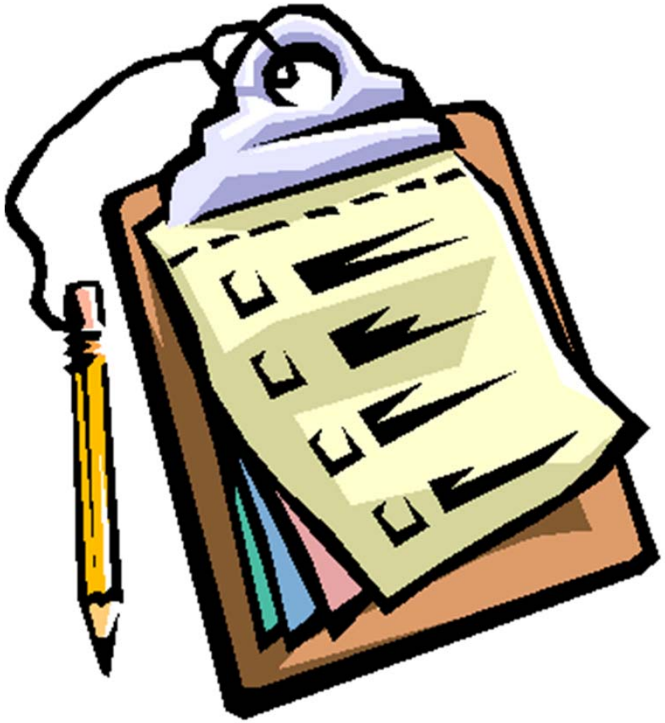
2015 User Conference

Creating your BLUEPRINT for practice SUCCESS

Quality Initiatives: PQRS

Presented by: Jennifer Bondar, Software Training Specialist

AGENDA



AGENDA

- What is PQRS?
- How to Report PQRS with MicroMD
- Measure Selection Considerations
- A Closer Look at the Measures
- Measures Applicability Validations (MAV)
- Value Based Modifier (VBM)
- Codes and Modifiers in MicroMD PM
- PQRS in the EMR
- Additional Resources for PQRS

WHAT IS PQRS?


PQRS
2%-4%
2017 Negative
Adjustment
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What is PQRS?

The Physician Quality Reporting System (PQRS) is a quality reporting program that ***encourages*** individual eligible professionals (EPs) and group practices to report information on the quality of care to Medicare.

(http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/)

This incentive program is separate from other CMS EHR incentive programs!

AND HERE IS THE ENCOURAGEMENT ….

2015 Payments	Reporting Year	Amount
Meaningful Use	2013/2014*	-1%
eRX	2013	-1%
PQRS	2013	-1.5%

-3.5%

2016 Payments	Reporting Year	Amount
Meaningful Use	2014	-2%
PQRS	2014	-2%
VBM if 10+ Providers	2014	-2%

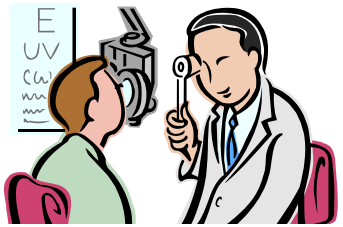
-6%

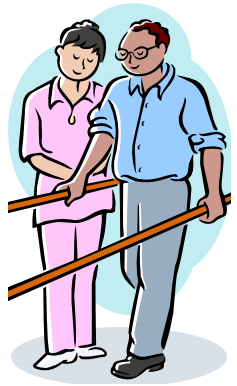
2017 Payments	Reporting Year	Amount
Meaningful Use	2015	-3%
PQRS	2015	-2%
VBM (-/+ 10 Providers)	2015	-2 to -4%

-7 to 9%

Who is Eligible for the PQRS Incentive?

Doctors of Medicine or Osteopathy
Doctors of Dental surgery or Dental Medicine
Doctors of Podiatry
Doctors of Optometry
Chiropractors
Physician Assistants
Nurse Practitioners
Clinical Nurse Specialists
Clinical Social Workers
Physical and Occupational Therapists
And many more…





*** Must bill Medicare at an individual NPI level**

In 2007, Physician Quality Reporting Initiative (PQRI), the predecessor to PQRS, was a pay-for-reporting program that included claims-based reporting on 74 individual quality measures. The program allowed EPs to report at least three applicable measures on a minimum of 80% of cases from July 1, 2007 through December 31, 2007. Those who met the criteria for submitting quality data were eligible to earn a lump-sum incentive payment equivalent to 1.5% of their total estimated allowable charges for Medicare Part B Physician Fee Schedule (PFS).

2015: A Whole New Ballgame

- **PQRS bonus payments are no longer available.**
- **The penalty phase has begun; -1.5% based on what was reported for 2013.**
- **PQRS will also affect your Value-Based Payment Modifier (VBM).**
- **Avoiding the penalty got significantly harder. In 2015, you must report 9 quality measures covering 3 domains; 1 of the 9 measures must be from a list of 19 'cross-cutting' measures. Only 3 measures were required in 2014. Measures must be reported for at least 50% of the Medicare patients seen who qualify for that measure.**

HOW TO REPORT PQRS WITH MICROMD

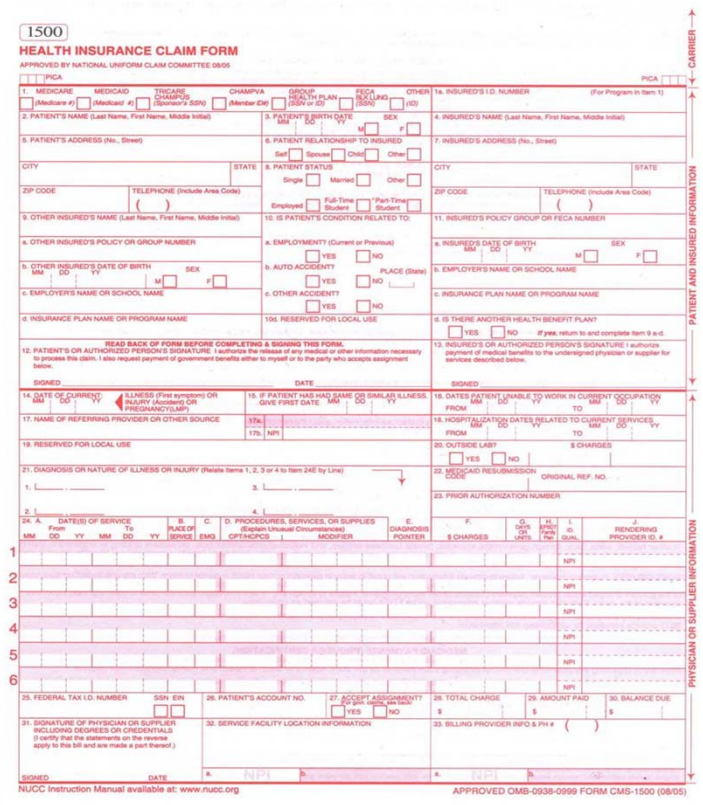
HENRY SCHEIN MicroMD

2015 MicroMD User Conference

How to Report with MicroMD

Eligible providers who wish to participate in PQRS to earn incentives and avoid penalties will need to report via Claims-Based Reporting, as the other options of EHR-Based reporting and Registry-Based reporting are currently not supported by MicroMD.

With claims-based reporting, Eligible Professionals (EPs) simply report PQRS using the Medicare Part B claim form CMS-1500 with the supporting HCPCS codes.


1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate Items 1, 2, 3 or 4 to Item 24E by Line)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1											NPI
2											NPI
3											NPI
4											NPI
5											NPI
6											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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To Report PQRS in 2015. . .

Choose appropriate measures for provider or practice

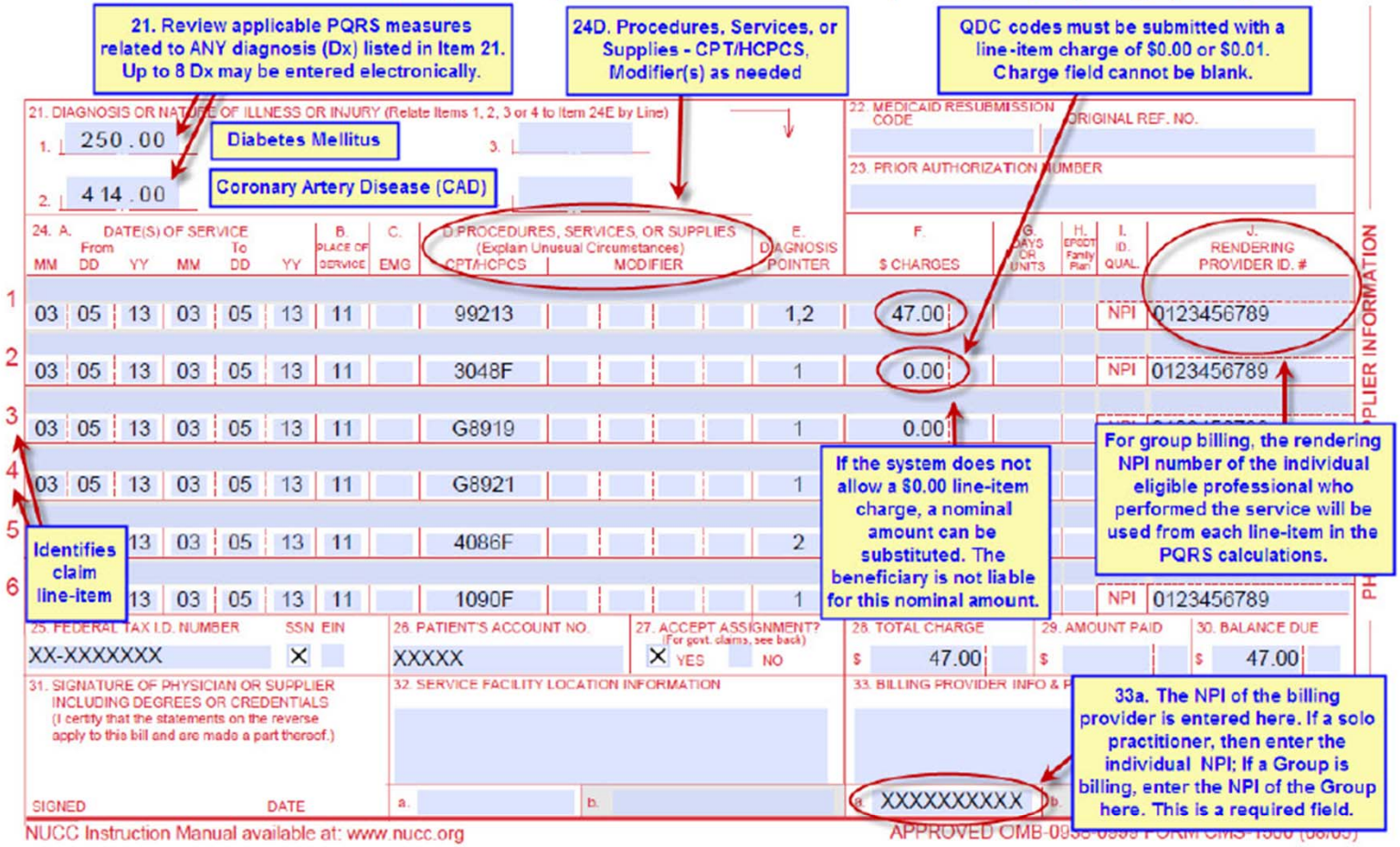
Begin Reporting January 1 through December 31, 2015

