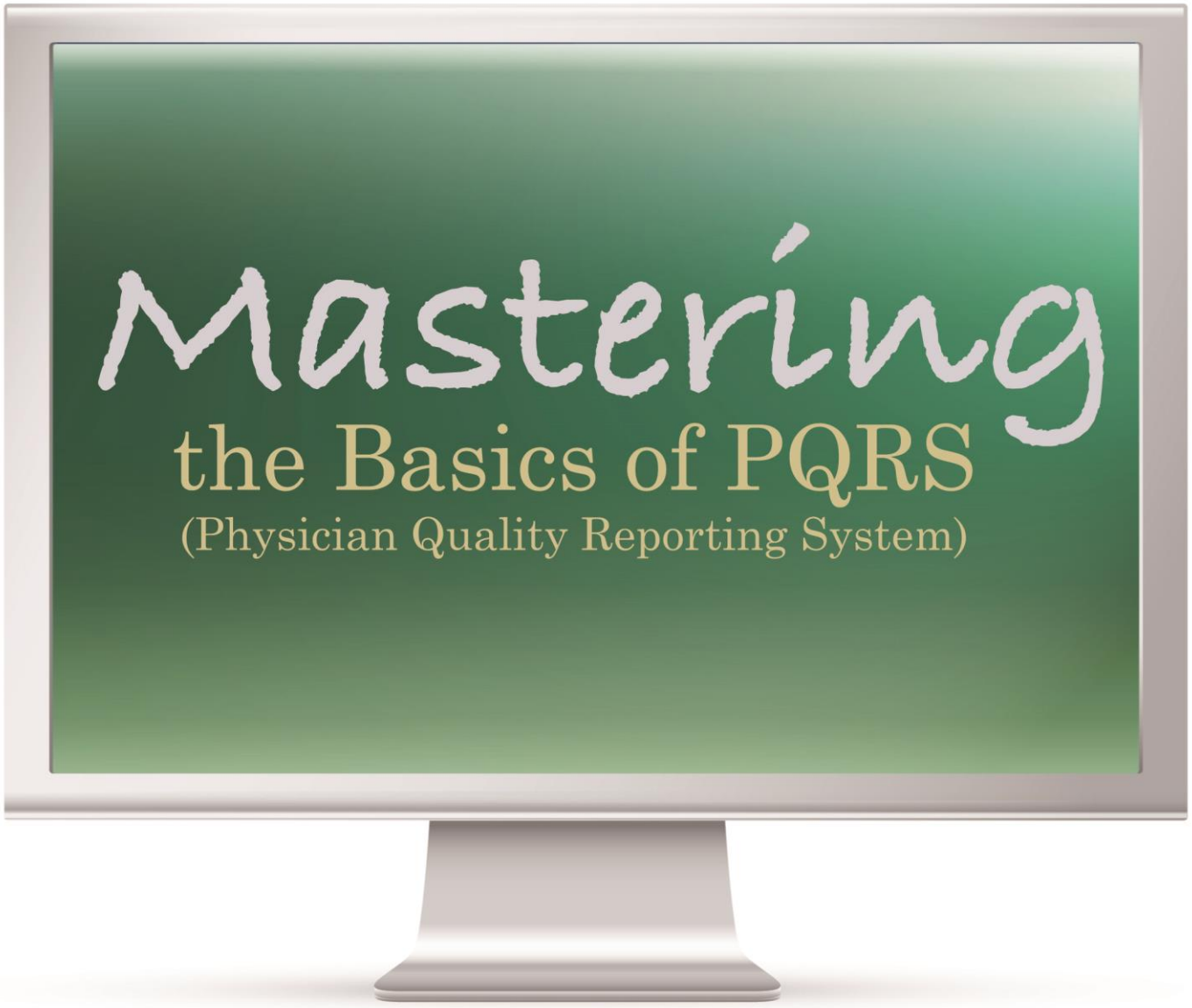

American Urological Association

Mastering the Basics of PQRS

Agenda

- Introduction
- Module 1 – Overview of PQRS
- Module 2 – Reporting Options
- Module 3 – Navigating through Measures
- Module 4 – Successful Reporting
- Module 5 – Obtaining and Understanding the Scorecard
- Module 6 – Tips for 2016 and Beyond

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Mastering the Basics of PQRS

Introduction

Welcome to the AUA's instructional program about the Medicare Physician Quality Reporting System or PQRS (formerly known as the Physician Quality Reporting Initiative or PQRI). This tutorial will assist urologists and the members of their care team to understand and carry out the mechanics of quality reporting as designed by the Centers for Medicare and Medicaid Services (CMS).

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Mastering the Basics of PQRS

Introduction

For many experienced in the healthcare delivery system, the tenets of PQRS are not intuitive and only through focused learning and practice in reporting will the skills become second nature. Therefore, this tutorial has built-in modules to allow users to master the skills of PQRS reporting at their own pace. Each module contains review questions to confirm the main points of the training.

We acknowledge that PQRS is not solely an outcomes measurement tool; however, urologists who treat Medicare patients will find the mastery of PQRS to be very helpful in equipping them for the future. In 2017, CMS will launch the Merit-based Incentive Payment System (MIPS) which includes a version of PQRS, that is more outcomes focused.

The content for this instructional session was developed by members of the American Urological Association staff.

All comments or suggestions for the improvement of this material are welcome. Feel free to send those to pqrs@auanet.org in order to help you succeed at PQRS.

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Module 1 – Overview of PQRS

How Did PQRS Begin?

Tax Relief and Health Care Act of 2006 Division B Title I, Section 101 provides CMS the statutory authority for PQRS and defines:

- Eligible professionals
- Quality measures
- Form and manner of reporting
- Determination of satisfactory reporting
- Bonus payment calculation
- Validation
- Appeals

Mastering the Basics of PQRS

Module 1 - Annual Changes to PQRS

Each year CMS updates PQRS in the Medicare Physician Fee Schedule Rule. The contents of this tutorial reflect the changes in the 2016 rule.

The reporting done in 2016 affects your 2018 Medicare payment.

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Module 1 – Overview of PQRS

PQRS is the first CMS national program to link the reporting of quality data to physician payment.

PQRS is a preliminary step to transition US healthcare away from the current "fee-for-service" payment model. PQRS uses value-based purchasing, which is aimed at controlling healthcare costs by reimbursing services that are shown to improve quality of care.

Through PQRS, eligible professionals who participate in the program transmit data to CMS regarding the quality measures used in the care for their Medicare Part B patients. CMS believes the data reported provides information about the care given/received in order to improve the overall delivery and coordination of care.

Module 1 – Overview of PQRS

Who is eligible to participate in PQRS?

- Anyone who holds a National Provider Identifier (NPI) and provides service to Medicare Part B beneficiaries. This includes physicians and other healthcare professionals such as nurse practitioners, physician assistants, and therapists.

Mastering the Basics of PQRS

Module 1 – Overview of PQRS

What are the benefits of PQRS participation:

- Providers can avoid the payment adjustment/penalty (2% for 2016 reporting) for not participating by successfully reporting on 9 measures across at least three domains of care for 50% of applicable patients.
- Providers avoid a further penalty through the Value-Based Modifier, which uses PQRS data. Those not reporting PQRS automatically get the highest penalty (on top of the PQRS penalty).
- Providers will receive confidential comparative feedback on the care provided in order to support quality measurement and improvement.

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Module 1 – Overview of PQRS

What is a Measure?

Mastering the Basics of PQRS

Module 1 – Overview of PQRS

- A measure is simply a way to evaluate provider performance in treating a patient for a particular condition.
- Most measures are derived from clinical guidelines such as those created by the AUA Guidelines Department.
- The PQRS program is strictly associated with treatment of Medicare Part B beneficiaries. Therefore, PQRS measures pertain to conditions routinely found on Medicare fee-for-service claims.

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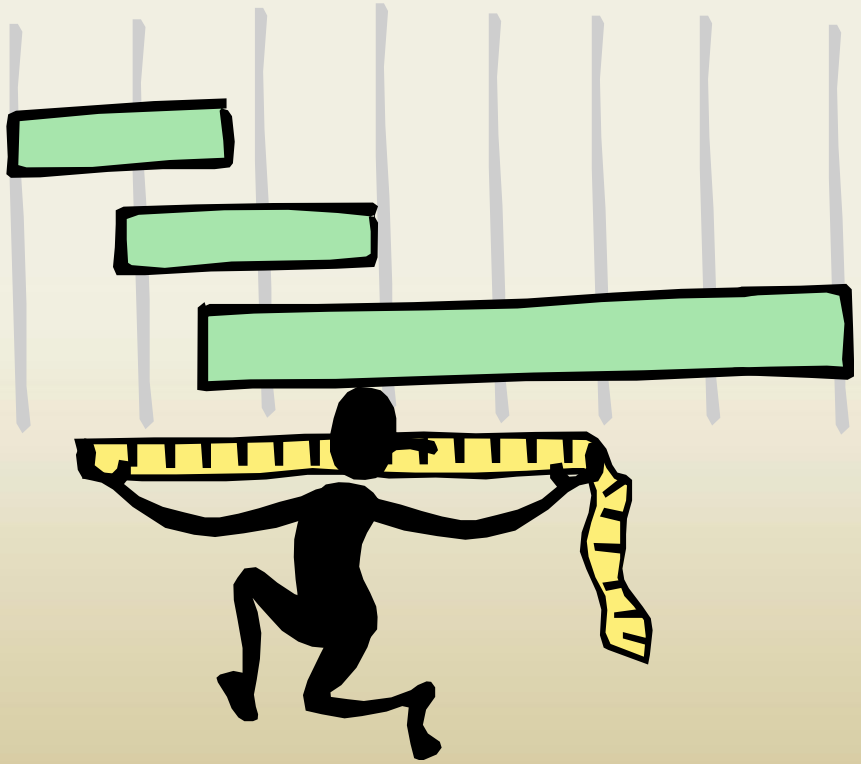
Module 1 – Overview of PQRS

- CMS determines a provider's success rate for a particular measure as a percentage or a fraction.
- Each measure has two components—a denominator and a numerator.

  Numerator (patients receiving specific services - which services to report)

  Denominator (patient population of interest - which patients to report)

- The denominator is the group of patients you are interested in measuring. The numerator is the care provided for actions taken for this group of patients. We will discuss this in detail in Module 3.



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Mastering the Basics of PQRS

Module 1 – Overview of PQRS

The government and other payors believe that reporting on quality will eventually change the way you practice medicine. The logic is:

- Evidence-based measures are developed by healthcare professionals.
- Providers will report on the measures developed by their peers or are applicable to them.
- Reporting on quality should lead to activities that change underlying behavior.
- The collective efforts of individual practices result in better care nationally.

In other words, payors are motivated to incorporate quality reporting into their payment systems in order to change provider behavior for the benefit of the patient and the overall improvement of medical care.

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Module 1 – Overview of PQRS

It is important to understand that CMS will penalize providers who are not successful in PQRS—either because they failed to participate or because they reported incorrectly.

Reporting is primarily on either the processes of care or the existence of important infrastructure that is expected to contribute to improved care. However, CMS is placing greater emphasis on outcomes-based measures.

Module 1 – Overview of PQRS

There are strategic decisions to make.

- A certain amount of patience is required due to the complexity of the processes involved, and there must be a commitment to ultimately become successful no matter how difficult the first steps turn out to be.

What reporting option would be best for my practice or me ?

- Do you want to report as an individual or as a group?
- Several options are available under each to allow you to select what would be simplest for you.

Do the measures fit your practice patterns?

Do I have:

- Sufficient patient populations to fit denominator specifications
- Information tracking available to capture all numerator services
- Delegated processes to avoid work flow disruption

Is there tolerance for glitches by you or CMS?

Is there dedication to turn challenges into successes?

Module 1 – Overview of PQRS
Start up planning session

- Your entire staff should be vested in this program. So, it is important to hold a start up planning
- Invite key staff to attend
  - Physicians
  - Nurses and MAs
  - Receptionists
  - Coding and billing staff
  - Management team
- Select the reporting option that fits your situation
- Review comprehensive list of current year measures as well as those targeted for urology
- Select measures most appropriate for your practice
- Discuss patients and actions that satisfy each measure you will use
- Identify gaps in processes and documentation
- Plan training regimen for all concerned
- Establish launch date

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Module 1 – Overview of PQRS

PQRS Preparation Steps

- Decide which reporting option to use.
- Select measures you will use and plan a method to gather quality data for reporting.
- Clarify what part each staff member will play in the reporting process.
- Assign tasks and provide instruction.
- Consider using tools (both electronic and other) for capturing data.
- Discuss system capabilities with software vendors, third party billing vendors/clearinghouses, etc.

