Medicare 2014 PQRS

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What is PQRS?
(Aside From Alphabet Soup)

PQRS is a reporting program that uses a combination of incentive payments (rewards) and payment adjustments (i.e. penalties) to promote reporting of quality information by eligible professionals (EPs):
- Includes patients with Railroad Medicare
- Includes patients for whom Medicare is the secondary payer
- Does NOT include Medicare Advantage patients

How Do I Register?

You do not need to “sign up” or “register” to participate in PQRS.
Am I Eligible To Participate?

- Clinical Psychologists are eligible
- Nurse Practitioners are eligible
- Clinical Social Workers are eligible
- Psychiatrists are eligible

Two Reasons To Participate in PQRS

1. To achieve the incentive payment
   - The 2014 incentive payment is 0.5%
   - However, the sequester reduces it by 2%
   - Here's how it works: An Eligible Professional has $100,000 in allowed charges. The 0.5% (0.005) incentive = $500. The $500 incentive will be reduced by 2% ($500 x 0.02 = $10), so the total incentive payment with sequestration would be $490. This 2% reduction will be applied to any PQRS incentive payment for a reporting period that ends on or after April 1, 2013.

PQRS requirements to earn incentive in 2016

- In 2014, an Eligible Professional / group practice must report 9 or more measures covering at least 3 National Quality Strategy (NQS) domains for incentive purposes.
- At least 50% of the Eligible Professional’s Medicare patients
- The NQS domains associated with the measures are as follows:
  - Patient Safety
  - Person and Caregiver-Centered Experience and Outcomes
  - Communication and Care Coordination
  - Effective Clinical Care
  - Community/Population Health
  - Efficiency and Cost Reduction
If you fall short, there might be hope

Eligible Professionals that submit quality data for **only 1 to 8 PQRS measures** for at least 50% of their patients, **OR** that submit data for **9 or more PQRS measures across less than 3 domains** for at least 50% of their patients will be subject to Measure-Applicability Validation (MAV).

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

If you fall short... English, Please?

The MAV process takes a look at the measures applicable to the Eligible Professional’s specialty and the EP’s claims history and decides if the EP “could have” reported on the required number.

- If the MAV process determines that there was no way the EP could have reported on the required number, the incentive may be granted.
2. To avoid the 2016 penalty
- The 2016 penalty is 2% of the Medicare Physician Fee Schedule.
- The PQRS payment adjustment applies to ALL of the eligible professional's Part B covered professional services under the Medicare Physician Fee Schedule (PFS)

PQRS requirements to avoid penalty in 2016

- Satisfactorily report and earn the 2014 PQRS Incentive.
  OR
- Report at least 3 measures covering 1 NQS domain for at least 50% of the EP's Medicare Part B FFS patients.
  - EPs who satisfactorily submit Quality Data Codes for only 1 or 2 PQRS measures for at least 50% of their patients or encounters eligible for each measure will be subject to the MAV process to determine whether an EP should have submitted additional measures.
PQRS Reporting Methods

- Electronic Health Record that is “certified”
  - Or, “Certified” data submission vendor

- PQRS registry
  - Or, participation through a Qualified Clinical Data Registry (QCDR)

- Claims
  - (PQRS Codes are reported on the 1500 form or electronic equivalent)
    Free!

PQRS Reporting Methods

- GPRO = Group Practice Reporting Option
  - PQRS defines a group practice as a single Tax Identification Number (TIN) with 2 or more individual Eligible Professionals that have reassigned their billing rights to the TIN.

  - Group practices may choose to report PQRS quality data via:
    1. GPRO Web Interface
    2. Qualified PQRS Registry
    3. EHR Direct Product that is CEHRT
    4. EHR data submission vendor that is CERT
    5. CMS-certified survey vendor
  - Must register by September 30, 2014

Ya Gotta Wonder...

Medicare is phasing out the claims-based reporting option. Each year there will be fewer measures available to report using the claims-based method.

Don’t ask me why!
4/7/2014

PQRS “Numerator”

* Describes the clinical action required by the measure for reporting & performance

PQRS “Denominator”

* Describes the eligible cases for a measure
  ➢ The eligible patient population associated with a measure’s numerator
Where Do I Find The Measures?