Report on 50% or more of the Medicare Part B patients seen who qualify for that measure; on at least 9 quality measures covering 3 of NQS Domains; 1 of the 9 measures must be from a list of 19 'cross-cutting' measures.

Prepare CMS-1500 Claim Forms or Electronic Claims with appropriate Reporting Codes and Modifiers

CMS-1500 Claim PQRS Example

Example of an individual NPI reporting on a single CMS-1500 claim for 2013 Physician Quality Reporting System (PQRS).



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:

- Measure #2 (LDL-C) with QDC 3048F + diabetes line-item diagnosis (24E points to DX 250.00 in Item 21);
- Measure #3 (BP in Diabetes) with G-codes G8919 + G8921 + diabetes line-item diagnosis (24E points to Dx 250.00 in Item 21);
- Measure #6 (CAD) with QDC 4086F + CAD line-item diagnosis (24E points to Dx 414.00 in Item 21); and
- Measure #48 (Assessment - Urinary Incontinence) with QDC 1090F. For Physician Quality Reporting, there is no specific diagnosis associated with this measure. Point to the appropriate diagnosis for the encounter.
- Note: All diagnoses listed in Item 21 will be used for PQRS analysis. Measures that require the reporting of two or more diagnoses on claim will be analyzed as submitted in Item 21.
- 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.

Claims submitted properly for the 2015 reporting period

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Avoidance of 2017 payment adjustment

MEASURE SELECTION CONSIDERATIONS

PQRS Measure Selection Considerations

The 2015 PQRS Measures address various aspects of patient care.

A provider should review The measure list to determine which measures may be of interest to their practice and benefit them in the care of their patients.

Some factors to consider when selecting the measures to be used for reporting include:

- Types of care provided by the practice
- Clinical conditions treated by the EP
- Care setting (office, hospital, etc.)
- Quality improvement goals for the EP or practice
- Other quality reporting programs in use in the practice

Beginning in 2015, PQRS reporting options require an EP or group practice to report *9* or more measures covering at least *3* National Quality Strategy (NQS) Domains and *1* of the 9 measures must be from the list of 19 ‘cross-cutting’ measures.

A	B	C	D	E	F
Measure Title	Measure Number			Measure Description	NQS Domain
	CMS	NQF	PQRS		
Diabetes: Hemoglobin A1c Poor Control	122v3	0059	001	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	Effective Clinical Care
Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL)	163v3	0064	002	Percentage of patients 18–75 years of age with diabetes whose LDL-C was adequately controlled (< 100 mg/dL) during the measurement period	Effective Clinical Care
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	135v3	0081	005	Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge	Effective Clinical Care

A	K	L	M	N	O	P	Q	R
Measure Title	Reporting Method(s)						Measure Group(s)	Crosscutting Measures
	Claims	CSV	EHR	GPRO (Web Interface)	Measure Groups	Registry		
Diabetes: Hemoglobin A1c Poor Control	X	-	X	X	X	X	Diabetes Mellitus	X
Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dL)	-	-	X	-	-	-	-	-
Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	-	-	X	-	X	X	Heart Failure	-

CMS revised the 2015 Measures list into a very user friendly excel spreadsheet

CMS Suggested Measures by Specialty

Physician Quality Reporting System

- Spotlight
- How To Get Started
- CMS Sponsored Calls
- Statute Regulations Program Instructions
- ICD-10 Section
- **Measures Codes**
- Registry Reporting
- Electronic Health Record Reporting
- CMS-Certified Survey Vendor
- Qualified Clinical Data Registry Reporting
- Group Practice Reporting Option

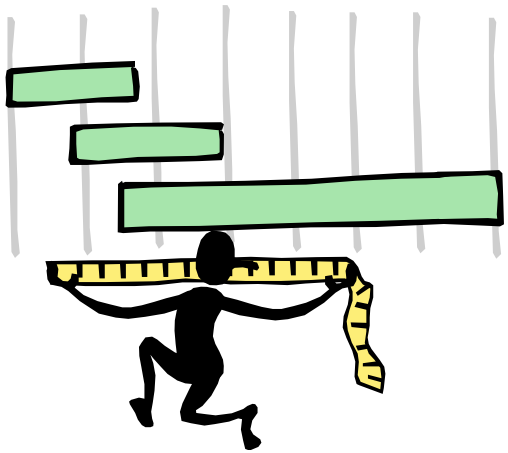
1. Potential Cardiology Preferred Measure Set
2. Potential Emergency Medicine Preferred Measure Set
3. Potential Gastroenterology Preferred Measure Set
4. Potential General Practice/Family Preferred Measure Set
5. Potential Internal Medicine Preferred Measure Set
6. Potential Multiple Chronic Conditions Preferred Measure Set
7. Potential Obstetrics/Gynecology Preferred Measure Set
8. Potential Oncology/Hematology Preferred Measure Set
9. Potential Ophthalmology Preferred Measure Set
10. Potential Pathology Preferred Measure Set
11. Potential Radiology Preferred Measure Set
12. Potential Surgery Preferred Measure Set

A CLOSER LOOK AT THE MEASURES

Closer Look at the Measures

Once the EP or Group Practice has selected the measures they wish to report on, they should review the specifications for each measure.

The following slides show a break-down of an Individual PQRS Measure…



Measure number and Official Title of PQRS Measure

♦ Measure #1 (NQF 0059): Diabetes: Hemoglobin A1c Poor Control – National Quality Strategy Domain: Effective Clinical Care 30

Measure Specification: Identifies measure specification reporting option(s)

2015 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

This segment provides a high-level description of the measure

DESCRIPTION:

Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period

The instructions detail when the measure should be reported and who should report

INSTRUCTIONS:

This measure is to be reported a minimum of **once per reporting period** for patients with diabetes seen during the reporting period. The most recent quality-data code submitted will be used for performance calculation. This measure may be reported by clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

This area better defines what is needed when reporting the measure via claims. To ensure satisfactory reporting, submit all measure specific coding on the claim.

Measure Reporting via Claims:
ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes and/or quality-data codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-9-CM/ICD-10-CM diagnosis codes, CPT codes, and the appropriate CPT Category II code(s) **AND/OR** a quality-data code **OR** the CPT Category II code(s) **with** the modifier **AND** quality-data code. The modifiers allowed for this measure are: 1P- medical reasons, 2P- patient reasons, 3P- system reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

The Denominator statement describes the population evaluated by the performance measure

DENOMINATOR:

Patients 18 - 75 years of age with diabetes with a visit during the measurement period

Patient population that will be counted to meet measure requirements

Denominator Criteria (Eligible Cases):

Patients 18 through 75 years of age on date of encounter

AND

Diagnosis for diabetes (ICD-9-CM) [for use 1/1/2015-9/30/2015]: 250.00, 250.01, 250.02, 250.03, 250.10, 250.11, 250.12, 250.13, 250.20, 250.21, 250.22, 250.23, 250.30, 250.31, 250.32, 250.33, 250.40, 250.41, 250.42, 250.43, 250.50, 250.51, 250.52, 250.53, 250.60, 250.61, 250.62, 250.63, 250.70, 250.71, 250.72, 250.73, 250.80, 250.81, 250.82, 250.83, 250.90, 250.91, 250.92, 250.93, 357.2, 362.01, 362.02, 362.03, 362.04, 362.05, 362.06, 362.07, 366.41, 648.00, 648.01, 648.02, 648.03, 648.04

Diagnosis for diabetes (ICD-10-CM) [for use 10/01/2015-12/31/2015]: E10.10, E10.11, E10.21, E10.22, E10.29, E10.311, E10.319, E10.321, E10.329, E10.331, E10.339, E10.341, E10.349, E10.351, E10.359, E10.36, E10.39, E10.40, E10.41, E10.42, E10.43, E10.44, E10.49, E10.51, E10.52, E10.59, E10.610, E10.618, E10.620, E10.621, E10.622, E10.628, E10.630, E10.638, E10.641, E10.649, E10.65, E10.69, E10.8. E10.9. E11.00. E11.01. E11.21. E11.22. E11.29. E11.311. E11.319. E11.321. E11.329. E11.331. E11.339, E11.341, E11.349, E11.351, E11.359, E11.36, E11.39, E11.40, E11.41, E11.42, E11.43, E11.44, E11.49, E11.51, E11.52, E11.59, E11.610, E11.618, E11.620, E11.621, E11.622, E11.628, E11.630, E11.638, E11.641, E11.649, E11.65, E11.69, E11.8, E11.9, O24.011, O24.012, O24.013, O24.019, O24.02, O24.03, O24.111, O24.112, O24.113, O24.119, O24.12, O24.13