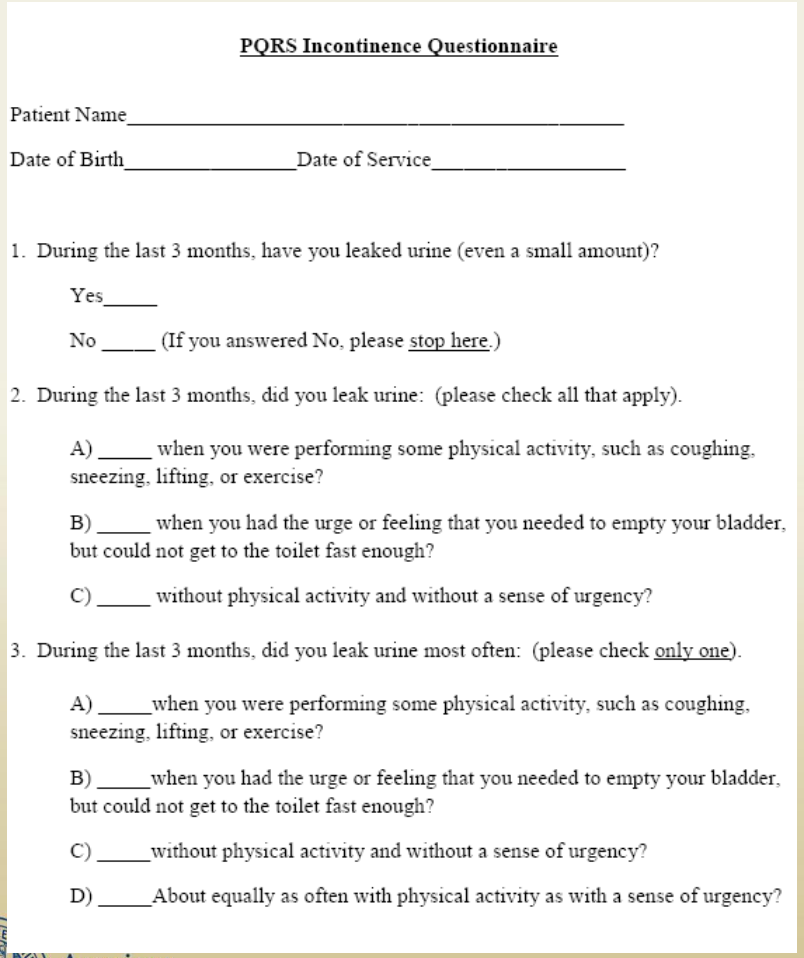
Module 1 – Overview of PQRS

New for 2016 - **Only select 9 measures for reporting**

Previously CMS and the AUA recommended selecting a few extra measures. If your reporting wasn't quite perfect on a few measures, hopefully your scores on the other measures would make up for that. However, with the advent of the Value-Based Modifier you are held liable for all reporting you do. So, unless you are absolutely perfect, CMS recommends reporting only 9 measures.

Mastering the Basics of PQRS

Module 1 – Overview of PQRS



PQRS Incontinence Questionnaire

Patient Name_____

Date of Birth_____Date of Service_____

1. During the last 3 months, have you leaked urine (even a small amount)?

   Yes_____

   No _____ (If you answered No, please stop here.)

2. During the last 3 months, did you leak urine: (please check all that apply).

   A) _____ when you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?

   B) _____ when you had the urge or feeling that you needed to empty your bladder, but could not get to the toilet fast enough?

   C) _____ without physical activity and without a sense of urgency?

3. During the last 3 months, did you leak urine most often: (please check only one).

   A) _____when you were performing some physical activity, such as coughing, sneezing, lifting, or exercise?

   B) _____when you had the urge or feeling that you needed to empty your bladder, but could not get to the toilet fast enough?

   C) _____without physical activity and without a sense of urgency?

   D) _____About equally as often with physical activity as with a sense of urgency?

There are many helpful tools (such as this form commonly used by urology practices for incontinence assessment) which can help you succeed at PQRS. Many tools can be found in the PQRS Toolkit at www.AUAnet.org, but check out the CMS and ACS websites (among others) for additional assistance.

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Mastering the Basics of PQRS

Module 1 – Overview of PQRS

Let's now review what has been learned:

The next few slides will be a quick review of this module.

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Module 1 – Overview of PQRS

Who is eligible to participate in PQRS?

A. Physicians
B. Non-physicians
C. Therapists
D. All of the above

Module 1 – Overview of PQRS

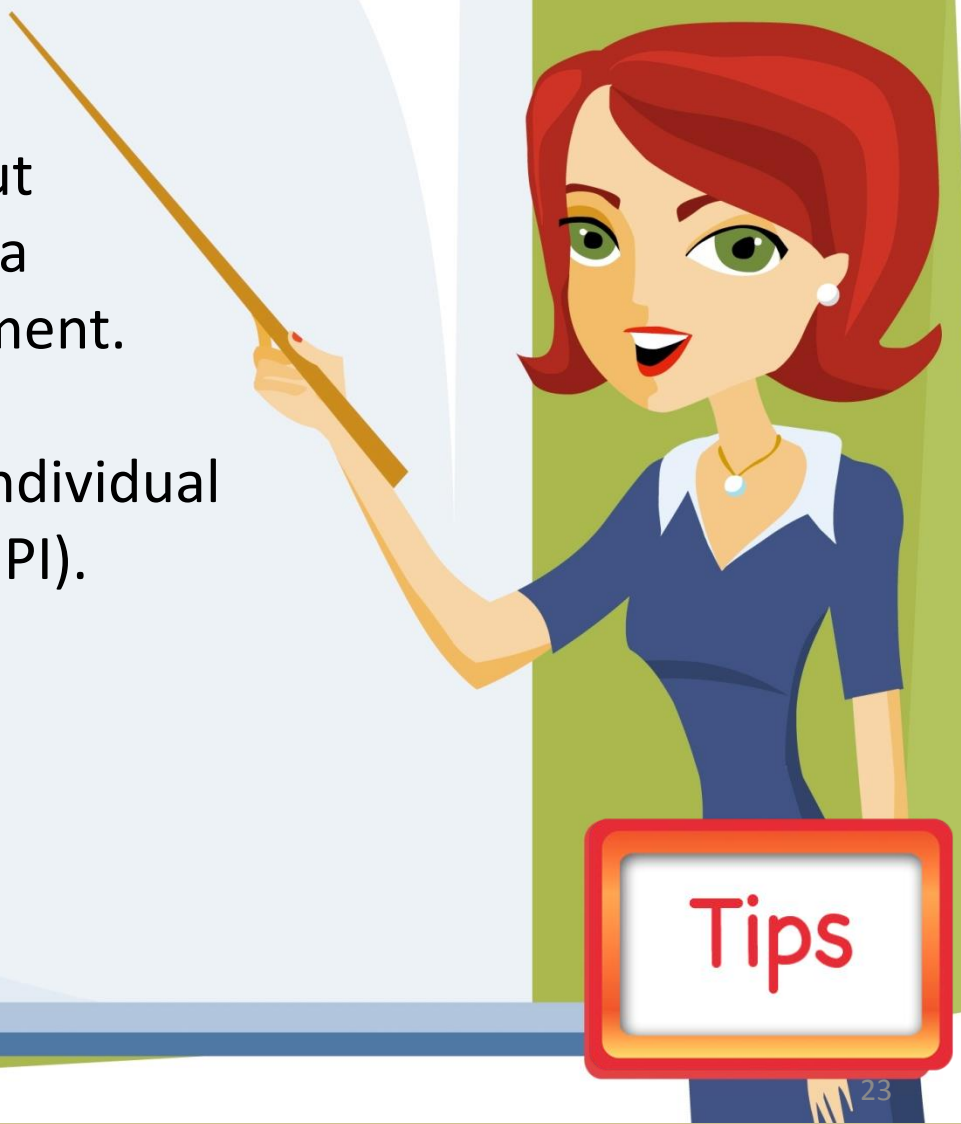
The correct answer is:

D. All of the above

Reporting information

- A participant must be an enrolled Medicare provider but does not need to have signed a Medicare participation agreement.

- A participant must have an individual National Provider Identifier (NPI).



When determining which reporting option you will use, consider the method that best suits your specific practice. There are several different reporting options:

- Claims reporting (electronic or paper claims)
- Registry reporting (individual measures or measures groups)
- Electronic Health Records (EHR) reporting (direct EHR or EHR data submission)
- Group Reporting Option or GPRO (groups of 2-24 providers or groups larger than 25 providers)
- Qualified Clinical Data Registry (QCDR)

Module 2 – Reporting Options
Claims-Based Reporting

What is Claims-Based Reporting?

Claims-based reporting is exactly what it sounds like. There are special PQRS measure codes reported on all of your normal Medicare claims submissions; these are also called quality data codes or CPT II codes. We will discuss the process in more detail in the module entitled "Navigating through Measures."

Claims-based reporting is the most commonly used reporting method. However, it is time-consuming and users are more prone to error.

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Module 2 – Reporting Options
Claims-Based Reporting

Claims reporting is done over a calendar year (January 1-December 31).

Only reporting on individual measures is permitted when using claims.

Module 2 – Reporting Options
Claims-Based Reporting

Timeliness of Quality Data Submission:

- Claims must reach the national Medicare claims system by the end of February of the following year to be included. CMS announces the submission deadline each year.
- Claims for services furnished toward end of reporting period should be filed promptly.

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Module 2 – Reporting Options
Claims-Based Reporting

Claims-based reporting requires that the PQRS codes applicable to a particular patient service be included on the claim filed on behalf of a Medicare beneficiary for that service. In order to receive credit, the PQRS code must appear on the same claim upon which the reportable service is billed.

CPT Category II code (s) and/or G-code(s), also described as Quality Data Codes (QDC), report the actions associated with PQRS:

- on the same claim as the billing code(s)
- for the same beneficiary
- for the same date of service (DOS)
- by the same provider (individual NPI) who performed the covered services

Module 2 – Reporting Options
Claims-Based Reporting

- Because PQRS measures often relate to specific patient conditions, the PQRS processing system recognizes the diagnosis codes associated with that particular patient service.
- All diagnosis codes reported on the claim will be included in PQRS analysis.
- As many as four (paper form) or eight (electronic form) diagnosis codes entered on the claim form will be recognized depending on the submission method you choose.

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Module 2 – Reporting Options
Claims-Based Reporting

- Quality Data Codes (QDC) are submitted with line-item charge of zero dollars.
- If your system does not allow a $0.00, a nominal amount can be substituted (e.g., $0.01).
- QDC line items will be denied for payment.
  - N365 This procedure code is not payable. It is for reporting/information purposes only.
- Some measures require submission of more than one QDC in order to properly report.

Mastering the Basics of PQRS

Module 2 – Reporting Options

The next slide shows examples of PQRS codes and associated diagnoses on a CMS 1500. Generally, the PQRS codes will follow the billing codes as shown in this illustration. Modifiers may be required to further explain the actions associated with a measure. We will discuss these further in the next module.

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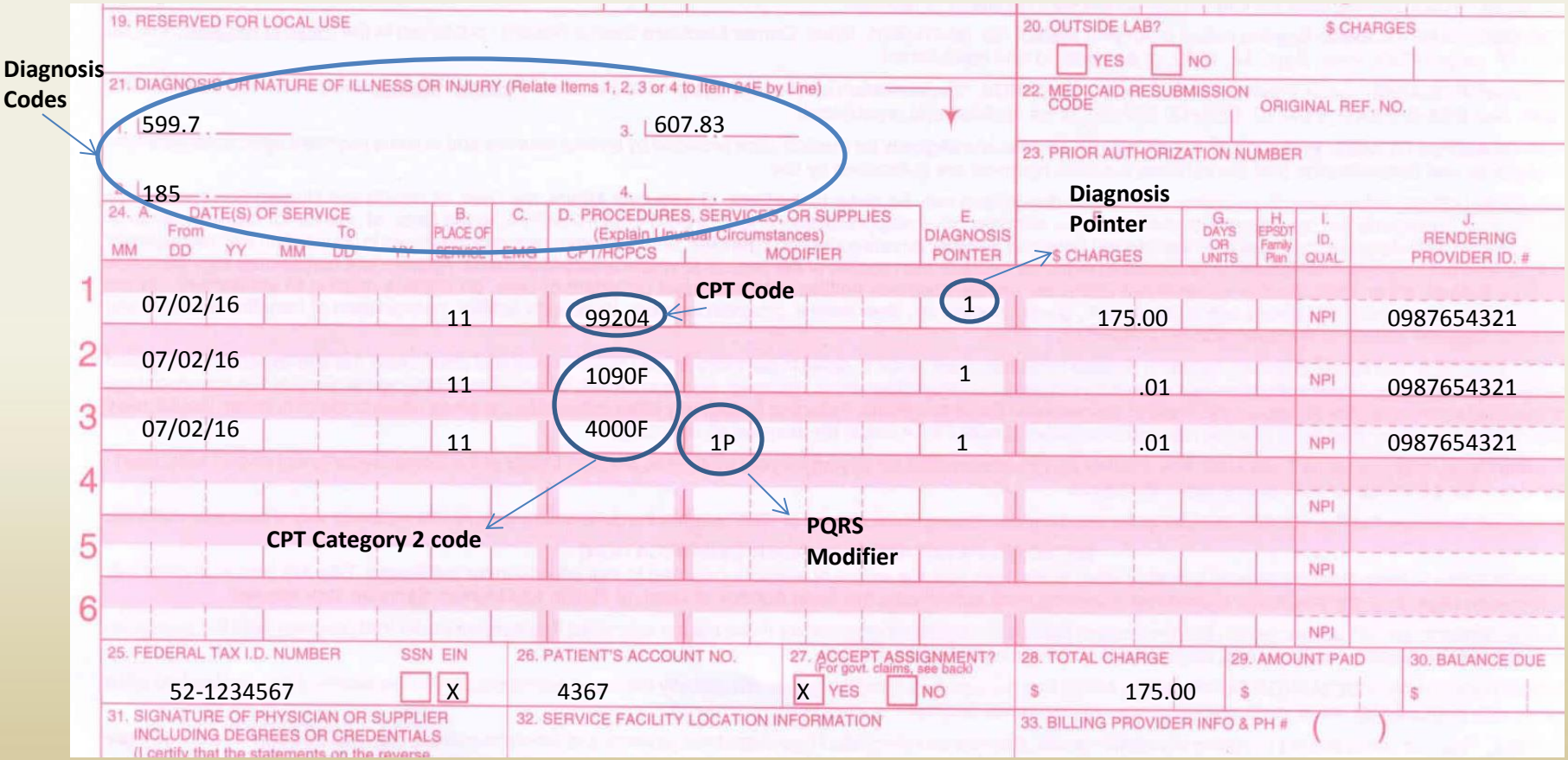
Module 2 – Reporting Options