Click on the zip file: 2014 PQRS Individual Claims Registry Measure Specification Supporting Documents

PQRS reporting frequency

Each measure specification includes a reporting frequency for each eligible patient seen during the reporting period. Reporting period = calendar year.
- **Patient Process**: Report a minimum of once per reporting period per individual eligible professional.
- **Patient Periodic**: Report once per timeframe specified in the measure for each individual eligible professional during the reporting period.
- **Episode**: Report once for each occurrence of a particular illness/condition by each individual eligible professional during the reporting period.
- **Procedure**: Report each time a procedure is performed by the individual eligible professional during the reporting period.
- **Visit**: Report each time the patient is seen by the individual eligible professional during the reporting period.

PQRS Claim-Based Quality Data Codes (QDC)

- QDCs are non-payable Healthcare Common Procedure Coding System (HCPCS) codes comprised of specified CPT Category II codes and/or G-codes that describe the clinical action required by a measure’s numerator.
- CPT II codes serve to encode the clinical action(s) described in a measure’s numerator. CPT II codes consist of five alphanumeric characters in a string ending with the letter “F.”
Exclusion Modifiers: indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record.

1P: Performance measure not performed due to medical reasons, such as:
- Not indicated (absence of organ/limb, already received/performe, other)
- Contraindicated (patient allergy history, potential adverse drug interaction, other)
- Other medical reasons

2P: Performance measure not performed due to patient reasons, such as:
- Patient declined
- Economic, social, or religious reasons
- Other patient reasons

3P: Performance measure not performed due to system reasons, such as:
- 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
Exclusion Modifiers: indicate that an action specified in the measure was not provided due to medical, patient, or system reason(s) documented in the medical record.

- Exclusion Modifiers:
  - 3P: Performance measure not performed due to system reasons, such as:
    - 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

Modifier 8P: (you don't want to use this!)
- Means an action described in a measure is not performed and the reason is not specified.
- If you append a modifier 8P to a QDC, you will NOT get credit!!

Claim Rules
QDCs must be reported:
- On the claim(s) with the denominator billing code(s) that represents the eligible Medicare Part B encounter
- For the same beneficiary
- For the same date of service (DOS)
- By the same eligible professional (individual rendering NPI) that performed the covered service, applying the appropriate encounter codes (ICD-9-CM, CPT Category I or HCPCS codes). These codes are used to identify the measure's denominator.
Claim Rules

- QDCs must be submitted with a line-item charge of one penny ($0.01) at the time the associated covered service is performed.
- The line item charge should be $0.01 – the beneficiary is not liable for the penny.
- When the $0.01 is submitted to the Medicare Administrative Contractor (MAC), the PQRS code line will be denied but will be tracked in the National Claims History (NCH) for analysis.
- The individual rendering/performing NPI must be placed on each line item (box 24J).

Better get it right the first time...

- Claims may NOT be resubmitted for the sole purpose of adding or correcting QDCs.
- If a denied claim is subsequently corrected through the appeals process to the MAC, with accurate codes that also correspond to the measure’s denominator, then QDCs that correspond to the numerator should also be included on the resubmitted claim as instructed in the measure specifications.
On The Medicare Remittance

- The RA/EOB denial code N365 is your indication that the PQRS codes were received into the CMS National Claims History (NCH) database.
- N365 reads: “This procedure code is not payable. It is for reporting/information purposes only.”
- The N365 denial code is just an indicator that the QDC codes were received. It does not guarantee the QDC was correct or that incentive quotas were met.

You Don’t Have 1 Year To File

- The Medicare “timely filing” period for claims is 1 year from the date of service.
- However, for purposes of PQRS, you do not have 1 year to file:
  - Claims processed by the MAC must reach the national Medicare claims system data warehouse (National Claims History file) by February 27, 2015 to be included in the analysis for 2014.

Where to Call for Help

- QualityNet Help Desk:
  - 844-286-9227  (TTY 877-713-6223)
  - 710 S. 470 E. 1st Flr. Salt Lake City, UT 84101
  - Newsletter@qualitynet.org

- CMS Incentive Program Questions:
  - 888-734-4631 (Toll Free)

- Provider Contact Center:
  - Questions on issues of CMS Incentive Program Incentive Payment during
    - 800-855-4515
    - See Provider Center Directory at

- DRG Incentive Program Information Center:
  - 888-734-4631 (Toll Free)
All you need to know about ICD-10 in 10 minutes

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What is ICD-10?