Enter correct combinations of codes on claim

AND

Patient encounter during reporting period (CPT or HCPCS): 97802, 97803, 97804, 99201, 99202, 99203, 99204, 99205, 99211,99212, 99213, 99214, 99215, 99217, 99218, 99219, 99220, 99221, 99222, 99223, 99231, 99232, 99233, 99238, 99239, 99281, 99282, 99283, 99284, 99285, 99291, 99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316, 99318, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0270, G0271, G0402, G0438, G0439

NUMERATOR:

A clinical action that meets the measure's requirements

Patients whose most recent HbA1c level (performed during the measurement period) is > 9.0%

Numerator Instructions: A lower calculated performance rate for this measure indicates better clinical care or control. Patient is numerator compliant if most recent HbA1c level >9% or is missing a result or if an HbA1c test was not done during the measurement year.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Most Recent Hemoglobin A1c Level > 9.0%

***Performance Met*: CPT II 3046F:** Most recent hemoglobin A1c level > 9.0%

OR

Hemoglobin A1c not Performed, Reason not Otherwise Specified

Append a reporting modifier (8P) to CPT Category II code **3046F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

***Performance Met*: 3046F *with* 8P:** Hemoglobin A1c level was not performed during the performance period (12 months)

OR

Most Recent Hemoglobin A1c Level ≤ 9.0%

***Performance Not Met*: CPT II 3044F:** Most recent hemoglobin A1c (HbA1c) level < 7.0%

OR

***Performance Not Met*: CPT II 3045F:** Most recent hemoglobin A1c (HbA1c) level 7.0 to 9.0%

Rationale is a brief statement that describes the intent for the measure

RATIONALE:

Diabetes mellitus (diabetes) is a group of diseases characterized by high blood glucose levels caused by the body's inability to correctly produce or utilize the hormone insulin. It is recognized as a leading cause of death and disability in the U.S. and is highly underreported as a cause of death. Diabetes may cause life-threatening, life ending or life-altering complications, including poor circulation, nerve damage or neuropathy in the feet and eventual amputation. Nearly 60-70 percent of diabetics suffer from mild or severe nervous system damage (American Diabetes Association 2009).

Randomized clinical trials have demonstrated that improved glycemic control, as evidenced by reduced levels of glycohemoglobin, correlates with a reduction in the development of microvascular complications in both Type 1 and Type 2 diabetes (Diabetes Control and Complications Trial Research Group 1993; Ohkubo 1995). In particular, the Diabetes Control and Complications Trial (DCCT) showed that for patients with Type 1 diabetes mellitus, important clinical outcomes such as retinopathy (an important precursor to blindness), nephropathy (which precedes renal failure), and neuropathy (a significant cause of foot ulcers and amputation in patients with diabetes) are directly related to level of glycemic control (Diabetes Control and Complications Trial Research Group 1993). Similar reductions in complications were noted in a smaller study of intensive therapy of patients with Type 2 diabetes by Ohkubo and co-workers, which was conducted in the Japanese population (Ohkubo et al. 1995).

This is a summary of the clinical recommendations based on best practices

CLINICAL RECOMMENDATION STATEMENTS:

American Geriatrics Society (Brown et al. 2003):

For frail older adults, persons with life expectancy of less than 5 years, and others in whom the risks of intensive glycemic control appear to outweigh the benefits, a less stringent target such as 8% is appropriate. (Quality of Evidence: Level III; Strength of Evidence: Grade B)

American Diabetes Association (2009):

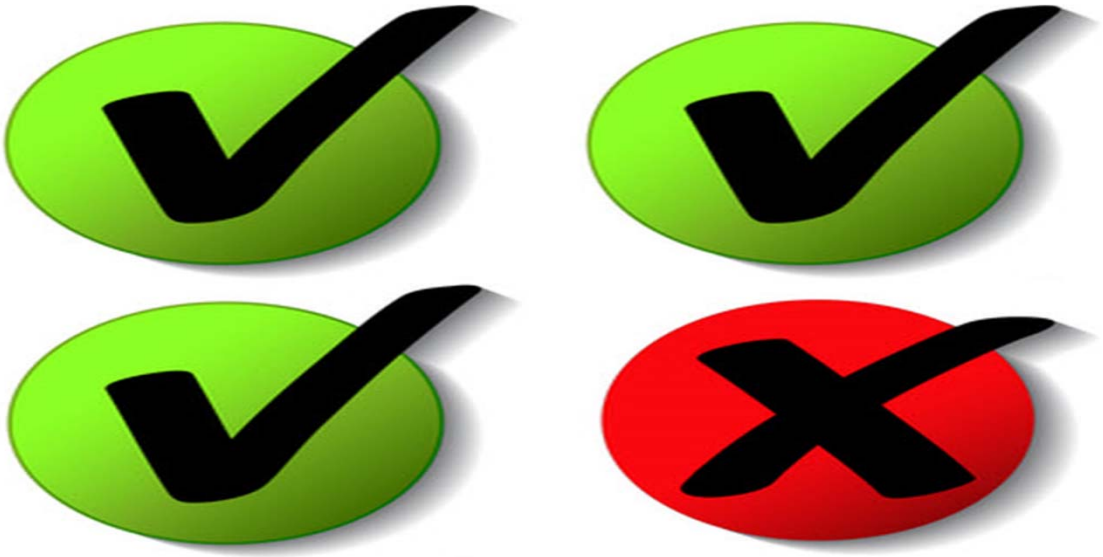
Lowering A1C to below or around 7% has been shown to reduce microvascular and neuropathic complications of type 1 and type 2 diabetes. Therefore, for microvascular disease prevention, the A1C goal for non-pregnant adults in general is <7%. (Level of Evidence: A)

In type 1 and type 2 diabetes, randomized controlled trials of intensive versus standard glycemic control have not shown a significant reduction in CVD outcomes during the randomized portion of the trials. Long-term follow-up of the Diabetes Control and Complications Trial (DCCT) and UK Prospective Diabetes Study (UKPDS) cohorts suggests that treatment to A1C targets below or around 7% in the years soon after the diagnosis of diabetes is associated with long-term reduction in risk of macrovascular disease. Until more evidence becomes available, the general goal of <7% appears reasonable for many adults for macrovascular risk reduction. (Level of Evidence: B)

Subgroup analyses of clinical trials such as the DCCT and UKPDS and the microvascular evidence from the Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation (ADVANCE) trial suggest a small but incremental benefit in microvascular outcomes with A1C values closer to normal. Therefore, for selected individual patients, providers might reasonably suggest even lower A1C goals than the general goal of <7%, if this can be achieved without significant hypoglycemia or other adverse effects of treatment. Such patients might include those with short duration of diabetes, long life expectancy, and no significant CVD. (Level of Evidence: B)

Conversely, less stringent A1C goals than the general goal of <7% may be appropriate for patients with a history of severe hypoglycemia, limited life expectancy, advanced microvascular or macrovascular complications, and extensive comorbid conditions and those with longstanding diabetes in whom the general goal is difficult to attain despite diabetes self-management education, appropriate glucose monitoring, and effective doses of multiple glucose lowering agents including insulin. (Level of Evidence: C)

MEASURE APPLICABILITY VALIDATIONS



Measure Applicability Validation (MAV)

The 2015 PQRS will include the MAV process. The MAV process will review and validate EP's inability to report on nine measures across three domains. CMS will analyze claims data to confirm whether or not more measures and/or domains were applicable to the EP's practice.

***Satisfactorily report 1-8 measures**

***Satisfactorily report less than 3 domains**

***Must report for at least 1 cross-cutting measure**

***Must report on at least 50% of eligible patients or encounters and have at least 1 patient in the numerator for any reported measure**

To MAV or not to MAV…

Satisfactorily report across 9 measures, 3 domains and 1 cross-cutting measure

=

No MAV and avoidance of 2017 PQRS Payment Adjustment

Reporting less than 50% of Medicare Part B FFS patients

OR

Individual provider with face-to-face encounters who does not satisfactorily report at least one cross-cutting measure

OR

No patient or procedure that qualifies for the numerator of the performance measure (i.e. rate = 0%, or 100% for inverse measures)

If any one of these conditions exist, then MAV will not be used and the 2017 PQRS Payment Adjustment will apply.

Value Based Payment Modifier (VBM)

Value Based Payment Modifier

The Value Modifier provides for differential payment to a physician or group of physicians under the Medicare Physician Fee Schedule (PFS) based upon the quality of care furnished compared to the cost of care during a performance period. In the future, the Value Modifier will be used to adjust Medicare PFS payments to non-physician eligible professionals (EPs), in addition to physicians. The Value Modifier is an adjustment made on a per claim basis to Medicare payments for items and services under the Medicare PFS. It is applied at the Taxpayer Identification Number (TIN) level to physicians (and beginning in 2018, to non-physician EPs) billing under the TIN.

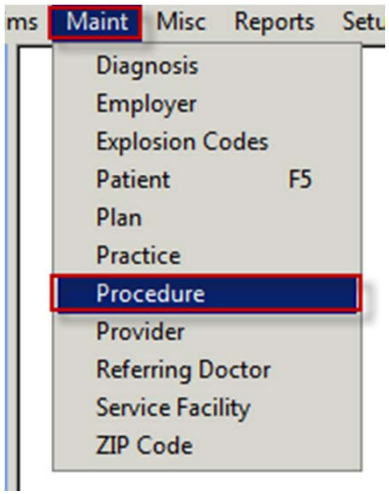
VBM compares physicians to their peers based on cost and quality of care. The cost evaluation will come from claims analysis done by Medicare. The quality comes from the EP's PQRS reporting. If you do not report PQRS or do not report sufficiently your penalty is equivalent to those with the highest costs and the lowest quality of care offered. Medicare estimates that 85% of practices will fall into the "No Change" category.