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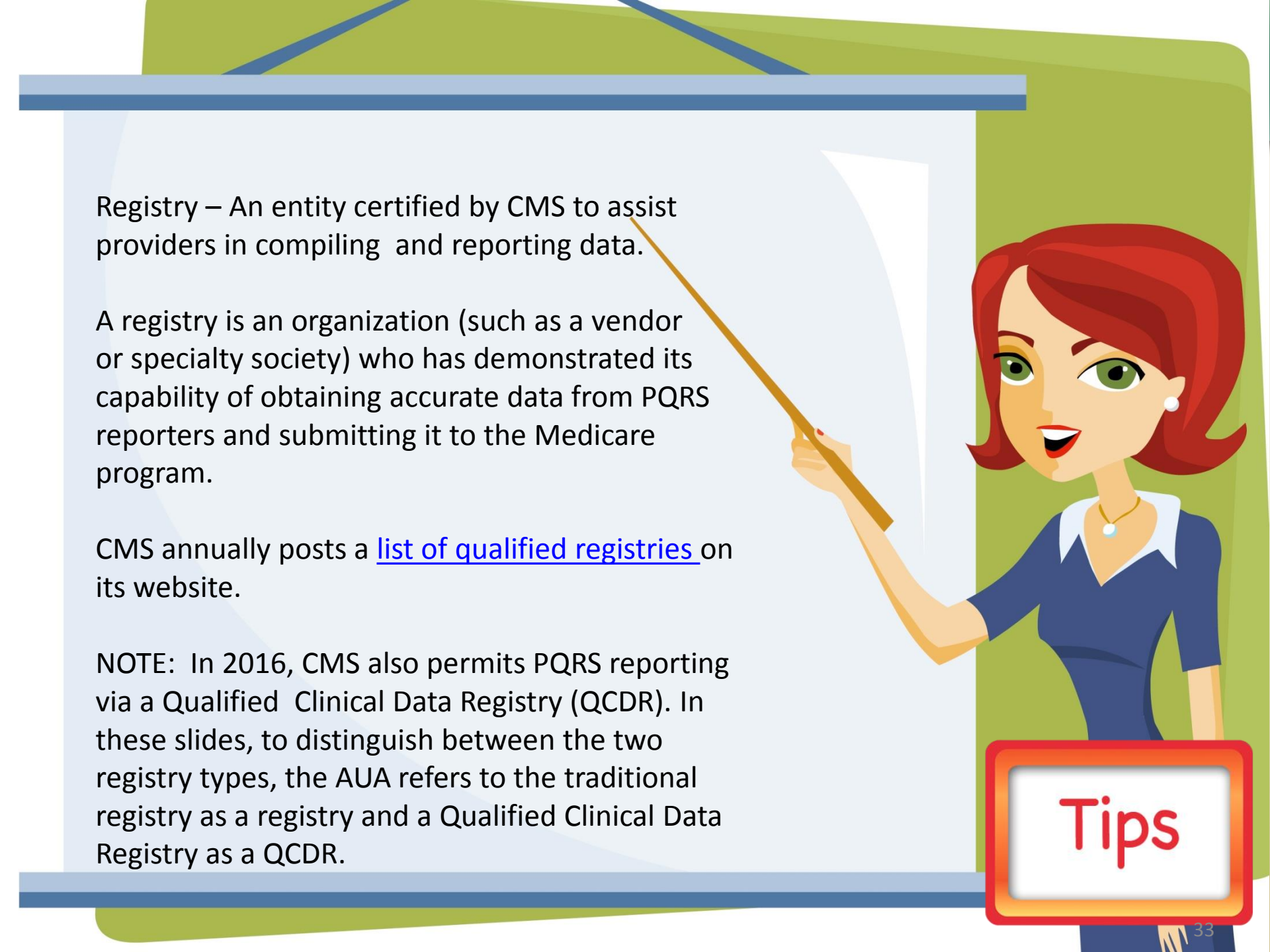
Registry – An entity certified by CMS to assist providers in compiling and reporting data.

A registry is an organization (such as a vendor or specialty society) who has demonstrated its capability of obtaining accurate data from PQRS reporters and submitting it to the Medicare program.

CMS annually posts a list of qualified registries on its website.

NOTE: In 2016, CMS also permits PQRS reporting via a Qualified Clinical Data Registry (QCDR). In these slides, to distinguish between the two registry types, the AUA refers to the traditional registry as a registry and a Qualified Clinical Data Registry as a QCDR.



Module 2 – Reporting Options
Registry-Based Reporting

Unlike other reporting options, registry reporters have the option to report on individual measures or measures groups. We will discuss the difference in Module 2.

Module 2 – Reporting Options
Registry-Based Reporting

Timeliness of Quality Data Submission:

- The timeframe for registry-based reporting - January 1 - December 31 (twelve months)
- Registry reports must reach the national Medicare claims system by the February deadline of following year to be included

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Mastering the Basics of PQRS

Module 2 – Reporting Options
Registry-Based Reporting

Those who supply registry-based reporting charge a fee to defray the cost of data processing. Despite the extra expense, this reporting option may be simpler for some, depending on the amount of information to be reported and available staff.

Also, CMS notes there are less provider errors when a registry is used for reporting.

If you are considering registry-based reporting, be sure to discuss the data entry requirements, EHR compatibility, timetable, and cost as well as any other concerns with any potential vendor you consider.

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Module 2 – Reporting Options
Registry-Based Reporting

To become certified, a registry must meet an extensive list of criteria.

For example, the registry must provide:

- Registry name
- Reporting period start date and end date
- PQRS measure numbers on which the registry is reporting
- Number of eligible instances (denominator)

Also, the registry must:

- Report the number of instances of quality services performed (numerator)
- Be able to transmit this data in a CMS-approved XML format
- Comply with a secure method for data submission
- Provide CMS access to review the Medicare beneficiary data on which the measure is based

Module 2 – Reporting Options
Registry-Based Reporting

New for 2016! AUA PQRS Registry

The American Urological Association offers its members a registry service entitled the AUA PQRS Registry (available in the fall); more information about the program is available on the AUA website. The AUA PQRS Registry is one example of a certified registry; for a list of all registries approved by CMS for PQRS, visit the CMS website.

To sign up for the AUA PQRS Registry or for more information, contact Quality@AUAnet.org.

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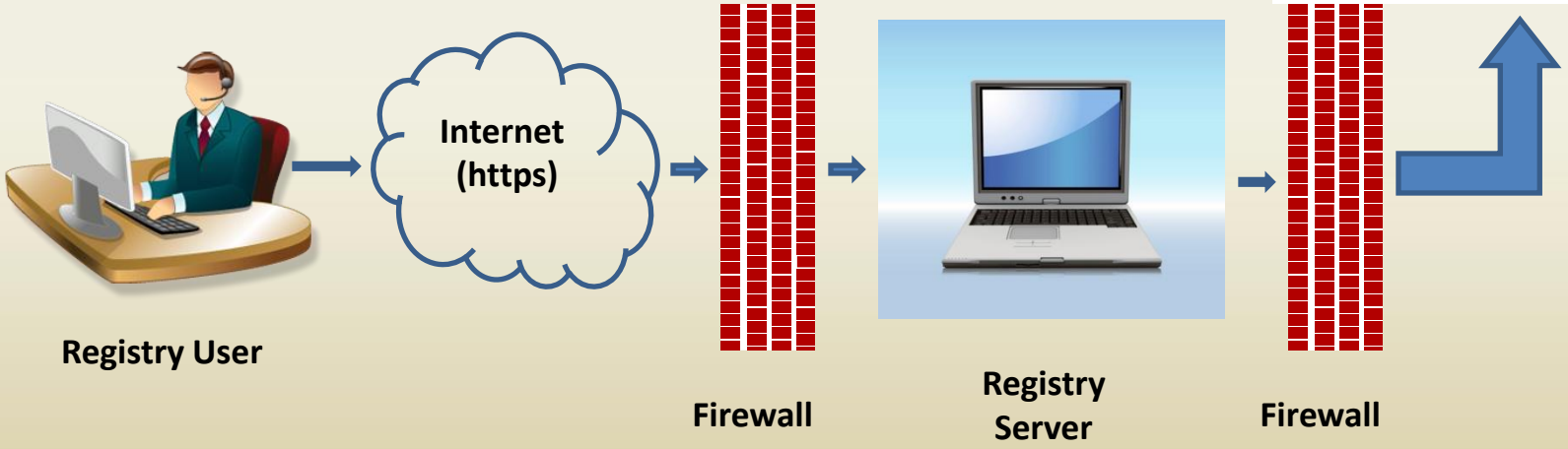
Module 2 – Reporting Options
Registry-Based Reporting

The slide depicts how your computer system would use the Internet to transmit data from your practice to a registry.



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Module 2 – Reporting Options

What is Group Practice Reporting (GPRO)?

GPRO allows practices to report to CMS one set of quality measures data on behalf of all eligible professionals within that group practice, thus reducing the need to keep track of each provider's reporting efforts separately.

We will note here that GPRO is an all or nothing option. Either everyone in the practice succeeds or they fail. So, it is very important that you thoroughly understand the reporting requirements if you select this option.

<u>To participate as a GPRO for 2016, a practice must have registered with CMS for this option by June 30, 2016.</u>

Definition of PQRS Group Practice:

A single tax identification number (TIN) with 2 or more eligible professionals, as identified by their individual National Provider (NPI), who have reassigned their billing rights to the TIN.

Module 2 – Reporting Options
Group Practice Reporting

- There are currently three reporting options under Group Practice Reporting.

- The options are based on practice size:
  - 2+ providers
  - 25-99 providers
  - 100+ providers

- Again, all three options require that you self-nominate by a designated date. The self-nomination deadline was June 30, 2016.

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Module 2 – Reporting Options
Group Practice Reporting

The following chart from the CMS PQRS Implementation Guide shows the three GPRO reporting options.

- The reporting period for all three is 12 months.
- Practices with fewer than 25 eligible professionals must participate through a traditional registry, QCDR, a certified survey vendor of CAHPS for PQRS, or EHR program. Larger groups may also choose from these option.
- The other two options (the first for groups of 25-99 providers and the second for those with over 100 providers) can report via the GPRO web interface.
- Groups of 100+ providers must use a CAHPS for PQRS certified survey vendor in addition to whatever other reporting method they choose.

Module 2 – Reporting Options
Group Practice Reporting

Practices opting to report through the GPRO web interface must report a set of **18** CMS selected composite measures. The measures cover disease modules, care coordination/patient safety, and preventive care measures. Most are not pertinent to urology, but you may still choose to participate through this option.

Module 2 – Reporting Options
Group Practice Reporting

EPs opting to use the certified survey vendor will report on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS summary for an equivalent of three measures and 1 domain of care. The data collected from your patients includes:

- 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

EPs will also need to report on at least 6 additional measures covering at least 2 domains of care.

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Module 2 – Reporting Options
EHR Reporting

In 2016, there are 2 options for EHR reporting:

- Direct EHR Vendor
- EHR Data Submission Vendor

Module 2 – Reporting Options
EHR Reporting

Direct EHR Vendor

- These vendors provide practices or providers with a certified EHR product and version which allows the practice or provider to directly submit PQRS measures data to CMS in the CMS-specified format.
- If a provider or practice is participating in this system, they must register for an EIDM (Enterprise Identity Management) account. (Previously CMS used Individuals Authorized Access to CMS Computer Services (IACS) system, but that is now retired.)

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Module 2 – Reporting Options
EHR Reporting

EHR Data Submission Vendor

- This entity collects an EP's or practice's clinical quality data directly and then submits the information in the required format to CMS on the EP's or practice's behalf.

Module 2 – Reporting Options
QCDR Reporting

Qualified Clinical Data Registry (QCDR)

- A QCDR is a CMS-approved entity that collects medical and/or clinical data for the purpose of patient and disease tracking to improve the quality of care provided to patients.
- The data submitted covers multiple payors (not just Medicare).
- A QCDR may develop its own measures. It is not limited to PQRS approved measures. So, the measures are most often specialty-specific.
- As with a standard registry, participants must report 9 measures (covering 3 domains of care). Of these measures, at least 2 must be outcome measures.

Module 2 – Reporting Options
QCDR Reporting

The AUA has its own QCDR (AQUA Registry) which is available now.

Look for more information about AQUA on the AUA's website.

Check out the CMS website for a list of other CMS approved QDCRs.

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Module 2 – Reporting Options

As mentioned earlier, you may choose from a variety of reporting options to submit individual PQRS measures.

Let's take a brief look at individual measures now.

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Most measures may be reported via claims or registry reporting.

There are over 300 CMS approved measures from which to choose

- A few are pertinent to most urology practices (e.g., urinary incontinence)
- Others apply to other specialties (e.g., heart disease) and others are general (e.g., medication reconciliation)

Some measures may only be reported by a registry.

Individual Measures Reporting

- When you report on individual measures, you can choose *any* nine that apply to your practice.

- In some practice situations, less than nine apply. If so, CMS will review these circumstances using the Measure-Applicability Validation (MAV) process. Be warned that CMS's determination of what measures are applicable to a provider are often much more liberal that what the provider may think. Therefore it is wise to check with the CMS QualityNet help desk before you assume there are less than 9 measures that apply to you. They can perform a "mini-MAV process" for you.

