the group Practice's Medicare Part B FFS patients seen during the reporting period to which the measure applies

If the Neurologist chooses to report on a diagnosis with no neurologic specific measures, (e.g. migraine), he/she could choose 3 general measures. This may include such measures as medication reconciliation or tobacco use. However, it is important to understand that when choosing more general measures, those measures may not be specific to a listed diagnosis. In that case, every Medicare patient may be eligible to be considered for that measure, (e.g. medication reconciliation measure). Reporting would then apply to everyone. <u>If a measure is not defined by a particular diagnosis code the eligible patient population would be all Medicare patients.</u>

PQRS reporting can be submitted in the following ways:

To CMS on the Medicare Part B claims form (Part B 1500 billing form)

To a qualified Physician Quality Reporting registry

To CMS via a qualified EHR

To a qualified Physician Quality Reporting data vendor

The 3 different reporting options available for PQRS:

<u>Reporting Individual Measures</u>: Easiest to understand. Most Neurologists will report Individual Measures

<u>Reporting Group Measures Options</u>: Clinically related measures focused on chronic and high cost conditions. Most measures are not as applicable to a Neurology practice

<u>Group Practice Reporting Option (GPRO)</u>: Overall more applicable to Internal Medicine and large multispecialty groups

Explaining the 3 different reporting options available for PQRS:

Individual Measures:

Least complicated for Neurology PQRS reporting and will probably be used by most Neurologists

Individual Measures are reported using claims, a PQRS qualified registry, or a PQRS qualified EHR

There are over 300 PQRS measures available

There are some clinical topics for individual PQRS measures specific to neurology, such as stroke and epilepsy

Neurologists may also choose general individual measures such as fall screening, pain management, medication reconciliation, smoking cessation and the use of the electronic health record. When using general measures, reporting may need to be on every eligible Medicare patient

When using individual measures, to avoid the penalty, the Neurologist must report on at least one individual measure (see above)

Measures Group reporting:

4 or more measures grouped together

It is anticipated, when using measures group, most Neurologists will primarily use the clinical topics of individual group measures that exist for the following neurological diseases:

Parkinson's disease, Dementia, Sleep, Back pain

If choosing to report on a measures group, **all** measures in the group must be reported for **all** applicable patients. Each patient within the eligible professional's patient sample must be reported a minimum of once during the reporting period

For example, choosing the Parkinson's disease measures group means reporting all six measures in the group for all Parkinson's patients

Report via claims or PQRS qualified registry.

Not available for EHR reporting

To receive the bonus, the Neurologist must report on 20 patients who qualify for the measures group

Under the 2013 program, greater than 50% of those patients must be Medicare patients

Failure to reach 20 patients does not meet the requirement

To avoid the 2015 penalty when reporting measures group, the Neurologist must report on 1 measures group. But failure to reach 20 patients does not meet requirement. Thus, if 20 patients are not reached, to avoid the penalty, choose another measures group or another reporting option.

<u>The Group Practice Reporting Option (GPRO):</u>

For at least two or more providers in a group

Different criteria of reporting depending on the group size

Group size: 2+ eligible professionals

Group size: 25-99 eligible professionals

Group size: 100+ eligible professionals

Single – specialty Neurology practices will be less likely to choose group reporting because these measures are more geared toward the primary care provider

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Details about the Neurology Specific PQRS Measures

Disease	# of Measures	Reporting Mechanism
Epilepsy	Three	Claims, Registry
Parkinson's disease	Six	Registry only Measures
Dementia	Nine	Claims, Registry
Sleep Apnea	Four	Registry

Stroke has seven measures but stroke is currently hospital level reporting and not individual EP reporting. Stroke can be reported as follows: four by claims and 6 by registry

The top 5 PQRS measures used by Neurologists are as follows:

(Cohen AB, Sanders AE, et.al..Quality measures for neurologists: Clinical Practice 2013l; vol 3;44-50)

Adoption and use of electronic health record (PQRS # 124)

Inquiry regarding tobacco use (#114)

Documentation and verification of current medications (#130)

Advising smokers to quit smoking (#115)

DVT prophylaxis for Ischemic stroke or Intracranial hemorrhage (31)

Incentives For Reporting:

2012	2013	2014	2015	2016
+0.5%	+0.5%	+0.5%	0.0%	0.0%

Penalties For Not Reporting:

2012	2013	2014	2015	2016
0.0%	0.0%	0.0%	-1.5%	-2.0%

As illustrated, there are still incentive payments for PQRS through 2014

The Patent Protection and Affordable Care Act (PPACA) requires penalty starting in 2015 (based on 2013 reporting), for providers who do not satisfactorily report PQRS