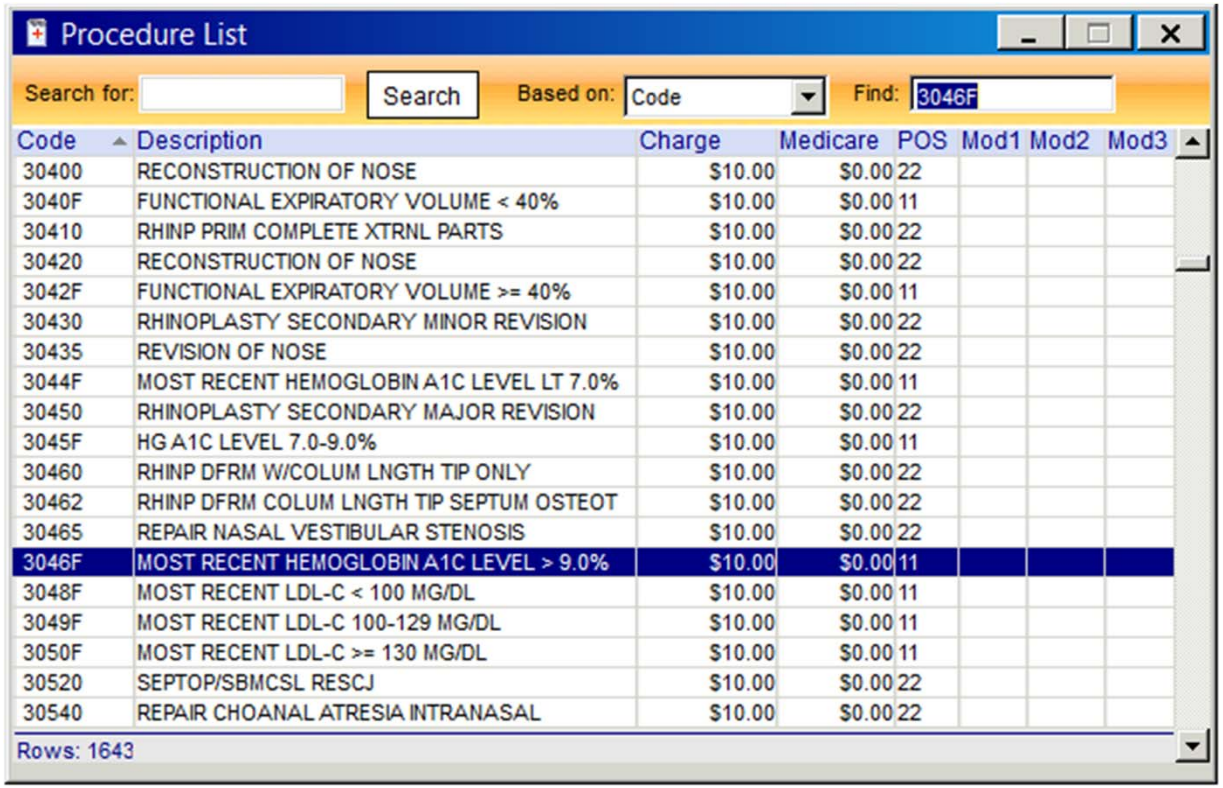
	Low Cost	Avg Cost	High Cost
High Quality	Highest Increase	Lower Increase	No Change
Average Quality	Lower Increase	No Change	Lower Penalty
Low Quality	No Change	Lower Penalty	Highest Penalty

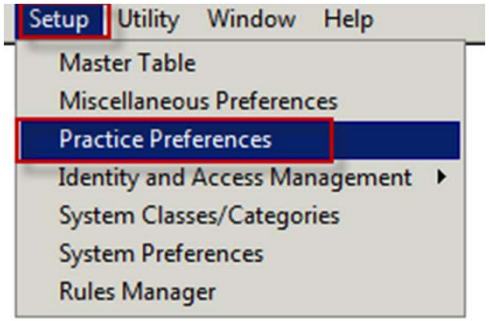
CODES AND MODIFIERS IN THE PM

PQRS Codes and Modifiers in MicroMD PM

Be sure appropriate codes and modifiers exist in your PM.
If not, add them!

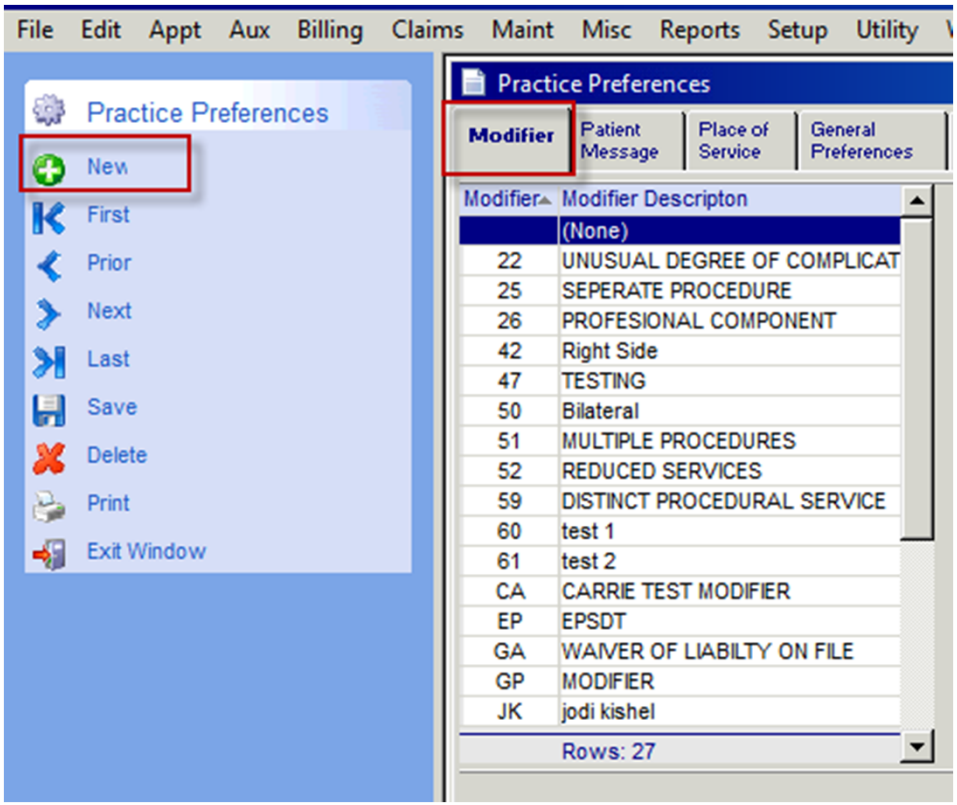






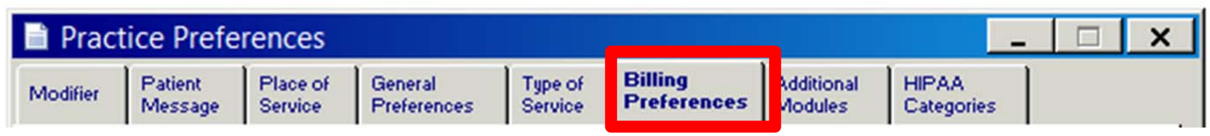
Modifiers needed to exclude from Performance sections:

1P = Medical Exclusion
2P = Patient Exclusion
3P = System Exclusion
8P = NOS Exclusion

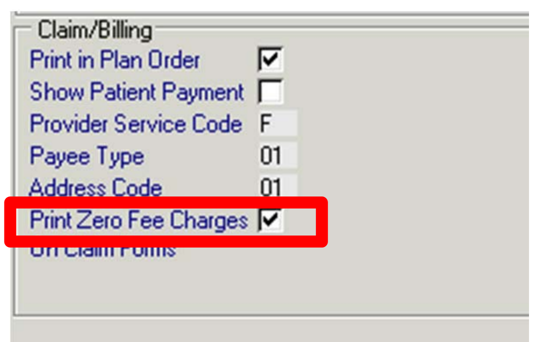


Making Sure PQRS is On Your Claim

Important: In an effort to streamline reporting of QDCs across multiple CMS quality reporting programs, CMS strongly encourages all EPs and practices to bill 2015 QDCs with a $0.01 charge.



If you associated a $0.00 charge to your PQRS codes, make sure your PQRS codes are going out on your claims! Go to Practice Preference>Billing Preferences and then on the bottom left check mark Print Zero Fee Charges.