Module 2 – Reporting Options

How do I report Measures Groups?

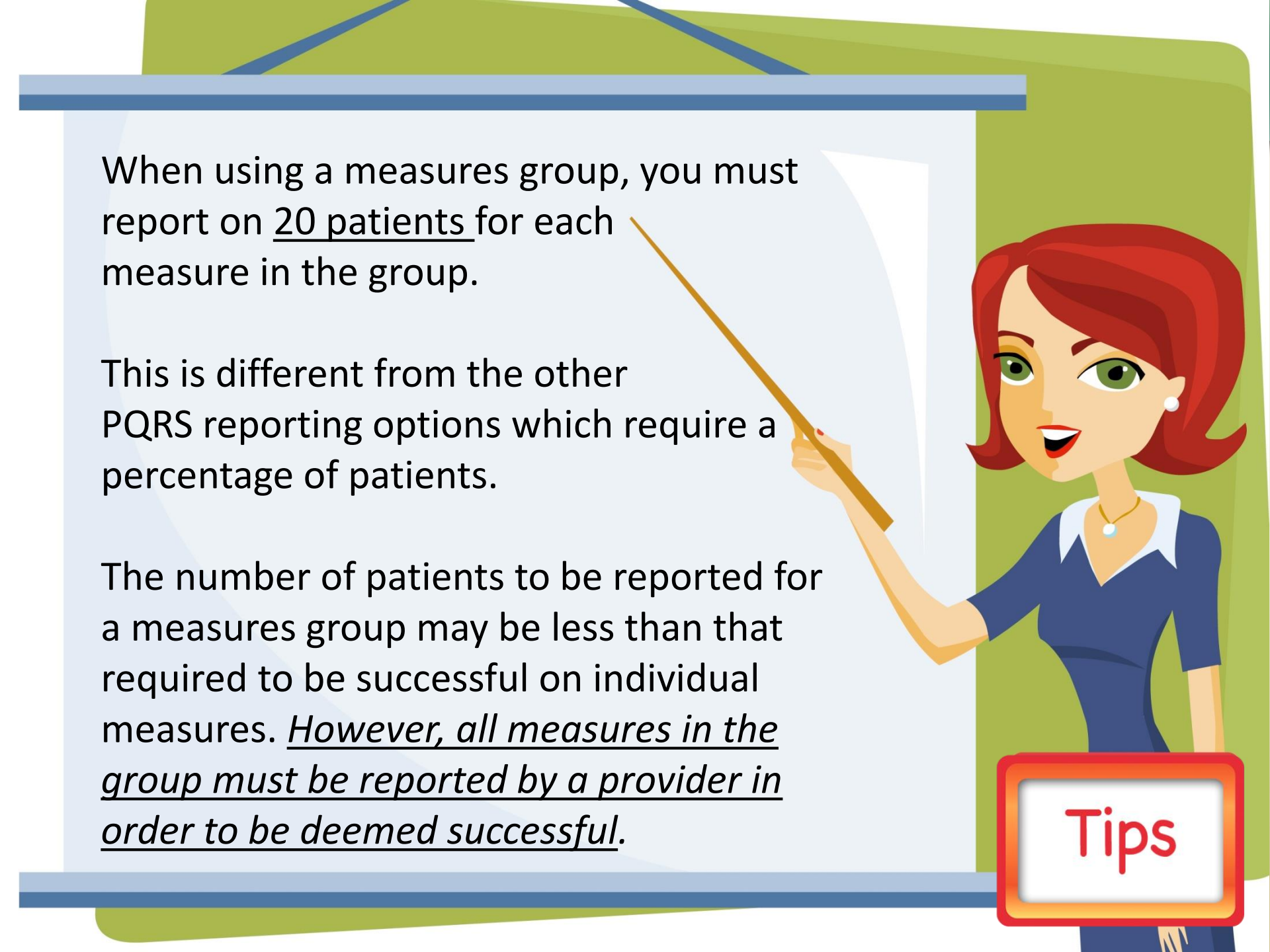
- CMS has also developed subsets of the individual measures that apply to a group of patients with common characteristics. These subsets are described as “measures groups.” They typically pertain to the same clinical condition.

Measures groups may be reported ONLY through **registry** reporting.

When using a measures group, you must report on 20 patients for each measure in the group.

This is different from the other PQRS reporting options which require a percentage of patients.

The number of patients to be reported for a measures group may be less than that required to be successful on individual measures. *However, all measures in the group must be reported by a provider in order to be deemed successful.*



Mastering the Basics of PQRS

Module 2 – Reporting Options

Let's now review what has been learned:

The next few slides will be a quick review of this module.

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Module 2 – Reporting Options

An individual provider must register with CMS to begin reporting measures through a registry.

True or False?

Module 2 – Reporting Options

The correct answer is:

False. The only PQRS registration required by CMS is for practices who wish to report as a group (or GPRO).

Module 2 – Reporting Options

If using the claims-based reporting option, QDCs must be reported on the same claim as the billing CPT codes.

True or False?

Module 2 – Reporting Options

The correct answer is:

True.

Module 2 – Reporting Options

The time frame option for claims-based reporting of individual measures is:

A. Any calendar quarter
B. July through December
C. The entire calendar year

Module 2 – Reporting Options

The correct answer is:

C. Claims-based reporting is required for the entire calendar year, January 1 through December 31.

Mastering the Basics of PQRS

Module 2 – Reporting Options

Any medical society can report PQRS measures for its members.

True or False?

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Module 2 – Reporting Options

The correct answer is:

False. Only a CMS-certified entities can report PQRS measures on behalf of a provider. CMS certifies registries, QCDRs, EHR vendors, etc.

Module 3 – Navigating through Measures

Module 3 is designed to give you an in-depth look at PQRS measures and to help you understand the anatomy of a PQRS measure so that you can choose ones that best fit your practice.

The measures we use as examples are not necessarily ones we think you should choose. However, they are of a urological nature and therefore should be easy to understand.

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Which measures you report depends on the conditions you most often treat and the reporting option you select.

Each practice should consider measure specifications that most naturally fit their patient population and the conditions they routinely treat. This is not just a financial exercise for practice management staff but also an exercise in learning tactics to improve patient care.

Module 3 – Navigating through Measures

- Measures consist of a denominator and a numerator
  - Denominator – patient population of interest (e.g., all females 65 and older) defined by patient characteristics, Category 1 CPT codes and ICD-9 codes

  The denominator will help you decide on which patients to report.
  - Numerator – patients receiving specific services related to the measure specifications, otherwise included in the CPT code and not separately billable.

  The numerator will help you decide which services to report.
- The successful reporting rate for each PQRS measure is determined as a fraction. For a specific group of patients having common characteristics (the denominator of the fraction), how many of them received care indicated by the numerator?

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Module 3 – Navigating through Measures: Selecting Patient Populations

- In order to select measures that fit the majority of your patients, you should review the denominator specifications for the measures you are considering.
- If you see a significant number of patients that meet those criteria, then review the numerator specifications for those measures to see if you routinely deliver those specified services to most of those patients.
- Once eligibility has been determined, report on every patient that meets the measure criteria as defined by numerator.
- The higher the ratio of patient population to services provided, the more likely successful reporting is.

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Module 3 – Navigating through Measures

For urologists, a few commonly reported measures are:

- Perioperative measures (#23)
- Incontinence measures (#48 & 50)
- Prostate cancer measures (#102 & 104)

Several of these are measures available for two of the common conditions treated by urologists - incontinence in women and prostate cancer in men. However, some urologists choose to report on non-urological topics such as medication reconciliation.

So again, it is important to review as many measures as possible and select those you encounter regularly in your patient care.

Module 3 – Navigating through Measures

- Each year the AUA posts a list of the PQRS measures it believes as most appropriate for urologists to use.
- Additionally, CMS also identifies the measures they believe the "typical" urologist could report.
- You will note the two lists are similar but not identical.

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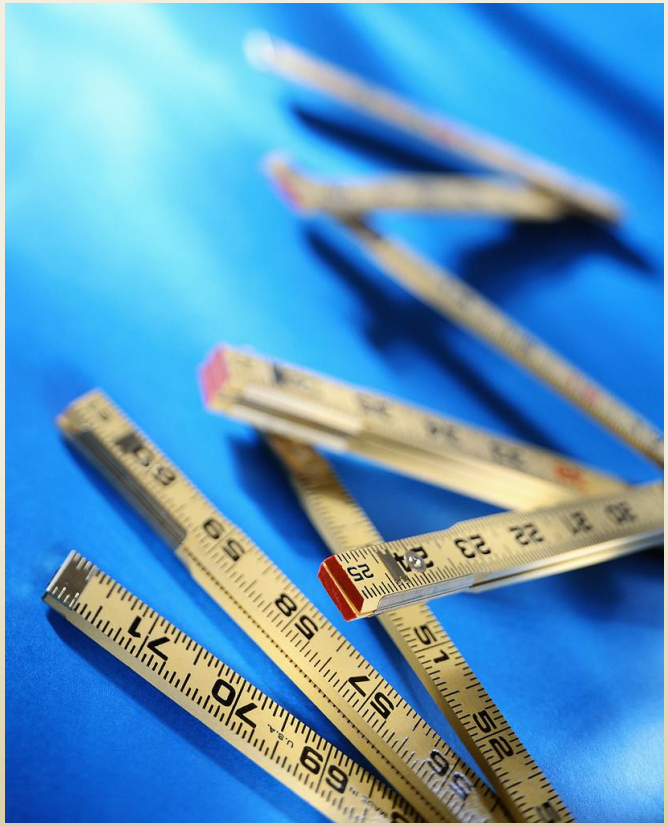
Module 3 – Navigating through Measures



Let's take an opportunity to analyze the specifications of a few commonly reported urology measures by those selecting individual measures using claims-based reporting.

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Module 3 – Navigating through Measures

- Measures 48 and 50 are measures designed to improve the rate at which elderly females are evaluated for urinary incontinence.
- Measure 48 is the first step--namely, determining if a female patient aged 65 or older suffers from incontinence as defined in the measure.
- The description from the CMS specifications on the next few slides defines the denominator of this measure--only female Medicare beneficiaries aged 65 and older. The instructions indicate the frequency with which you must report on each qualifying beneficiary--once per reporting period which as explained earlier is a calendar year.

Module 3 – Navigating through Measures

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

Measure #48: Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

2016 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of female patients aged 65 years and older who were assessed for the presence or absence of urinary incontinence within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. This measure is appropriate for use in the ambulatory setting only and is considered a general screening measure. There is no diagnosis associated with this measure. 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.

Measure Reporting via Claims:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The modifiers allowed for this measure are: 1P- medical reasons, 8P- reason not otherwise specified. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure Reporting via Registry:
CPT or HCPCS codes and patient demographics are used to identify patients who are included in the measure's denominator. The numerator options as described in the quality-data codes are used to report the numerator of the measure.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data.

Module 3 – Navigating through Measures

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

The denominator specifications are the most important decision-making factor in helping you determine which measures you plan to report. By understanding the denominator criteria, a urologist can decide if he/she sees patients that fall into the denominator.

In many cases, the actions required to achieve the numerator are services that are routinely supplied by the specialist. The next slide shows the final criteria defining the denominator for Measure #48. Only those female patients 65 or older seen for **an Evaluation and Management visit** on the list shown are counted in the denominator of the measure. So if you see this patient but do not bill her on a Medicare claim for a new or established office visit, then do not count her in the Measure #48 denominator. For example, a female patient who has previously suffered from urinary tract infection who is just dropping off a specimen and does not see a provider would not fall into the denominator population for that particular activity.

Module 3 – Navigating through Measures

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

DENOMINATOR:

All female patients aged 65 years and older with a visit during the measurement period

Denominator Criteria (Eligible Cases):

All female patients aged ≥ 65 years on date of encounter

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

RATIONALE:

Female patients may not volunteer information regarding incontinence so they should be asked by their physician.

CLINICAL RECOMMENDATION STATEMENTS:

Strategies to increase recognition and reporting of UI are required and especially the perception that it is an inevitable consequence of aging for which little or nothing can be done. (ICI)

Patients with urinary incontinence should undergo a basic evaluation that includes a history, physical examination, measurement of post-void residual volume, and urinalysis. (ACOG) (Level C)

Health care providers should be able to initiate evaluation and treatment of UI basing their judgment on the results of history, physical examination, post-voiding residual and urinalysis. (ICI) (Grade B for women)

Module 3 – Navigating through Measures

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

- The numerator describes what service must be provided to the patients who fall into the denominator in order to report the PQRS code.
- If you did not perform the service in question, you can use a modifier code to note why you did not provide the service required. Using a 1P modifier counts as satisfying the measure in most cases, but using the 8P modifier does not.

Module 3 – Navigating through Measures

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

NUMERATOR:

Patients who were assessed for the presence or absence of urinary incontinence within 12 months

PQRS Modifiers

1P Performance Measure Exclusion Modifier due to Medical Reasons
Not indicated (absence of organ/limb, already received/performed, other

8P Performance Measure Reporting Modifier – action not performed, reason not otherwise specified

Module 3 – Navigating through Measures

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

- So on the example for Measure #48, you are reporting whether or not you assessed the patient for urinary incontinence.
- You are not concerned with the diagnosis.
- The manner of your assessment is up to your practice.