The full title, in all its glory:
The International Statistical Classification of Diseases and Related Health Problems, 10th revision.
Published by the World Health Organization.
OMG.

Some of the uses of ICD-10

- Morbidity & Mortality statistics
- Public Health Uses
- Medical Research
- Reimbursement
- Standardization of electronic medical records
  - Treatment documentation
  - Better coordination of care among treating professionals if they all use the same "language"
It is an international “standard diagnostic tool for epidemiology, health management and clinical purposes.”

http://www.who.int/classifications/icd/en

The full U.S. version of the ICD-10, called the ICD-10 CM (Clinical Modification), has at least 68,000 codes.

Compare that to the ICD-9-CM, which has a paltry 17,000 codes.

ICD-10 is not new; it was completed in 1990. In fact, the ICD-11 is slated to be published in 2017.

In 2008, U.S. adoption of the ICD-10 was originally mandated for October 1, 2011.

There have been several implementation delays with the new deadline set for October 1, 2015.
Actually, not for billing purposes, you don’t.
(Not if you want to get paid, anyway. Unless it is an EAP.)

CMS mandates the use of ICD-9-CM codes for diagnosis on claim forms.

Until October 1, 2015

On this date, the entire U.S. healthcare industry is required to adopt ICD-10.

Fortunately, the new DSM-5 crosswalks to both ICD-9 and ICD-10 diagnosis codes.

Keep Calm and Don’t Throw Away Your DSM

Keep Calm and Don’t Throw Away Your DSM…
In ICD-10, the section on Mental / Behavioral Disorders is Chapter 5. (wonder who thought that up?)

In coding terms, the letters/numbers you will become familiar with over the next few years are F00-F99.

Just one chapter: 5 (no, not DSM-5)

Chapter 5 at a glance

* F00-F09 Organic Mental Disorders
* F10-F19 Disorders Due To Substance Use
* F20-F29 Schizophrenia & Delusional
* F30-F39 Mood Disorders
* F40-F48 Stress-related & somatoform
* F50-F59 Syndromes associated with physical factors

Chapter 5 at a glance

* F60-F69 Adult personality/behavior disorders
* F70-F79 Mental retardation
* F80-F89 Disorders of psychological development
* F90-F98 Disorders with onset in childhood/adolescence
* F99 Unspecified mental disorder
DSM-V “conscientious objector”?

Or just don't want to spend about $125-$150 for the full version...?

There is a FREE website that can convert the ICD-9-CM codes in your DSM-IV-TR to ICD-10-CM codes come the fateful day when ICD-10 is mandatory.

www.icd9data.com

Free is good...

And if all that weren't bad enough, now there's a new claim form too!?

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**Background (brief)**

- The NUCC (National Uniform Claim Committee) began working on the new form in 2009.
- The goal was to align the paper form more closely with updates that have been made to electronic claims standards.
- The new form was approved in February 2012 and is referred to as the Version 02/12 CMS-1500 form.
- The new form went into use on April 1, 2014.

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**What are the major changes?**

- The QR code at the top for easy identification of the 02/12 version.
- Removed references to social security #’s
- Box 8 (marital & employment status) removed
- Box 9B & 9C removed
- 11B is now “other claim ID”
- Changes to boxes 14 & 15 (not relevant to us)

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**What are the major changes?**

- Box 17 now has a 2-digit qualifier before the name of the ordering/referring/supervising provider to tell the payer what role the provider is performing.
- Ok, here’s where it really gets critical…
What are the major changes?

- Box 21 (diagnosis listing) now has room for 12 diagnoses. This is to accommodate the transition to ICD-10.
- There is a little field in box 21 that says “ICD Ind.” This is to tell the payer which version of the ICD you are using.
  - If ICD-9, enter a 9
  - If ICD-10, enter a 0

What are the major changes?

- The diagnoses listed in box 21 are now lettered instead of numbered.
- And in box 24E, the “diagnosis pointer” must now be the letters of your diagnosis codes. Note that only 4 will print even though you have room for 12 diagnosis codes.
- Box 30 “balance due” has been removed.