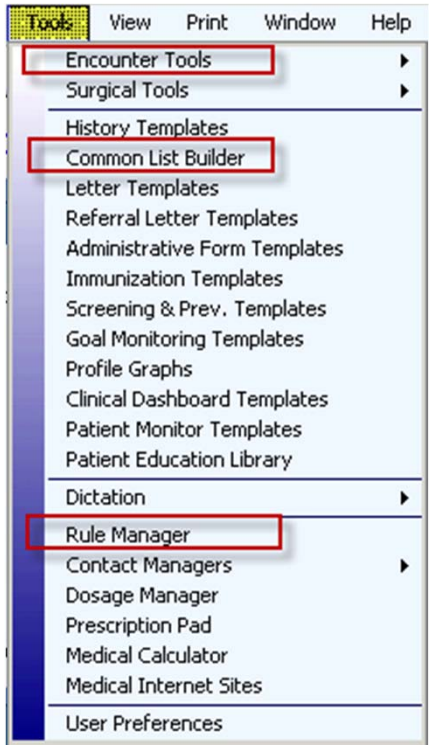


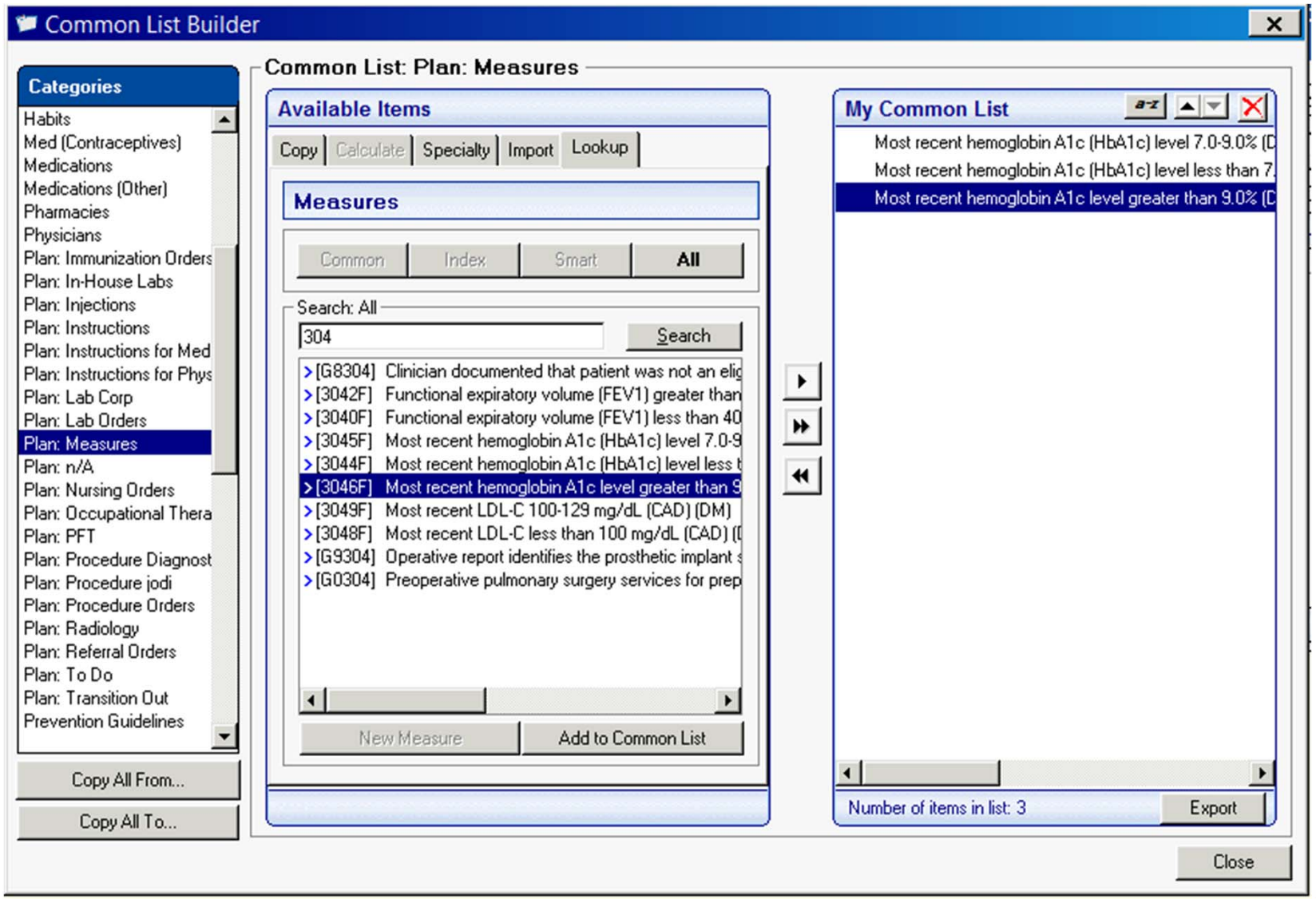
PQRS IN THE EMR

PQRS in the EMR

Areas where you can find Measures Codes in the EMR and incorporate into your templates and encounters:

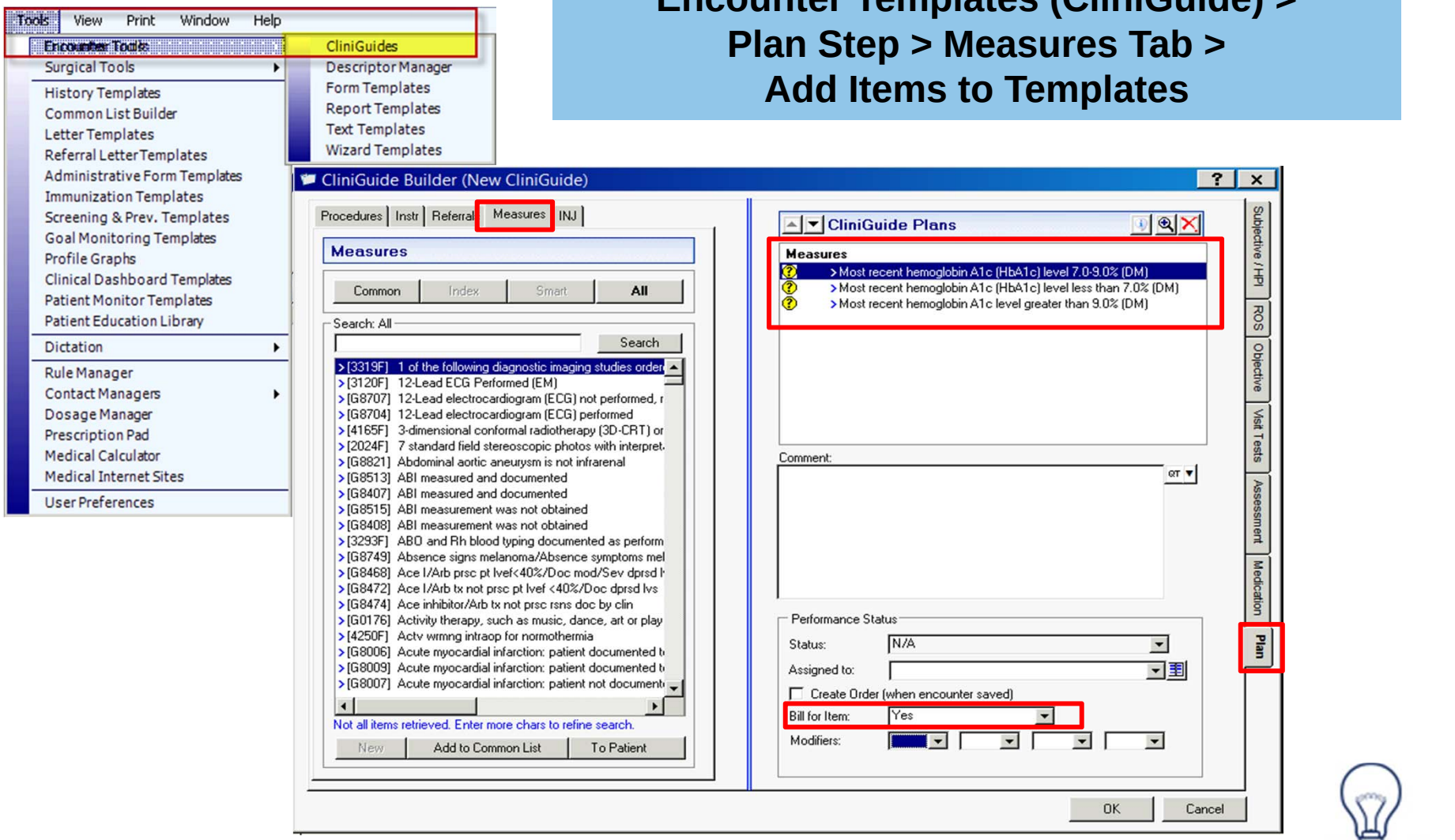
- Common List Builder > Plan: Measures
- Encounter Templates > Plan > Measures Tab
- Incorporate into Rules
- Encounter > Plan > Measures Tab