Module 3 – Navigating through Measures

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

In this same example, there are three options of numerator codes to use:

- 1090F - you did a urinary incontinence assessment
- 1090F with 1P - there was a medical reason why you did not do the assessment.
- 1090F with 8P - you did not do the assessment and you do not have documentation of any reason. NOTE: <u>You may report this option, but CMS records this as not completing the measure.</u>

Module 3 – Navigating through Measures
Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

<u>Numerator Quality-Data Coding Options for Reporting Satisfactorily</u>:

Presence or Absence of Urinary Incontinence Assessed

CPT II 1090F: Presence or absence of urinary incontinence assessed

OR

Presence or Absence of Urinary Incontinence not Assessed for Medical Reasons

Append a modifier (**1P**) to CPT Category II code **1090F** to report documented circumstances that appropriately exclude patients from the denominator.

1090F *with* 1P: Documentation of medical reason(s) for not assessing for the presence or absence of urinary incontinence

OR

Presence or Absence of Urinary Incontinence not Assessed, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **1090F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

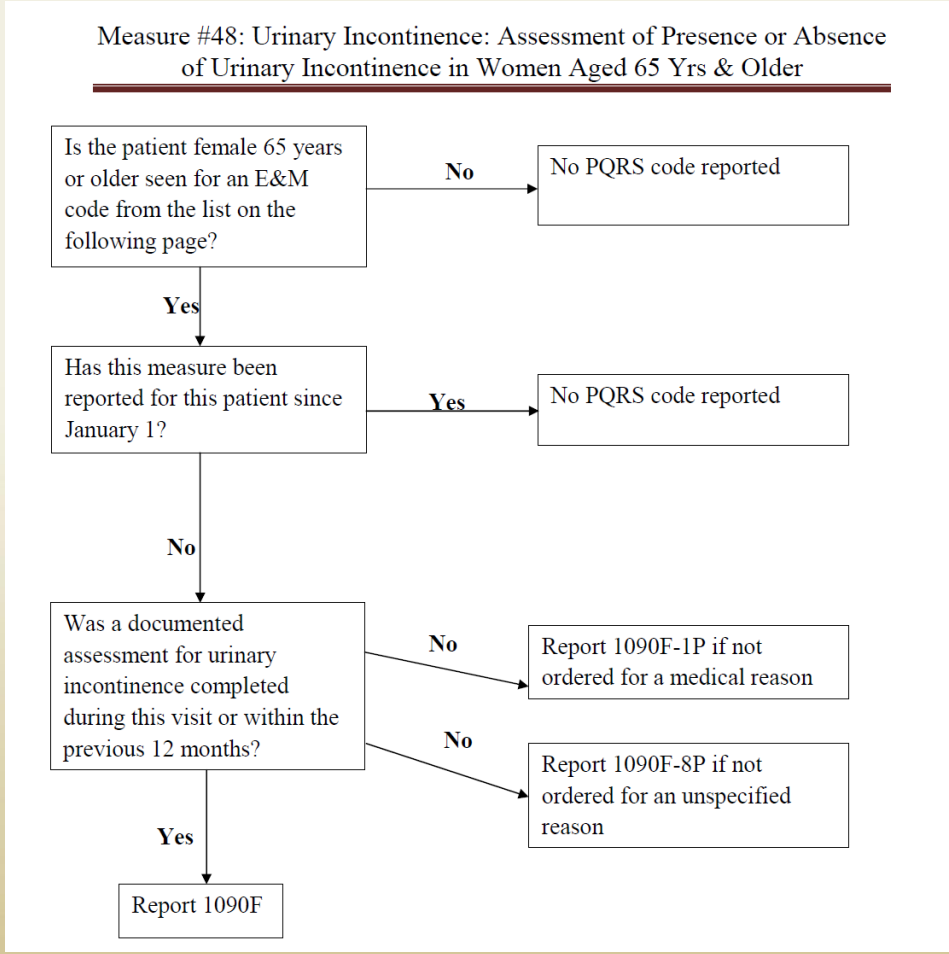
1090F *with* 8P: Presence or absence of urinary incontinence **not** assessed, reason not otherwise specified

Module 3 – Navigating through Measures

Measure #48: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older

Flow charts, such as this, are available on the AUA website in the PQRS Toolkit for many measures commonly used by urologists.

They will walk you through the various aspects of the measure to determine what should be reported.



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Module 3 – Navigating through Measures

Measure #50: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

Next, let's briefly review the specifications for the next urinary incontinence measure #50.

This logically follows Measure #48 for female patients 65 and older because if they answer yes to your questions about suffering from urinary incontinence, then you would naturally want to establish a plan of care.

The plan of care selected is up to the doctor and patient. You are not concerned about the detail in the plan. All you are reporting for this measure is that a plan was noted in the medical record.

Module 3 – Navigating through Measures

Measure #50: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

Measure #50: Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older – National Quality Strategy Domain: Person and Caregiver-Centered Experience and Outcomes

2016 PQRS OPTIONS FOR INDIVIDUAL MEASURES:
CLAIMS, REGISTRY

DESCRIPTION:
Percentage of female patients aged 65 years and older with a diagnosis of urinary incontinence with a documented plan of care for urinary incontinence at least once within 12 months

INSTRUCTIONS:
This measure is to be reported a minimum of **once per reporting period** for patients seen during the reporting period. This measure is appropriate for use in the ambulatory setting only. It is anticipated that **clinicians who provide services for patients with the diagnosis of urinary incontinence** will submit this measure.

Measure Reporting via Claims:

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. CPT Category II codes are used to report the numerator of the measure.

When reporting the measure via claims, submit the listed ICD-10-CM diagnosis codes, CPT or HCPCS codes, and the appropriate CPT Category II code **OR** the CPT Category II code **with** the modifier. The reporting modifier allowed for this measure is: 8P- reason not otherwise specified. There are no allowable performance exclusions for this measure. All measure-specific coding should be reported on the claim(s) representing the eligible encounter.

Measure 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.

The quality-data codes listed do not need to be submitted for registry-based submissions; however, these codes may be submitted for those registries that utilize claims data. There are no allowable performance exclusions for this measure.

Module 3 – Navigating through Measures

Measure #49: Characterization of Urinary Incontinence in Women Aged 65 Years and Older

- The next slide again details the denominator.
- Note that an E&M code is required to report this measure.
- So in a typical scenario, the urologist may have seen a patient for an E&M visit previously and determined that the patient suffered from incontinence. The physician reported measure #48. However, the urologist may have recommended that the patient return to the office for urodynamics testing. The testing was completed and billed to Medicare, but there was no separate and medically necessary service performed on that day to justify billing an E&M code. The numerator code for Measure #50 would not be reported on the claim with the urodynamics testing. Only when the patient returns for an E&M visit would the urologist report the code for the type of incontinence because that claim contains a denominator code for measure #50. If the patient's return E&M is where the urologist reports the results of the urodynamics testing and counsels the patient on a treatment plan for the incontinence, the urologist can report measure #50.

Module 3 – Navigating through Measures

Measure #50: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

DENOMINATOR:

All female patients aged 65 years and older with a diagnosis of urinary incontinence

Denominator Criteria (Eligible Cases):

All female patients aged ≥ 65 years on date of encounter

AND

Diagnosis for urinary incontinence (ICD-10-CM): F98.0, N39.3, N39.41, N39.42, N39.43, N39.44, N39.45, N39.46, N39.490, N39.498, R32

AND

Patient encounter during the reporting period (CPT or HCPCS): 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350, G0402

RATIONALE:

A treatment option should be documented for the patient with incontinence.

CLINICAL RECOMMENDATION STATEMENTS:

All conservative management options used in younger adults can be used in selected frail, older, motivated people. This includes:

- Bladder retraining
- Pelvic muscle exercises including biofeedback and/or electro-stimulation (ICI) (Grade B)

Pharmacologic agents, especially oxybutynin and tolterodine, may have a small beneficial effect on improving symptoms of detrusor overactivity in women. (ACOG) (Level A)

Oxybutynin and potentially other bladder relaxants can improve the effectiveness of behavioral therapies in frail older persons. (ICI) (Grade B)

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Module 3 – Navigating through Measures

Measure #50: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older

NUMERATOR:

Patients with a documented plan of care for urinary incontinence at least once within 12 months

Definition:

Plan of Care – May include behavioral interventions (eg, bladder training, pelvic floor muscle training, prompted voiding), referral to specialist, surgical treatment, reassess at follow-up visit, lifestyle interventions, addressing co-morbid factors, modification or discontinuation of medications contributing to urinary incontinence, or pharmacologic therapy.

Numerator Quality-Data Coding Options for Reporting Satisfactorily:

Plan of Care for Urinary Incontinence Documented

Performance Met: **CPT II 0509F:** Urinary incontinence plan of care documented

OR

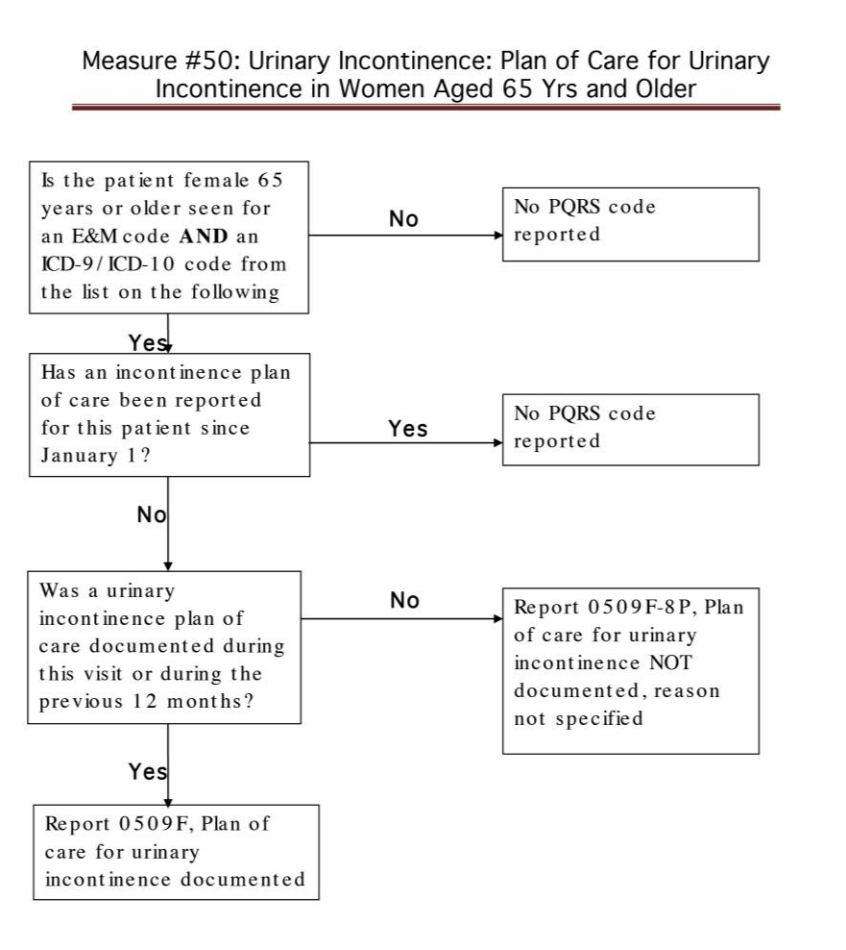
Plan of Care for Urinary Incontinence not Documented, Reason not Otherwise Specified

Append a reporting modifier (**8P**) to CPT Category II code **0509F** to report circumstances when the action described in the numerator is not performed and the reason is not otherwise specified.

Performance Not Met: **0509F *with* 8P:** Urinary incontinence plan of care

Module 3 – Navigating through Measures

Measure #50: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older



Again, flowcharts for this and many other measures are available in the AUA's PQRS Toolkit on the AUA website.

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Module 3 – Navigating through Measures

Measure #49: Characterization of Urinary Incontinence in Women Aged 65 Years and Older

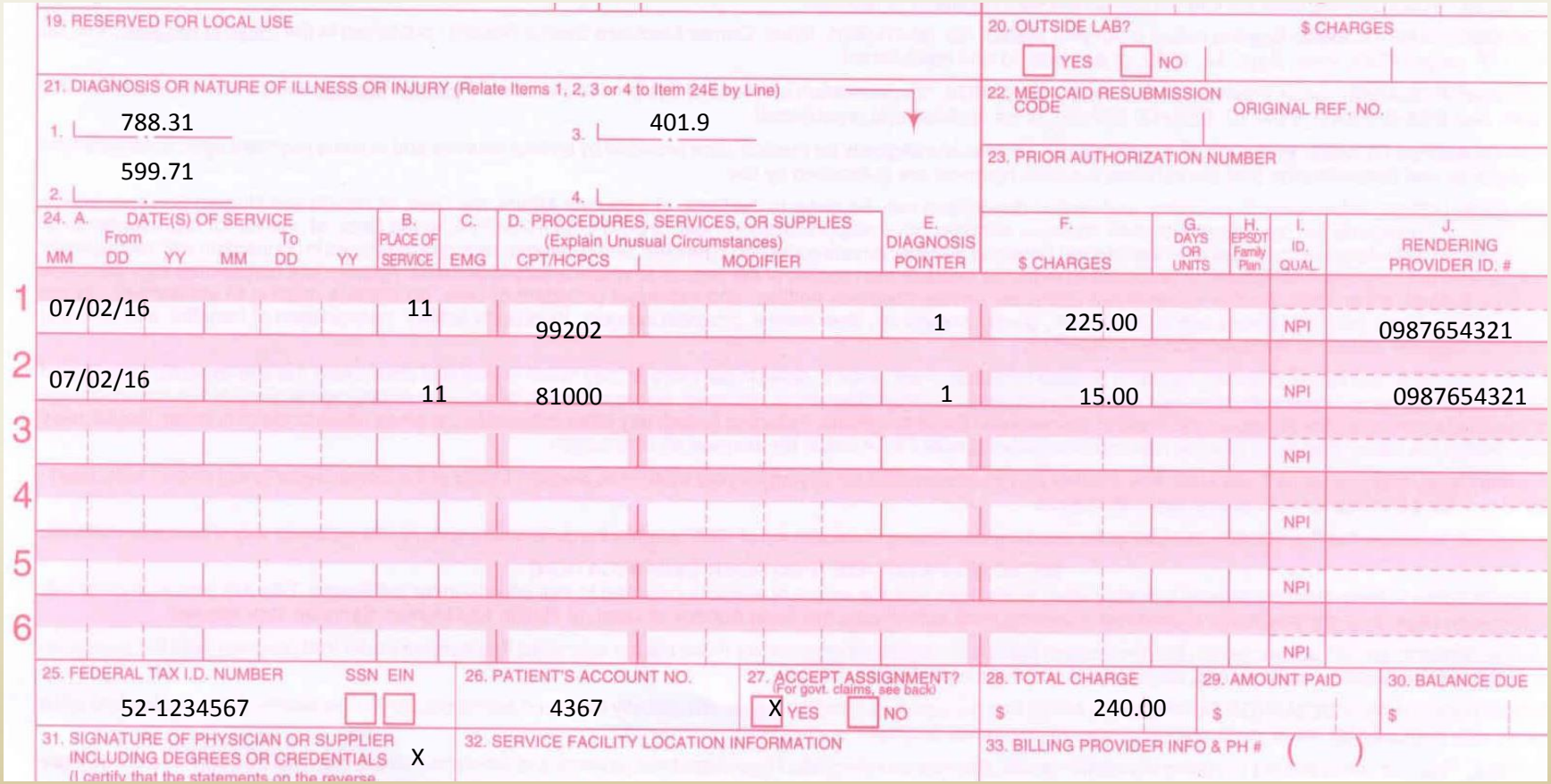
The next two slides show 1500 forms for our example.