For a Neurologist to get started in PQRS:

Determine which reporting option is best for your practice

Select 3 measures group to submit (to receive incentive)

Select 1 measures group to submit (to avoid penalty)

Perform a personal review of the measure specifications chosen

PQRS is reported using Category 11 CPT Codes (described above)

There are CPT Modifiers which explain the reason for not performing a quality procedure:

1PModifier: Procedure not performed due to medical reasons

2P Modifier: Procedure not performed due to patient reasons

3P Modifier: Procedure not performed due to system reasons

8P Modifier: Procedure not performed due to reasons otherwise not specified

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General Examples:

Example #1: Choosing to report Epilepsy:

<u>There are 3 Measures for reporting Epilepsy:</u>

1. "Percentage of patient visits with a diagnosis of epilepsy who had the type(s) of seizure(s) and current seizure

frequency(ies) for each seizure type documented in the medical record"

2. "All visits for patients with a diagnosis of epilepsy who had their etiology of epilepsy or with epilepsy syndrome(s) reviewed and documented if known, or documented as unknown or crytogenic"
3. "All female patients of childbearing potential (12-44 years old) diagnosed with epilepsy who were counseled about epilepsy and how its treatment may affect contraception and pregnancy at least once a year"

To illustrate, when reporting the first measure, the CPT Category 11, "Seizure Type(s) and Current Seizure Frequency(ies)", is designated 1200F in the numerator

The Neurologist must document the reason for not performing a measure by appending the modifier to the CPT 11 Code. Thus, for "Seizure Type(s) and Current Seizure Frequency(ies)"

Medical Reason 1200F-1P

Patient Reason 1200F-2P

Another example of documenting the reason for not performing a measure: *For Counseling for Women of Childbearing Potential with Epilepsy* (Measure 3 above)

To document the medical reason for not performing that measure, append the modifier to the CPT 11 code 4340F as follows: 4340F–1P

The Neurologist could choose the 3 epilepsy measures and apply exclusion to the male patients. Reporting must still be on 50% of eligible patients if reporting via claims and for 80% of eligible patients if through a qualified registry.

If the Neurologist were reporting on epilepsy, just using one measure, it is worth re-emphasizing that the Neurologist must still report this measure on at least 50% of his/her epilepsy patients to avoid the penalty.

Example #2: A Neurologist chooses to report on measure 126: *Diabetic foot and Ankle Care, Peripheral Neuropathy-Neurological Evaluation*, primarily to avoid the PQRS penalty.

> He/she can bill as little as one individual measure to avoid the penalty. However, the physician still must report on at least 50% of eligible patients (those meeting the numerator and denominator criteria outlined in the measure specifications).

Important to know: There are two different types of vender reporting

Direct Vender Reporting through a Direct Qualified EHR Vendor

Data Submission Vendors (DSV): outside vendors used by the EHR

Neurologists using an EHR that is not qualified for EHR direct reporting must submit quality measures through a Data Submission Vendor if they want to use an EHR-based reporting method

Risk of data integrity issues: When converting data from one system to another, there is always the risk of losing information. Reporting through the

registry-based or DSV that uses registry submission options could risk data integrity. Be sure to consider this when choosing a PQRS reporting method

Some PQRS reporting methods are more complex than others. Claims-based and group practice reporting options appear to be the most complex

There may be costs involved in registry-based reporting and data submission vendor reporting (DSV). EHR direct reporting usually do not involve additional cost

A list of 2013 Qualified EHR Direct Vendors and Qualified Registries is available on the CMS website. In addition, the AAN has been very proactive in trying to simplify the entire PQRS process. The AAN has partnered with CECity, as one registry reporting option to help meet PQRS requirements. This spring CECity is offering a discount to AAN members. CECity also has the ability to report on all the neurology related measures. More information can be found on the AAN website. In addition, the AAN toolkit for PQRS might be helpful and can be found at www.aan.com/go/practice/pay/pqrsguide.

Authors Note: The PQRS program has proven to be daunting to many colleagues who try to understand its requirements and implement the measures according to the guidelines. It is hoped that this condensed but comprehensive review of PQRS will be of benefit to our TNS membership. 17% of Neurologists participated in the PQRS program in 2010. In 2010 PQRS incentive payments for all eligible providers totaled $391,635,495 which was paid to 169,843 practitioners. The average incentive was $2,157 per practitioner. More detailed instructions on PQRS are published on the CMS and Neurology Web sites:

http://www.cms.gov/pqrs

http://www.aan.com/go/practice/pay/resources.

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