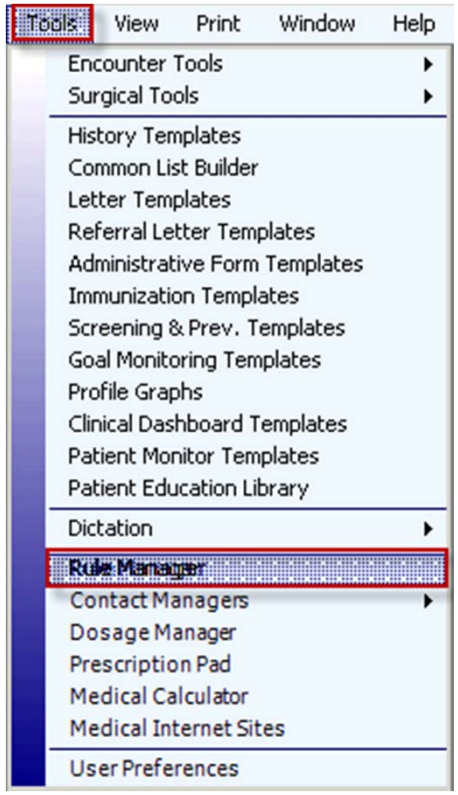


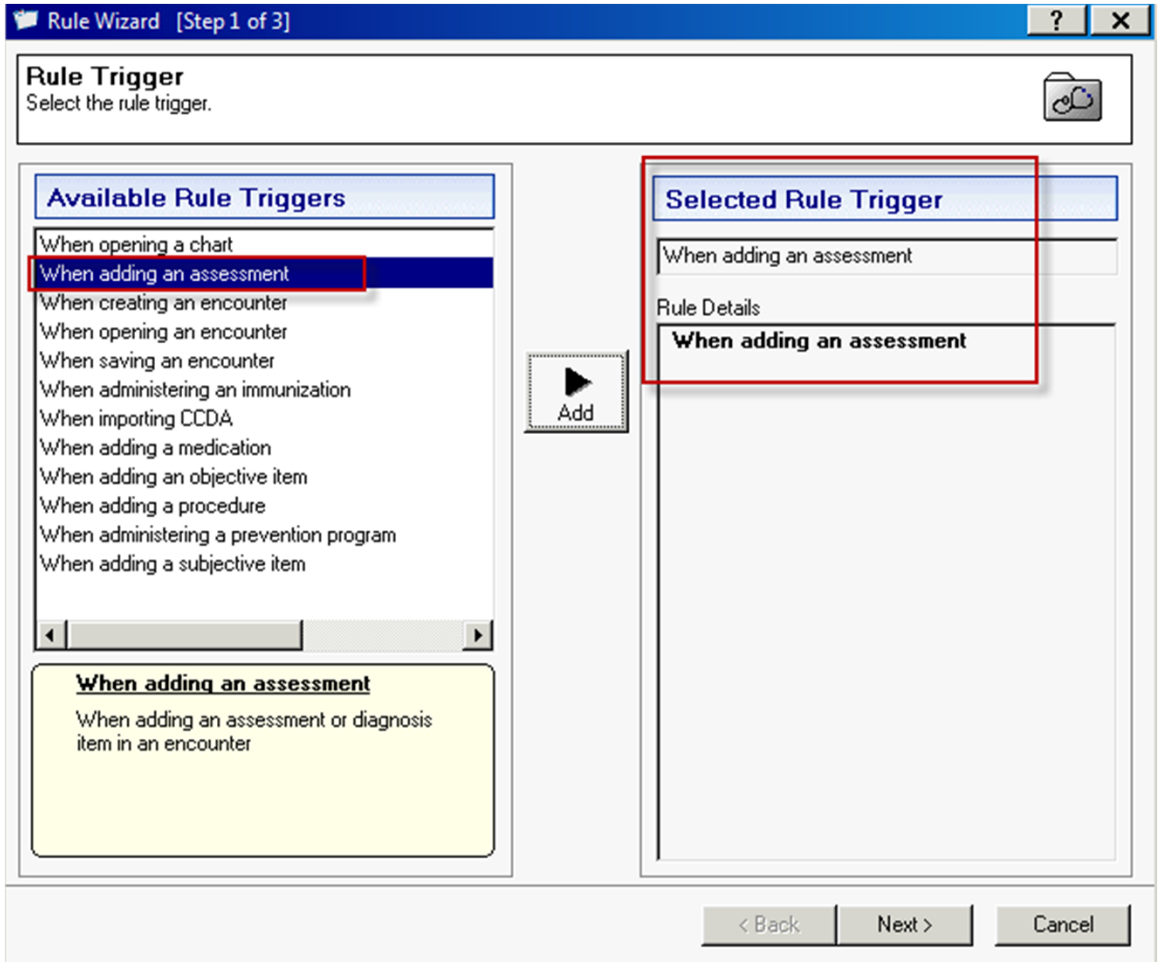


Common List Builder

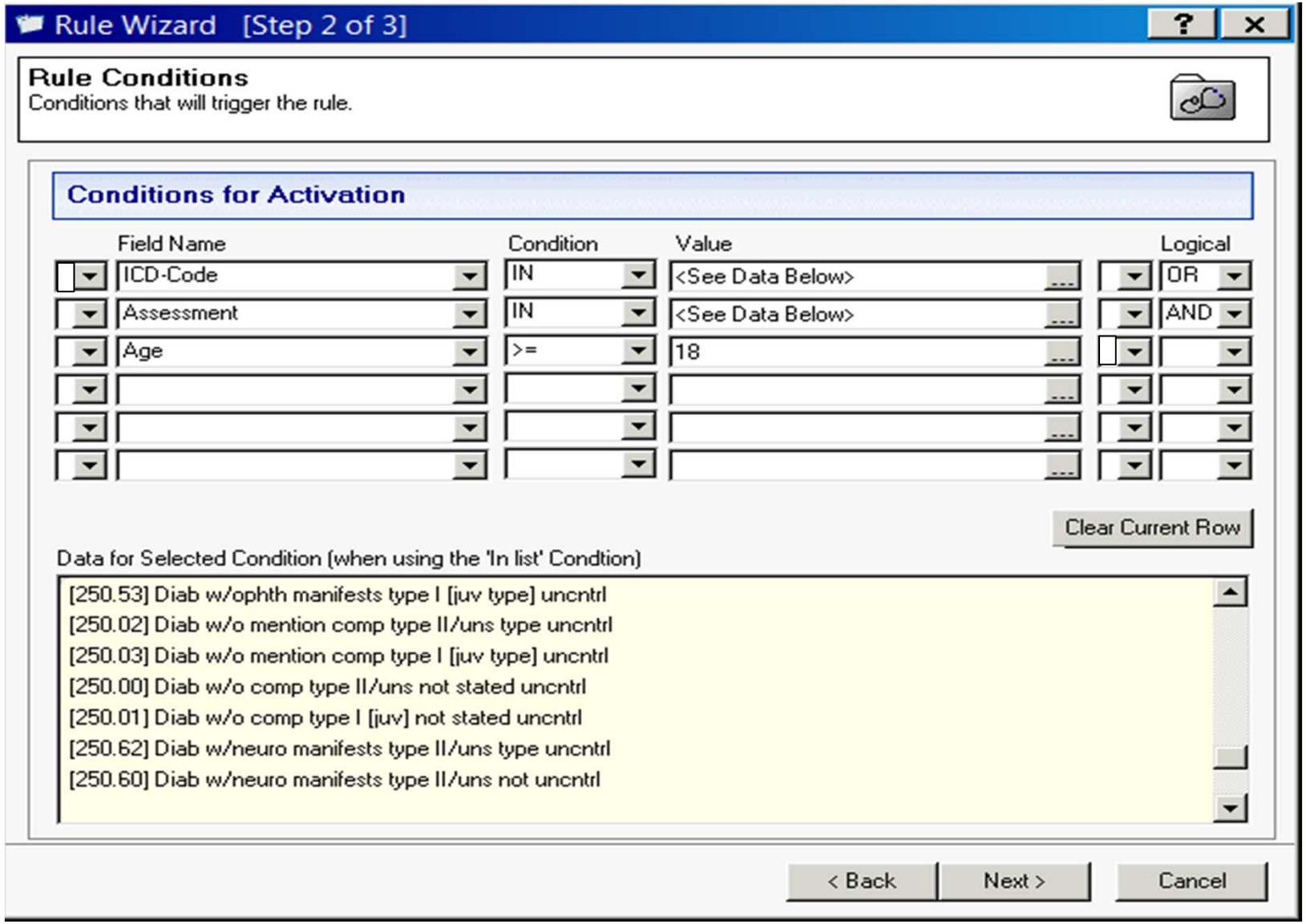
Encounter Templates (CliniGuide) > Plan Step > Measures Tab > Add Items to Templates