Note the placement of the billable E&M and/or CPT codes on the claim on the first slide.

The second slide shows the placement of the PQRS reporting codes after the billing codes on the same claim form. Note that on this particular claim, the assessment and the plan of care are reported on the same claim. Perhaps the scenario here is that incontinence was originally assessed by a primary care physician who sent the patient initially for urodynamics testing. Once the testing was completed and analyzed, the patient returned to the urologist for an E&M visit.

Therefore, the urologist reported the existence of urinary incontinence and that a plan of care was determined on the same claim. In this case, the date of service for the measured activity may or may not be the same date as the E&M visit but should be reported on the same claim with the same date of service. There is no limit on how many physicians can report a certain measure. So even though, in the scenario we just described, the primary care physician may have reported 1091F that does not prevent the urologist from reporting the same code. The patient fell into the denominator; so, if the urologist did not report the assessment measure code, it would count against him or her.

Module 3 – Navigating through Measures



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. 788.31
2. 599.71
3. 401.9
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 07/02/16		11		99202		1	225.00			NPI	0987654321
2 07/02/16		11		81000		1	15.00			NPI	0987654321
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 52-1234567 ☐ ☐

26. PATIENT'S ACCOUNT NO.: 4367

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

28. TOTAL CHARGE: $ 240.00

29. AMOUNT PAID: $

30. BALANCE DUE: $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse X

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

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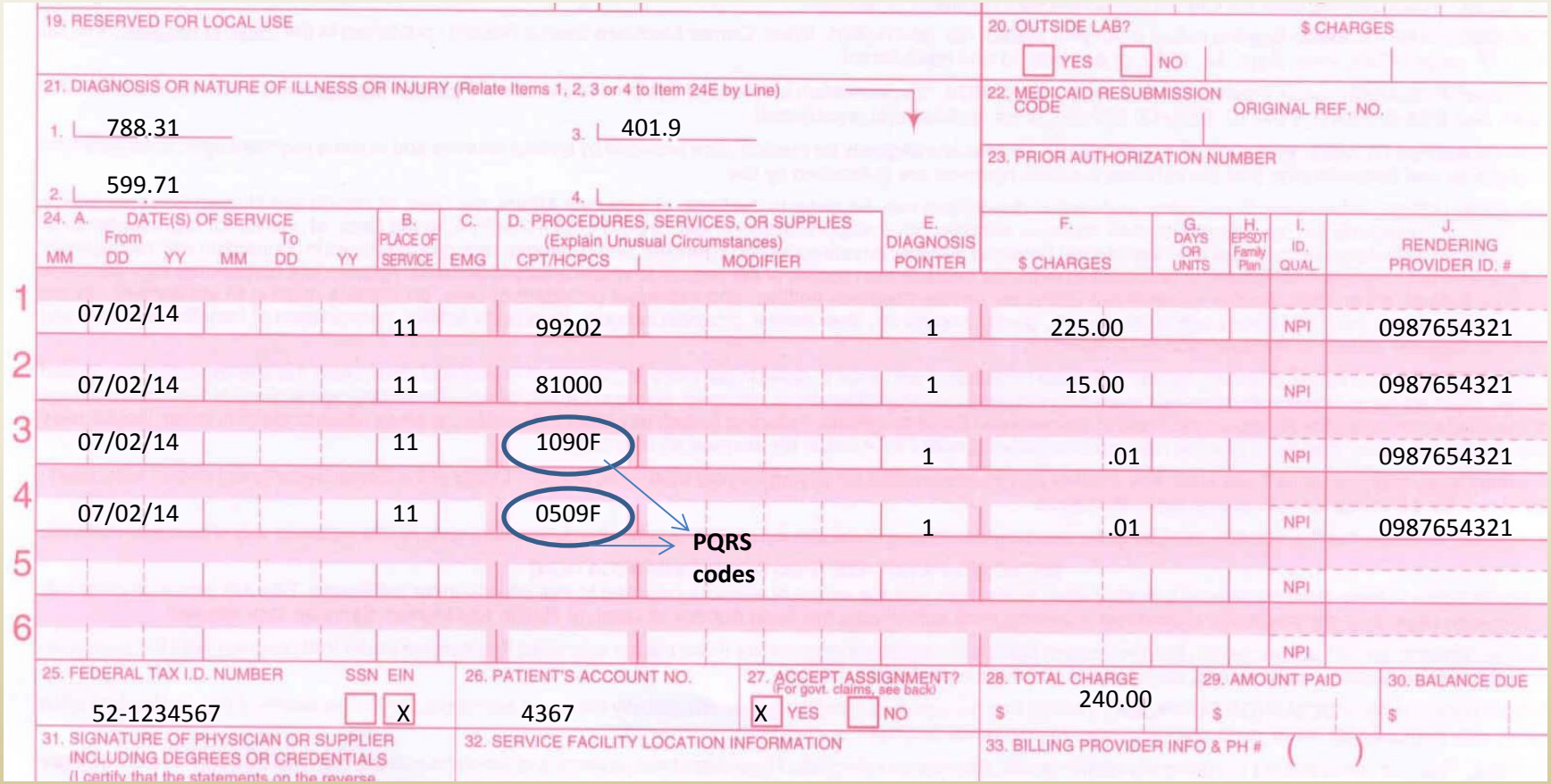
Module 3 – Navigating through Measures



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. 788.31 3. 401.9

2. 599.71 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 07/02/14		11		99202		1	225.00			NPI	0987654321
2 07/02/14		11		81000		1	15.00			NPI	0987654321
3 07/02/14		11		1090F		1	.01			NPI	0987654321
4 07/02/14		11		0509F		1	.01			NPI	0987654321
5										NPI	
6										NPI	

PQRS codes

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☒ 52-1234567

26. PATIENT'S ACCOUNT NO. 4367

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

28. TOTAL CHARGE $ 240.00

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH # ( )

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Module 3 – Navigating through Measures

Some measures basics for 2016:

- If using individual measures, you need to report on 9 measures in 2016 (CMS now recommends you not select more than 9 measures).
- The measures must cover at least 3 domains of care.
- You need to report at least 1 cross-cutting measure. Since there are few urology-focused measures, there are many examples on the AUA's list of recommendations.

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Module 3 – Navigating through Measures

More measures basics for 2016:

- You need to report on 50% of the applicable patients for each measure. For some measures, this might be 20 patients, but for another, it might be 200 patients. You need to make that determination for each measure you select.

Module 3 – Navigating through Measures

Measures Groups

- As explained earlier, if your patient population is homogeneous enough that they are apt to require services that fit within one of the CMS measures groups, that is another way to select the measures you intend to report.
- Measures groups are pre-determined by CMS, and you must satisfactory report all measures in that group for at least 20 applicable patients.
- Over half (at least 11) of the applicable patients for a measure must be Medicare Part B patients. The other patients must fit the denominator but do not have a coverage requirement.
- Some measures may not apply to your practice of medicine; so, we urge you to carefully review the measure specifications before selecting this option.
- Let's explore measures groups a little to see if it might fit your needs.

Module 3 – Navigating through Measures

25 measures groups have been created for PQRS:

- Sinusitis
- Acute Otitis Externa (AOE)
- Preventive Care
- Chronic Kidney Disease (CKD)
- Coronary Artery Disease (CAD)
- Heart Failure (HF)
- Asthma
- Total Knee Replacement
- General Surgery
- Dementia
- Parkinson's Disease
- Cardiovascular Prevention
- Multiple Chronic Conditions
- Rheumatoid Arthritis
- Diabetes
- Coronary Artery Bypass Graft (CABG)
- Hepatitis C
- HIV/AIDS
- Optimizing Patient Exposure to Ionizing Radiation
- Chronic Obstructive Pulmonary Disease (COPD)
- Inflammatory Bowel Disease (IBD)
- Cataracts
- Oncology
- Sleep Apnea
- Diabetic Reinopathy

Module 3 – Navigating through Measures

- The following two slides contain the measures groups that, while not a perfect fit, would be most appropriate for a urologist to use.
- As we said before, it is important for the practice leaders to carefully review the specifications for these measures before adopting group measures reporting.

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Module 3 – Navigating through Measures
Chronic Kidney Disease Measures Group

For urology practices that see a lot of chronic kidney disease patients, this measures group may be of interest. If you are interested in seeing a listing of all the measures group specifications, check out the CMS website.

#47. Care Plan
#110. Preventive Care and Screening: Influenza Immunization
#121. Adult Kidney Disease: Laboratory Testing (Lipid Profile)
#122. Adult Kidney Disease: Blood Pressure Management
#130. Documentation of Current Medications in Medical Record
#226. Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Module 3 – Navigating through Measures
Preventive Care Measures Group

The Preventive Care measures group is primary care based, but we know of several urology practices that use it.

#39 Screening for Osteoporosis for Women Aged 65 - 85 Years of Age
#48 Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
#110 Preventive Care and Screening: Influenza Immunization
#111 Pneumonia Vaccination Status for Older Adults
#112 Breast Cancer Screening
#113 Colorectal Cancer Screening
#128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
#134 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
#431 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

Module 3 – Navigating through Measures
Preventive Care Measures Group

Let's look at the Preventive Care Measures Group.

Patient A is a 68 year old male who comes in for any reason. He would satisfy the following measures in the group:

#110 Preventive Care and Screening: Influenza Immunization
#111 Pneumonia Vaccination Status for Older Adults
#113 Colorectal Cancer Screening
#128 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan
#134 Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan
#226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
#431 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

So, be sure you include these screenings in his appointment.

Module 3 – Navigating through Measures Preventive Care Measures Group

Since Patient A didn't satisfy Measures #39, 48, and 112, you need to find someone else who will. In the case of these measures, it must be a woman.

You don't have to have the same 20 patients for each measure; it just needs to be a total of 20 who satisfy (answer yes) for each measure.

Also, you don't have to screen only women for this measure group, but you know that all of the measures will probably apply to them.

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Module 3 – Navigating through Measures

- The next slide shows the factors that should be considered as you choose between reporting individual measures or measures groups.

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Module 3 – Navigating through Measures

Individual measures

Pros	Cons
Maximum flexibility – each practice may select measures that apply to their practice	Too many measures to consider
	Hard to determine which measures are the best to use

Measures groups

Pros	Cons
Significantly fewer patients must be seen to achieve the limit (20)	Reporting on non-applicable measures may apply
Achieve success using one group – focus training on specifications	Few measures groups apply to urology
Data shows that registry users are more successful	Can only report via a registry
	Difficulty finding 20 patients for each measure
	Cost of the registry

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Module 3 – Navigating through Measures

Streamline Reporting

For several years, CMS has been streamlining their reporting programs so that providers can report once to satisfy both PQRS and Meaningful Use (the electronic health record incentive program). If you are participating in both programs, we urge you to speak to your EHR vendor to see what electronic clinical quality measures (or eCQMs as they are called in Meaningful Use) are available to you. Not all vendors make all measures available; so, the measures which might help you succeed in PQRS may not be available through your EHR. However, if they are, you should consider this single reporting option. You would need to elect either EHR reporting option for PQRS reporting.

Module 3 – Navigating through Measures

Let's now review what has been learned:

The next few slides will be a quick review of this module.

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Module 3 – Navigating through Measures

The denominator is usually associated with patient characteristics and billing codes.

True or False?

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Module 3 – Navigating through Measures

The correct answer is:

True.

Module 3 – Navigating through Measures

On measure 48 (Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 and Older), modifier 1P indicates:

A. The patient is under-aged
B. The patient has a medical reason why the measure cannot be reported
C. The patient denies incontinence

Module 3 – Navigating through Measures

The correct answer is:

B. The measure does not apply for medical reasons.

Mastering the Basics of PQRS

Module 3 – Navigating through Measures

When reporting measures groups, you must report on every measure in the group.

True or False?

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Module 3 – Navigating through Measures

The correct answer is:

True. You must have a pool of 20 patients who satisfy each measure. However, it does not need to be the same 20 patients for each measure.

Mastering the Basics of PQRS

Module 4 – Successful Reporting

The next module will help you understand how successful reporting is determined.

Different reporting options have different standards for success.

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Module 4 – Successful Reporting

Success Criteria Individual Measure Reporting

- 12 months – **Claims Success (paper submissions)** = 50% of all denominator patients for nine individual measures (covering 3 domains). Must include at least 1 cross-cutting measure.

- 12 months – **Claims Success (EHR submissions)** = 50% of all denominator patients for nine individual measures (covering 3 domains). Must include at least 1 cross-cutting measure.

Module 4 – Successful Reporting

Success Criteria Individual Measure Reporting

- 12 months – **Registry Success for Individual Measures** = 50% of all denominator patients for nine individual measures (covering 3 domains). Must include at least 1 cross-cutting measure.

- 12 months – **Registry Success for Measures Groups** = Complete reporting on at least 20 patients for each of the measures in the measures group.

Module 4 – Successful Reporting

Success Criteria Individual Measure Reporting

- 12 months – **QCDR Success** = 50% of all denominator patients for nine measures (covering 3 domains). Must include at least 2 outcome measures. 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, efficiency appropriate use, or patient safety measure.

Module 4 – Successful Reporting

For individual measures reported either via paper claims, EHR submission or registry, you must report PQRS codes for nine measures for 50% of the patients who fall in a measure's denominator within the reporting period.

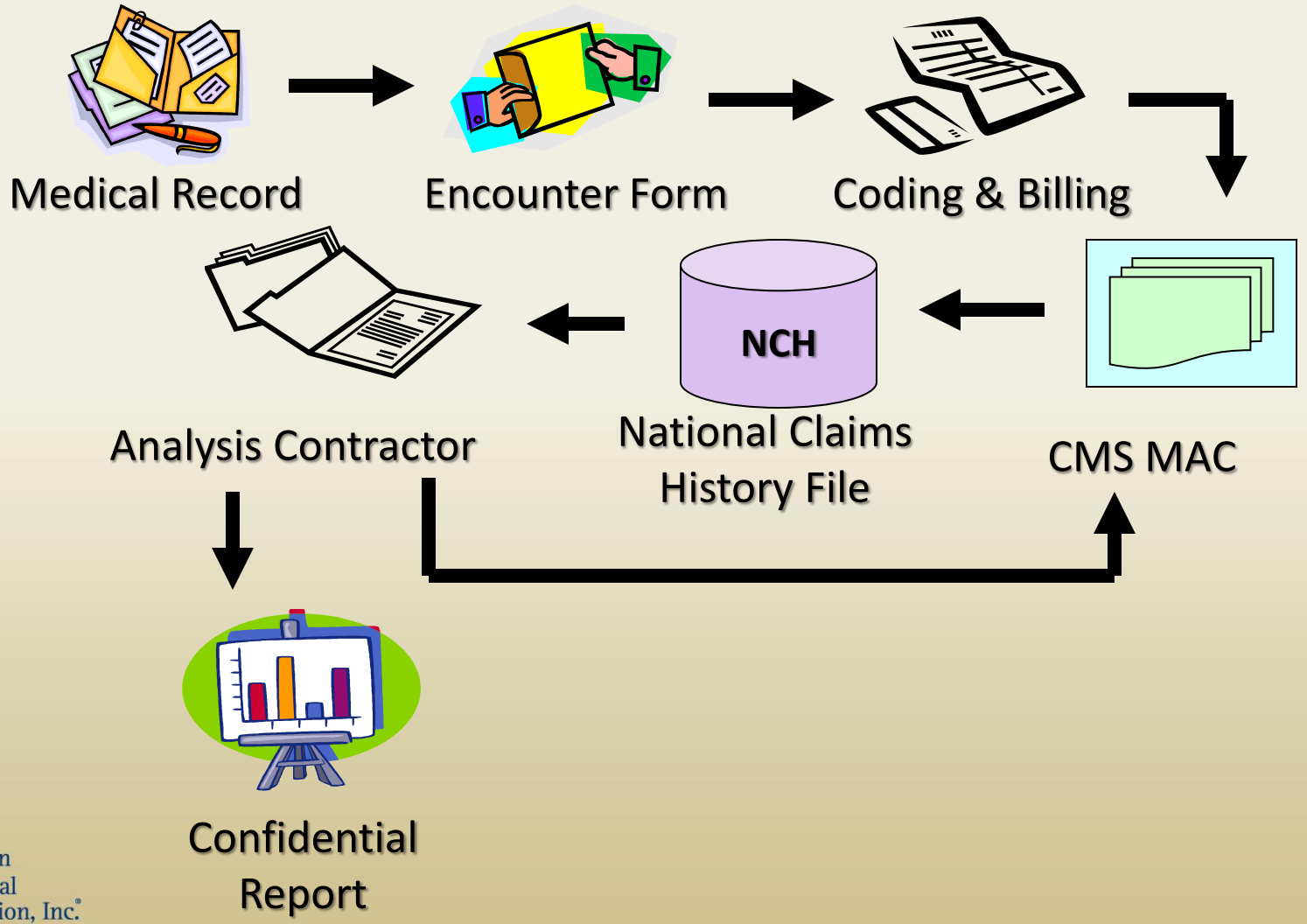
The claims you submit to Medicare allow the PQRS processor to determine which patients fit any denominator. So when you submit a claim on a female Medicare beneficiary, her date of birth will trigger Medicare's computer to calculate her age. The diagnosis codes on her claim will trigger recognition of certain denominators. The procedure codes may trigger other denominators. At that instant, the PQRS processor's computer starts looking for PQRS codes.

Later, we will look at some sample success reports to show how they calculate the percentages per measure per NPI. As mentioned before, there are special rules if you only see patients whose denominator characteristics only fall into one or two measures. You can still participate, but the standards are higher.

Module 4 – Successful Reporting

- The next slide is a flow chart of the PQRS claims submission process.
- Eligible professionals should document measure requirements in the medical record. Quality data codes are then entered onto an encounter form and are then captured for the claims submission process.
- The claim is submitted to the Medicare claims processing contractor.
- The PQRS codes will show as denied on the EOB that you receive from the Medicare carrier or MAC, but they will be transmitted for processing into the National Claims History file.
- The Medicare contractor hired to do the data analysis will calculate your reporting rate for each NPI number in your practice and will create a confidential report showing how you did.
- Keep in mind that the analysis contractor will wait until the majority of calendar year claims are processed which is one reason why reports are delayed until later in the following year.

Module 4 – Successful Reporting



Module 4 – Successful Reporting

How much would I stand to lose if I don't report to PQRS?

The PQRS payment adjustment (penalty) is 2% of your total Medicare Part B earnings. This could be substantial for some providers.

The payment adjustment for data reported in 2016 would impact your 2018 payments.

Additionally, this will affect your score for the Value-Based Payment Modifier (or Value Modifier or VM) which also has an associated incentive and penalty.

Module 4 – Successful Reporting

- The Value-Based Modifier (VM) is a very complex program, and we will only present a high-level snapshot of it here. For more information, we recommend that you visit the CMS website or contact QualityNet.com.

- The overall goal of the Value-Based Modifier program is to deliver better care at a lower cost. The VM adjusts Medicare physician fee schedule payments to physicians based on a quality and cost formula created by CMS. The quality portion of the formula (based on the 6 domains of care discussed previously) uses PQRS data while the cost side utilizes other provider information. One's composite quality and cost performance based on this formula can translate into payment incentives for providers who provide high quality, efficient care, while providers who underperform may be subject to a downward adjustment.

- The next slide gives a snapshot of the factors which go into the Value Modifier.

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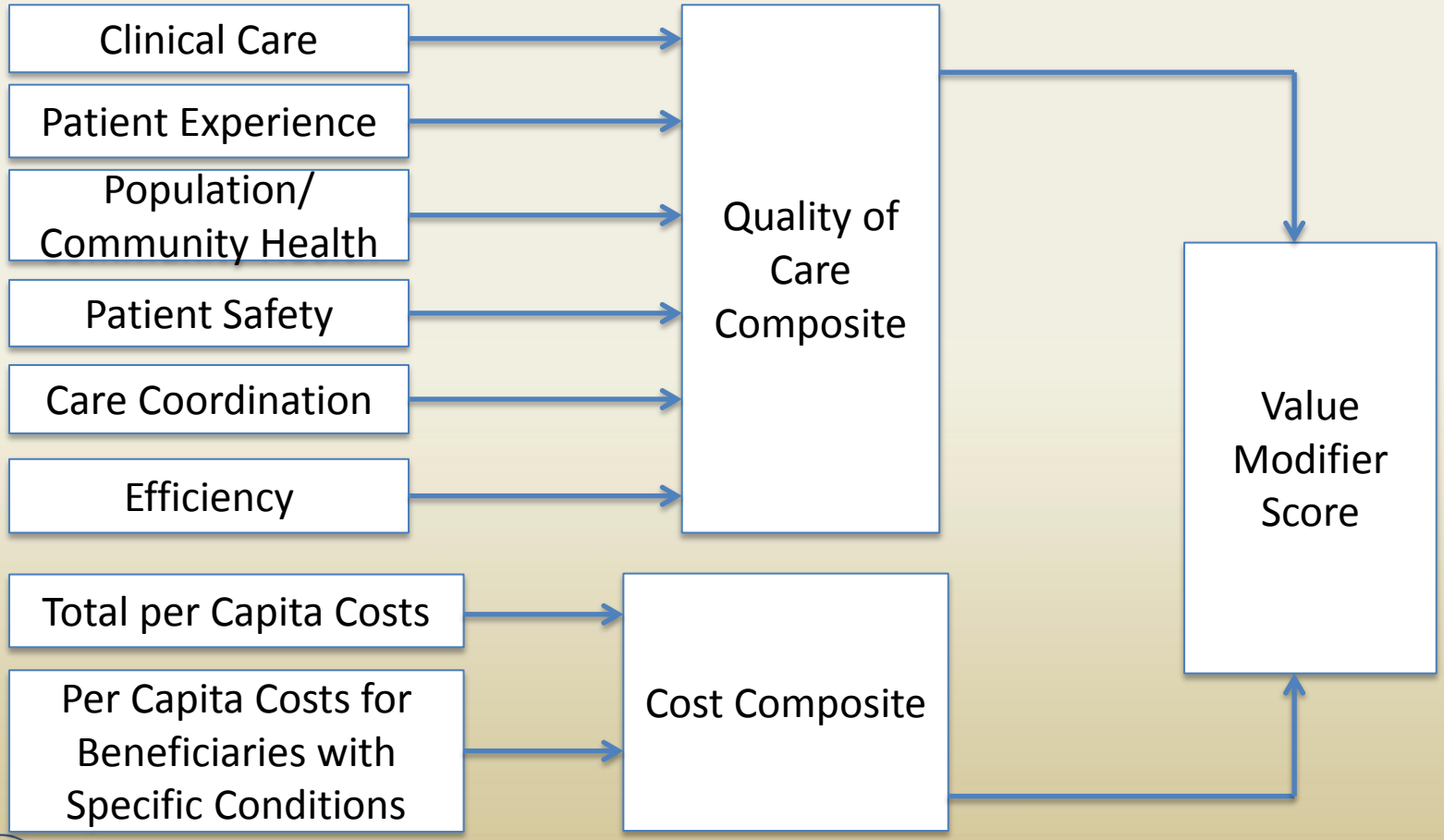
Module 4 – Successful Reporting

Relationship between Quality of Care and Cost Composites and the Value Modifier



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Module 4 – Successful Reporting

- In the 2016 PQRS reporting year, the VM applies to all providers and non-physicians who are required to report PQRS.

- As with previous years, CMS will divide providers into 2 categories, as the following slide demonstrates. Category 1 will include those who satisfactorily report for PQRS 2016, and Category 2 includes those who do not participate in PQRS or do so incorrectly.

- Category 2 physicians will face a payment adjustment. The size of this penalty will be determined by the size of the practice.

- For Category 1, you would naturally assume that everyone who successfully reports for PQRS would receive a VM incentive, but that is not so. Statute requires that the Value-Based Modifier must be implemented in a budget neutral manner, generally meaning that incentives (or upward payment adjustments) for high performance must balance the downward payment adjustments or penalties applied for poor performance. This is important to note. Even though one might not receive a PQRS penalty, if your peers score better than you, you may be penalized through the Value-Based Modifier so that the highest scoring provider receives an incentive.

Module 4 – Successful Reporting

For CY 2018 payment adjustment, EPs and groups with 2+ EPs

PQRS Reporters – 3 types

1a. Group reporters – Register for GPRO Web Interface, Registry, or EHR AND meet the criteria to avoid the 2018 PQRS payment adjustment

OR

1b.Individual reporters in the group – at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment.

2. Physician solo practitioners – Report PQRS measures as individuals AND meet the criteria to avoid the 2018 PQRS payment adjustment

Mandatory Quality-Tiering Calculation

Groups with 2-9 EPs and solo practitioners

Upward or neutral VM adjustment based on quality-tiering (+0.0% to +2.0x of MPFS)

Groups with 10+ Physicians

Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)

Non-PQRS Reporters
Do not register for GPRO Web Interface, registry, or EHR or 50% EP threshold **OR** do not avoid the 2018 PQRS payment adjustment

-2.0% (for groups with 2-9 EPs and solo practitioners)
-4.0% (for groups with 10+ EPs)
(Automatic VM downward adjustment)

Note: The VM payment adjustments are separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

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Module 4 – Successful Reporting

- The following two charts show the payment adjustments based on practice size for those physicians who participate in PQRS. Practices with 10 or more physicians have been subject to the Value-Based Modifier in previous years. Therefore their penalties and rewards are greater while those practices with less than 10 providers are given a grace period with no penalties.