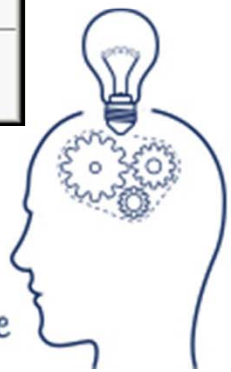




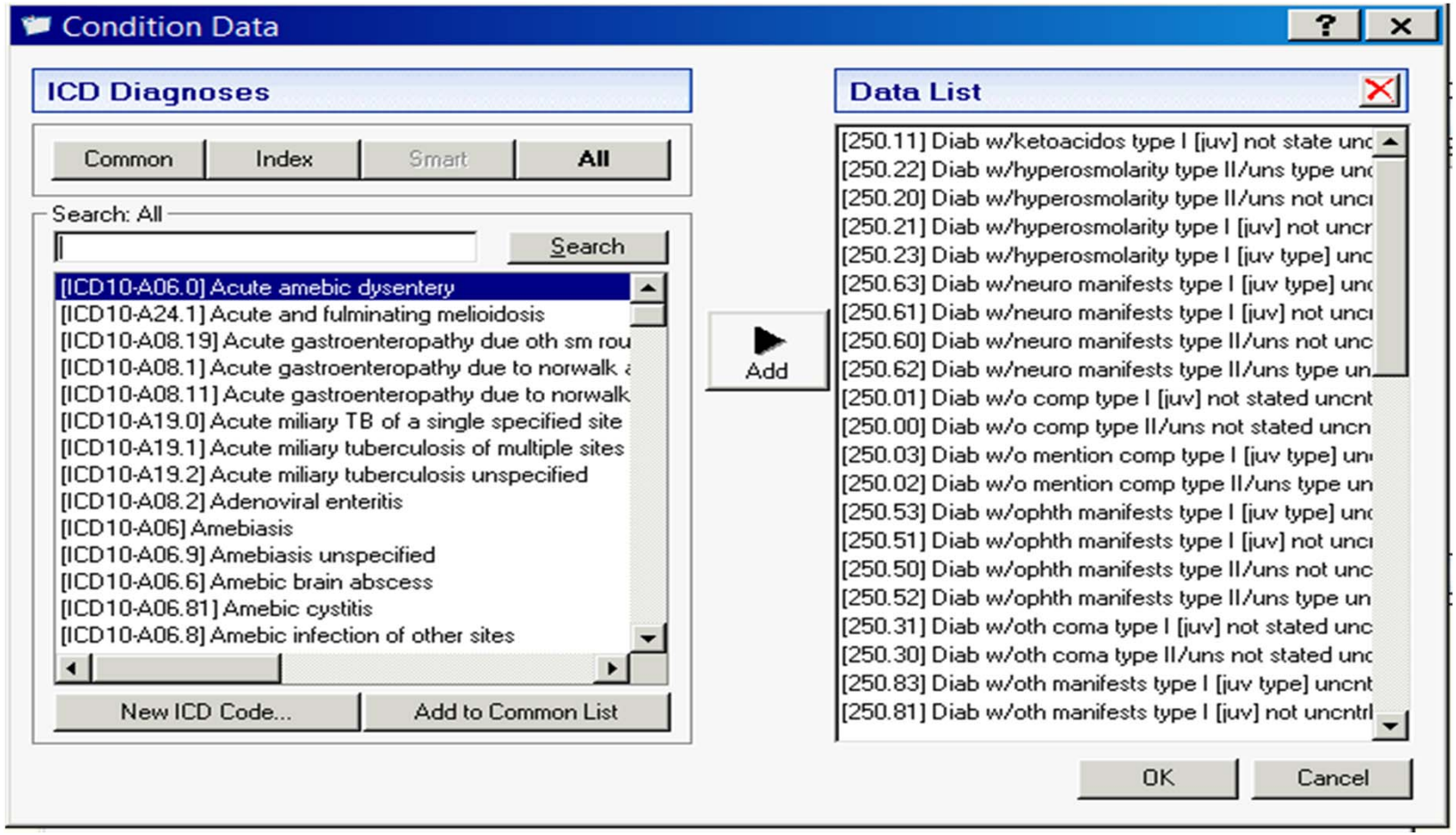


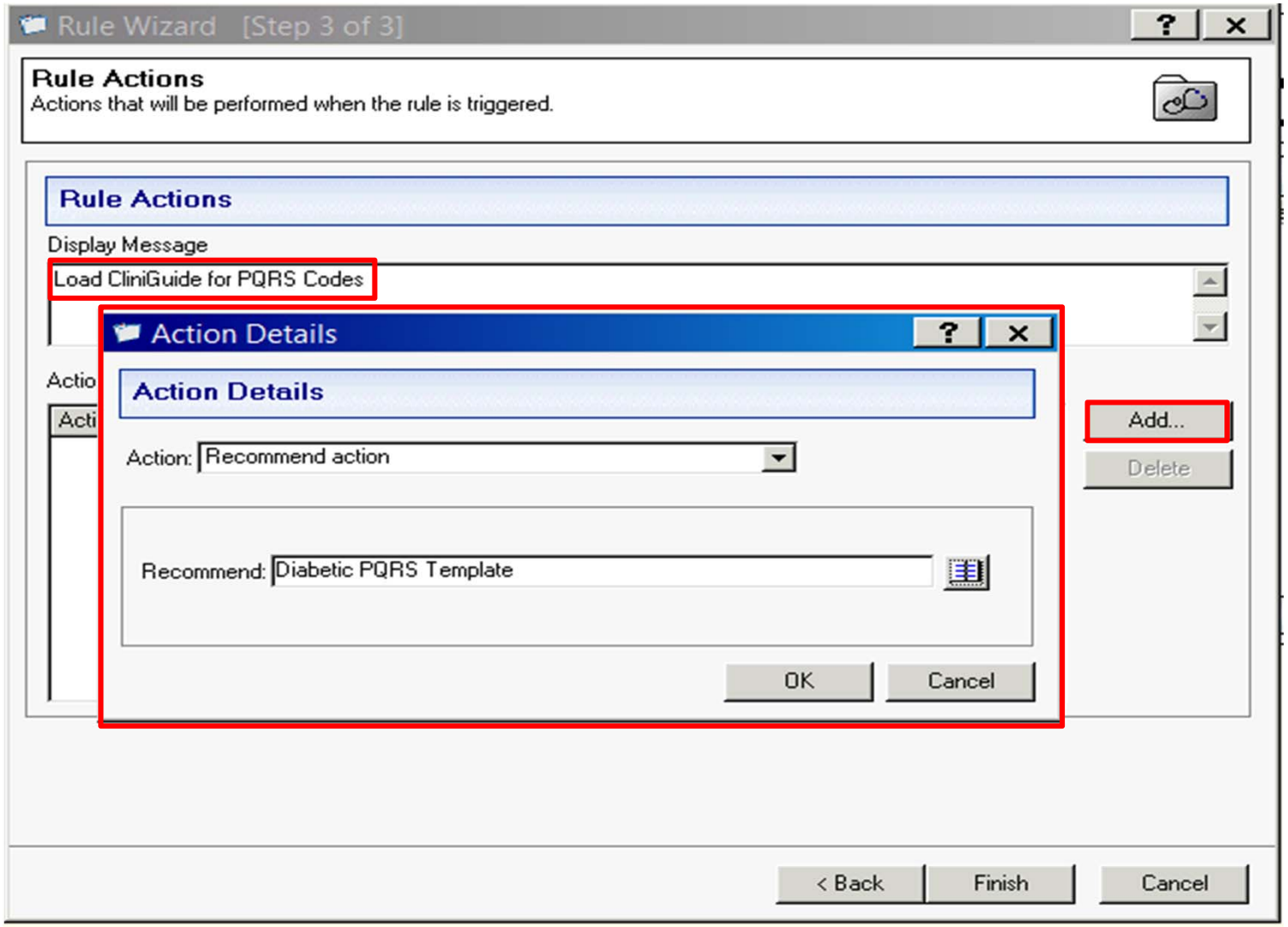
Rule Manager to create rules which will automatically load PQRS Templates

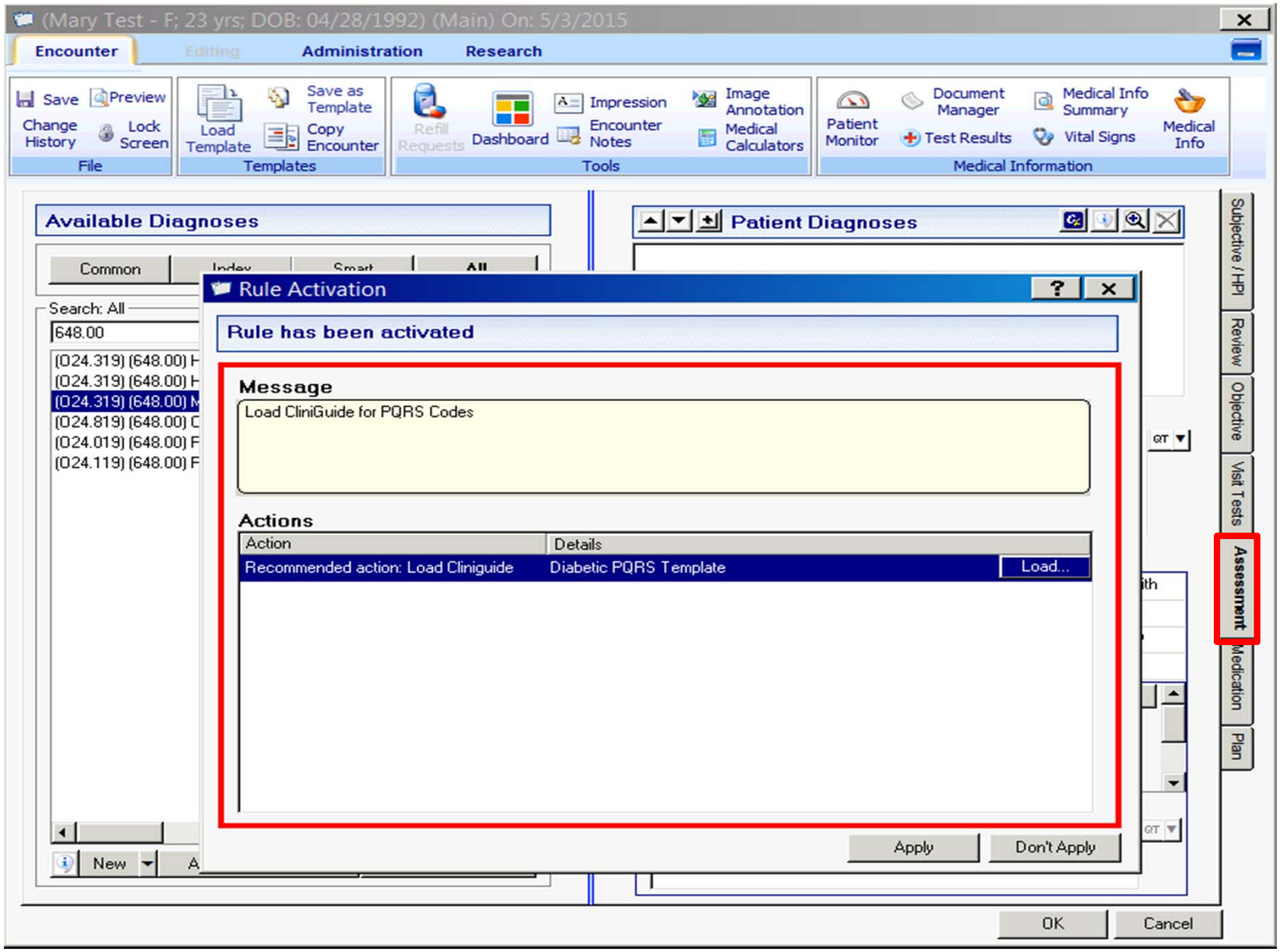

Rule Wizard [Step 2 of 3]
Rule Conditions
Conditions that will trigger the rule.
Conditions for Activation
Field Name
Condition
Value
Logical
ICD-Code
IN
<See Data Below>
OR
Assessment
IN
<See Data Below>
AND
Age
>=
18
Clear Current Row
Data for Selected Condition (when using the 'In list' Condtion)
[250.53] Diab w/ophth manifests type I [juv type] uncntrl
[250.02] Diab w/o mention comp type II/uns type uncntrl
[250.03] Diab w/o mention comp type I [juv type] uncntrl
[250.00] Diab w/o comp type II/uns not stated uncntrl
[250.01] Diab w/o comp type I [juv] not stated uncntrl
[250.62] Diab w/neuro manifests type II/uns type uncntrl
[250.60] Diab w/neuro manifests type II/uns not uncntrl
< Back
Next >
Cancel



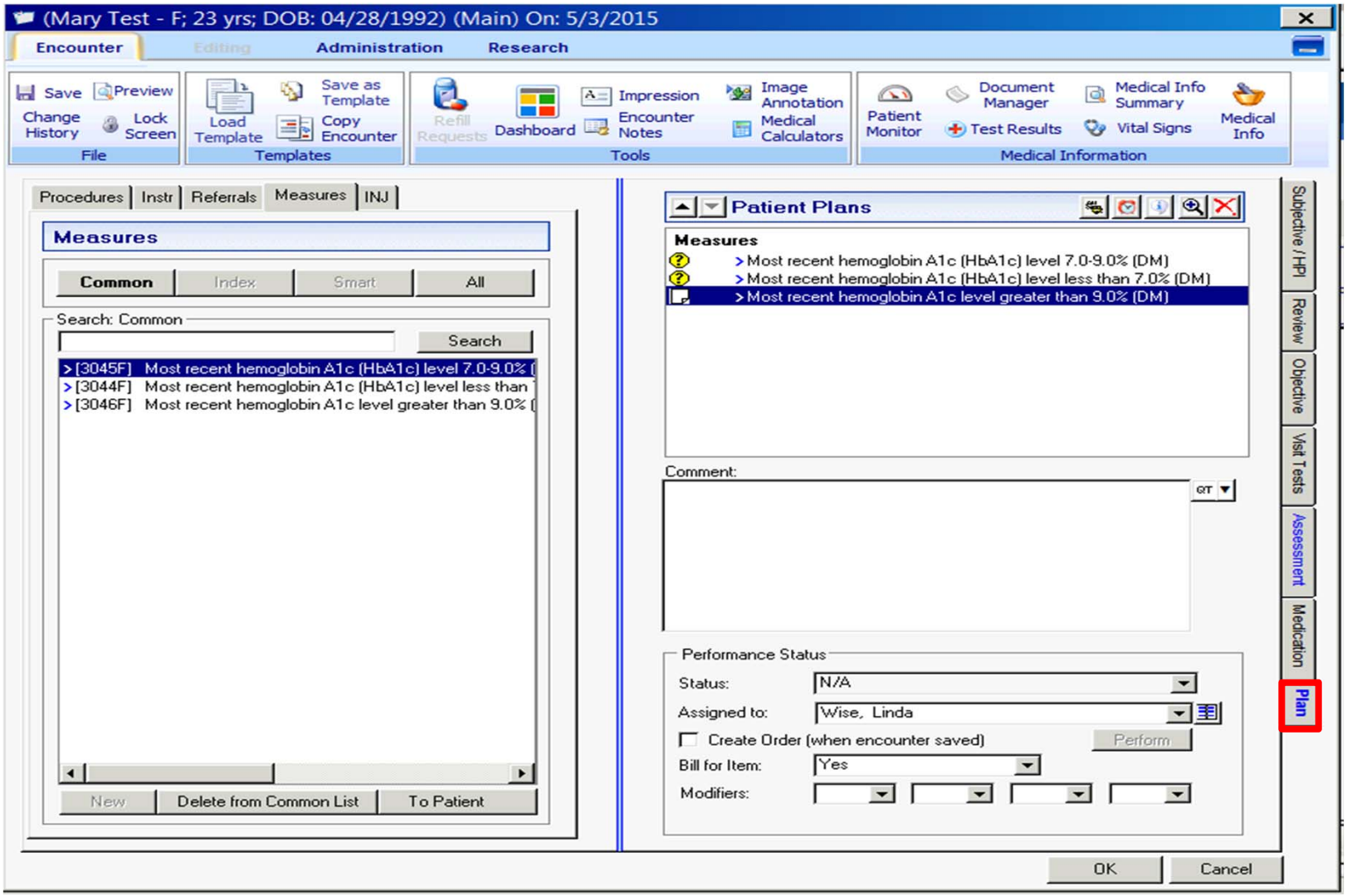
Add all the diagnosis codes for the measure to make sure you capture as many applicable patients as you can!



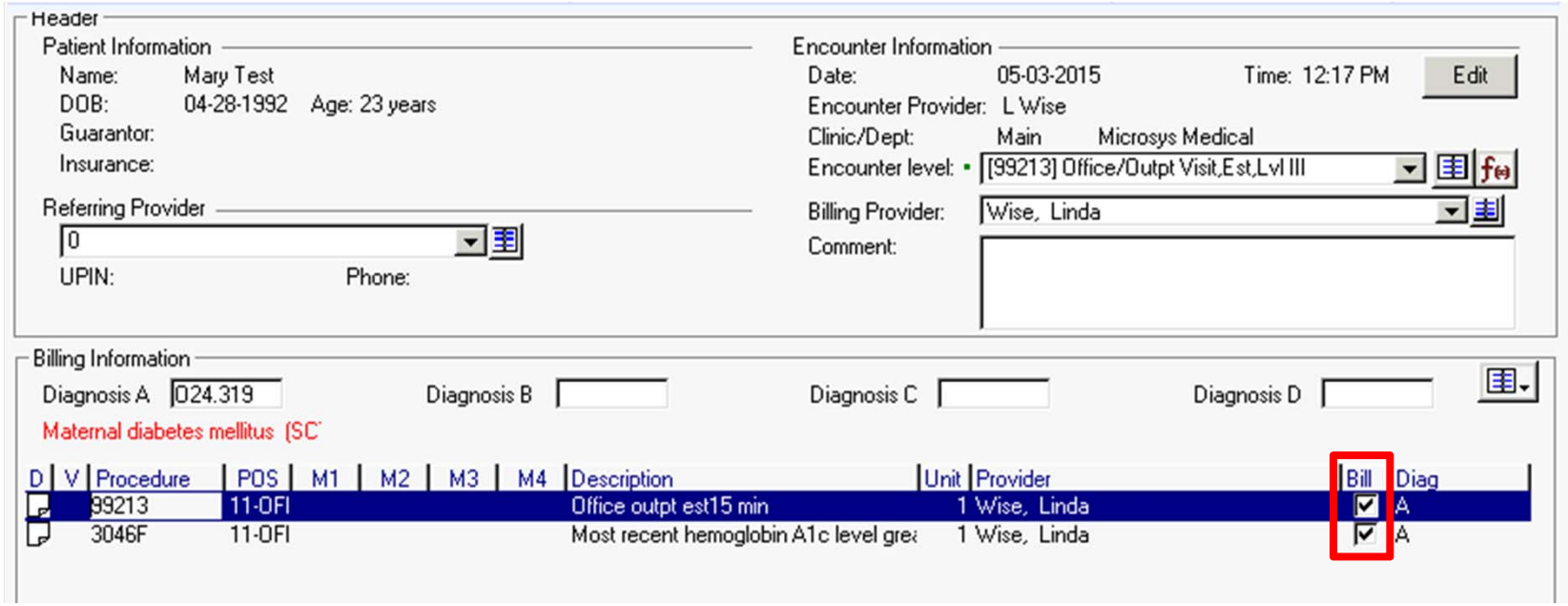

Rule Wizard [Step 3 of 3]
Rule Actions
Actions that will be performed when the rule is triggered.
Rule Actions
Display Message
Load CliniGuide for PQRS Codes
Action Details
Action Details
Action: Recommend action
Recommend: Diabetic PQRS Template
OK
Cancel
Add...
Delete
< Back
Finish
Cancel



In Assessment Step of Encounter



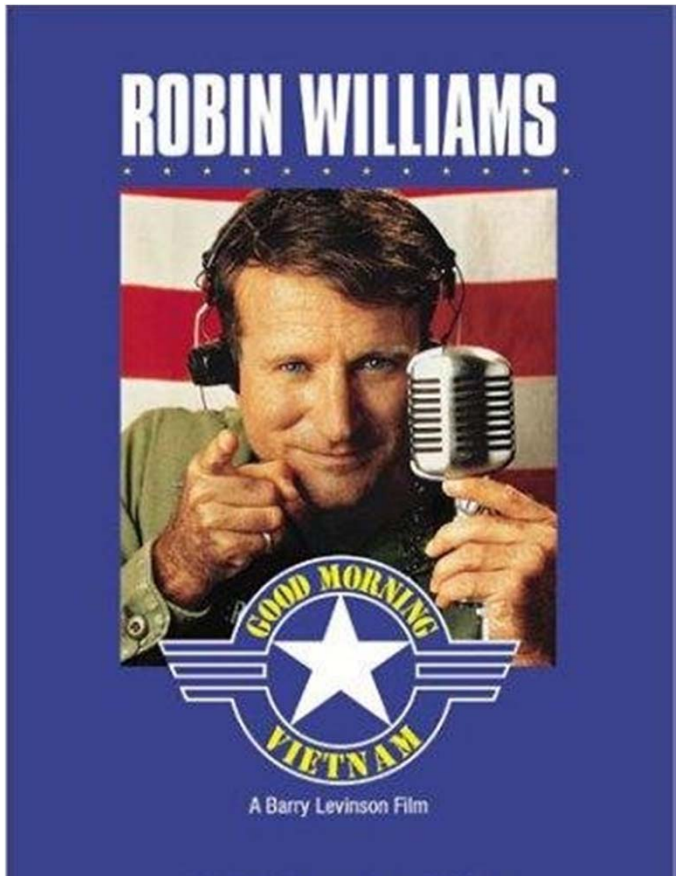
In Plan Step of Encounter



Claims may not be resubmitted only to add or correct QDCs. Claims with only QDCs on them with a zero or $0.01 total dollar amount may not be resubmitted to the MAC. Make sure your QDCs are on your outbound claims!

Bill Builder Screen

All These Acronyms!



"Excuse me, sir.
Seeing as how the V.P.
is such a V.I.P.,
shouldn't we keep the
P.C. on the Q.T.?
'Cause if it leaks to the
V.C. he could end up
M.I.A., and then we'd
all be put out in K.P."

All These Acronyms

- **PQRS – Physician Quality Reporting System**
- **MAV – Measure Applicability Validation**
- **NQF – National Quality Forum**
- **QDC – Quality Data Code**
- **MU – Meaningful Use**
- **CQM – Clinical Quality Measure**
- **EP – Eligible Professional**
- **VBM – Value Based Payment Modifier**
- **MAC – Medicare Administrative Contractor**

ADDITIONAL RESOURCES FOR PQRS

Additional Resources for PQRS

For more information regarding the Physician Quality Reporting System (PQRS), including a listing of all Individual and Group Measures, Applicable codes, etc., please visit the CMS Website at the links below:

CMS PQRS Webpage: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html

List of Eligible Professionals: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/Eligible_Professionals03-08-2011.pdf

PQRS Quality Measures Info: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/MeasuresCodes.html

THANK YOU FOR ATTENDING QUALITY INITIATIVES (PQRS)