- The "x" in these boxes represents the incentive. If providers are eligible, the incentive will be multiplied by whatever the appropriate number is. Since the program is budget neutral, CMS must determine how much money it has to distribute before it can set the incentive amount each year. Note there is an also asterisk in both charts. That means that those who fall within these boxes are eligible for even more reward if the patient population they see is considered to be within the top 25% most serious patients.

Module 4 – Successful Reporting

Final Rule CY 2018 AM Amounts for Groups with MORE than 10 EPs

Cost/ Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+2.0x*	+4.0x*
Average Cost	-2.0%	+0.0%	+2.0%
High Cost	-4.0%	-2.0%	+0.0%

Final Rule CY 2018 AM Amounts for Groups with LESS than 10 EPs

Cost/ Quality	Low Quality	Average Quality	High Quality
Low Cost	+0.0%	+1.0x*	+2.0x*
Average Cost	+0.0%	+0.0%	+1.0x*
High Cost	+0.0%	+0.0%	+0.0%

* Eligible for an additional +1.0x if reporting measures and average beneficiary risk score in the top 25 percent of all beneficiary risk scores

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Mastering the Basics of PQRS

Module 4 – Successful Reporting

- CMS provides an indication on how physicians will do on in the Value-Based Modifier through Quality and Resource Use Reports (or QRURs) which provide feedback on the quality and cost of care furnished to Medicare beneficiaries. The following slide gives a sample page from a QRUR. Some of the metrics used in the QRUR are not directly applicable to specialists (including urologists); yet, CMS applies them all the same. So, scores can appear to be skewed. CMS continues to say they are assessing how to modify the QRUR to make it more applicable to everyone, but at this time we have heard of no changes.

- Again, this is a very simple summary of the Value-Based Modifier. The AUA urges you to seek more information on the program on its website or elsewhere.

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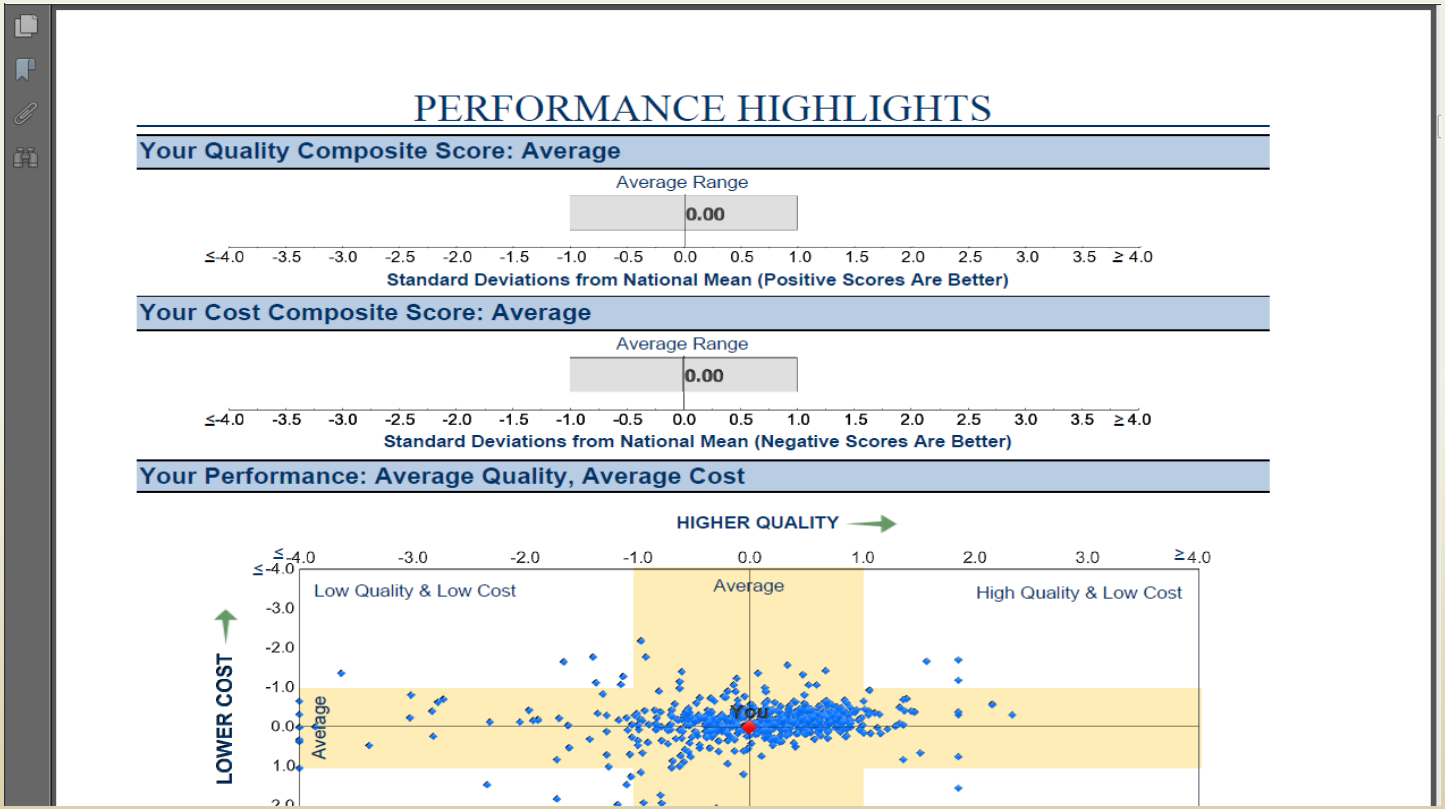
Module 4 – Successful Reporting



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Module 4 – Successful Reporting

CMS makes QRURs available in the fall of the year following reporting. For example, the 2015 QRUR will be available in the fall of 2016.

Look for the announcement that QRURs are available and then take steps to obtain yours from CMS. It is not automatically sent to you.

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Module 4 – Successful Reporting

Let's now review what has been learned:

The next few slides will be a quick review of this module.

Module 4 – Successful Reporting

True or False

To successfully report claims using individual measures, a provider only needs to report on 20 patients for 9 measures.

Module 4 – Successful Reporting

False

To successfully report individual measures via any reporting method, a provider needs to report on at least 50% of the eligible patients that fall into a measure's denominator. This would need to be done for 9 measures.

If a provider is reporting a measures group, then he/she would only report on 20 patients for all the measures in that group.

Mastering the Basics of PQRS

Module 4 – Successful Reporting

Question: The Value Based Modifier:

A. Is a healthcare delivery program aimed at creating better care at a lower cost.
B. Is budget neutral, meaning the incentives are awarded based on the penalties paid.
C. Is figured using a formula measure both a cost and quality composite.
D. All of the above.

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Module 4 – Successful Reporting

The answer is D.

All of the answers are true.

Module 5 – Obtaining and Understanding the Scorecard

In order to get more details about how you did in your reporting process so that you can improve, you will need to obtain a feedback report.

Feedback reports are available in September of the following year. For example, the 2015 report will be available in September 2016.

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A PQRS feedback report will be generated for each Taxpayer Identification Number/National Provider Identifier (TIN/NPI) combination that reported PQRS data OR that submitted Medicare PFS claims that included denominator-eligible events but did not submit PQRS data.

Module 5 – Obtaining and Understanding the Scorecard

Before you can receive your feedback report, you must first have an Enterprise Identity Management System (EIDM) account.

Visit the CMS Enterprise Portal at **https://portal.cms.gov** to set up an account.

Mastering the Basics of PQRS

Module 5 – Obtaining and Understanding the Scorecard

To access your feedback report:

- Log onto https://portal.cms.gov
- Select Get Started in the Physician Value box on the CMS Enterprise Portal

The system will walk you through the information you need to enter in order to get your report.

A guide for the process is available on the CMS website.

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Module 5 – Obtaining and Understanding the Scorecard

The following two charts are reproductions of an actual urology practice group performance report from a few years ago.

The first slide notes the numbers and percentages of patients that fell into the denominators for the PQRS measures. This provider chose to report on only the three incontinence measures. This was a gamble since the provider was very close to 80% on each one, but it paid off.

Note: In previous PQRS reporting periods, to be deemed successful, providers were required to report 80% of the eligible patients who fell into the 3 measure they chose to use.

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PQRS Scorecard

Earned Incentive

NPI	NPI Name	Yes/ No	Rationale	Measures Eligible	Measures Reported	Measures Satisfactorily Reported	NPI Total Incentive Amount
		Yes	Reported Satisfactorily	10	3	3	

Measure Statement (Measure #)	Opportunities to Report	Reported Instances	Reporting Rate	Measure Validation Clinical Focus Area
Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Yrs and Older (#48)	42	37	88.1%	N/A
Plan of Care for Urinary Incontinence in Women Aged 65 yrs and Older (#50)	14	12	85.7%	Urinary Incontinence
Characterization of Urinary Incontinence in Women aged 65 Yrs and Older (#49)	14	12	85.7%	Urinary Incontinence
Advance Care Plan (#47)	317	0	0.0%	N/A
Screening for Future Fall Risk (#42)	254	0	0.0%	N/A
Screening or Therapy for Osteoporosis for Women Aged 65 Yrs and Older (#39)	42	0	0.0%	N/A
Medication Reconciliation (#46)	28	0	0.0%	N/A

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Module 5 – Obtaining and Understanding the Scorecard

Next you will see how each NPI is compared to the national average for the measures for which he or she is successful.

CMS uses these physician comparisons for various government programs, such as the Value-Based Modifier.

Also, as the national percentile rates rise, it is reasonable to expect that the success rate might rise as well. Also, when the performance rate hovers in the 90th percentile, CMS has considered the measure "topped out" and has frequently decided to retire the measure from reporting programs.

Mastering the Basics of PQRS

Performance Information

		Eligible Instances Excluded						Clinical Performance Not Met			
Measure #	Opportunity to report	Clinical (1P)	Patient (2P)	System (2P)	Other	Clinical Performance Denominator	Clinical Performance Numerator	QDC Reported	QDC not reported	Insufficient QDC Info	Clinical Performance Rate
#48	42	0	0	0	0	42	37	0	5	0	88.1%
#49	14	0	0	0	0	14	12	0	2	0	85.7%
#50	14	0	0	0	0	14	12	0	2	0	85.7%

	National Comparison For Performance		
Measure #	25th Percentile	50th Percentile	75th Percentile
#48	11.1%	33.3%	64.6%
#49	44.4%	74.2%	94.4%
#50	40.0%	69.2%	91.7%

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Module 5 – Obtaining and Understanding the Scorecard

If, after reviewing your feedback report, you think there has been an error in your PQRS assessment, you can request an **informal review**.

When feedback reports are available, CMS also announces a timeframe for requesting an informal review.

Module 5 – Obtaining and Understanding the Scorecard

- To request, visit CMS's Physician and Other Health Care Professionals Quality Reporting Portal.
- Select "Communication Support Page" under "Related Links" in the upper left navigation pane.
- In the drop down menu, select "Informal Review Request" and choose the appropriate option.

Module 5 – Obtaining and Understanding the Scorecard

Let's now review what has been learned:

The next few slides will be a quick review of this module.

Module 5 – Obtaining and Understanding the Scorecard

Feedback reports are issued with one report for the entire practice.

True or False?

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Module 5 – Obtaining and Understanding the Scorecard

The correct answer is:

False. The reports are issued for each NPI provider.

Mastering the Basics of PQRS

Module 6 – Tips for 2016 and Beyond

In 2017, CMS will transition to a new payment system based on quality reporting – the Merit-based Incentive Payment System (MIPS).

Part of MIPS is the Quality Program (which is basically PQRS by another name).

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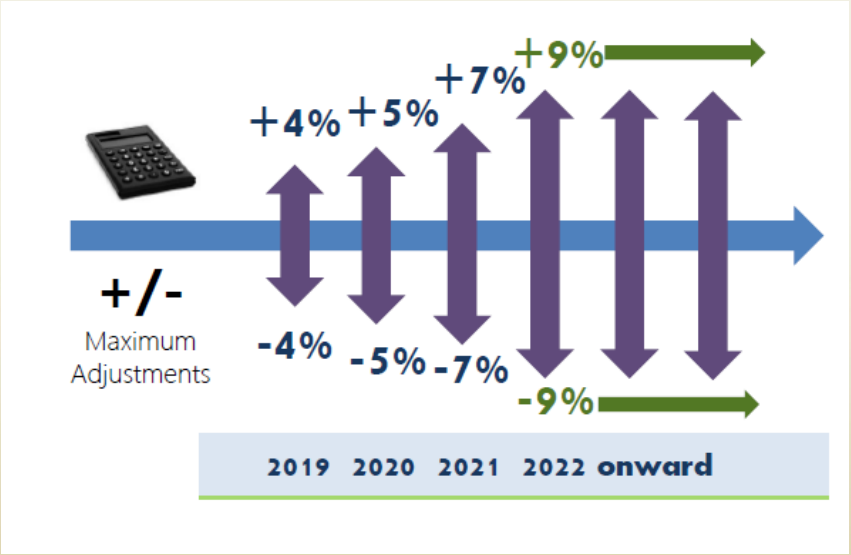
Module 6: Tips for 2016 and Beyond

- The payment adjustment for 2019 (which is based on 2017 reporting) will be +/-4%, and it only increases from there.
- Participating will become even more important. So, it is best to start now rather than wait.



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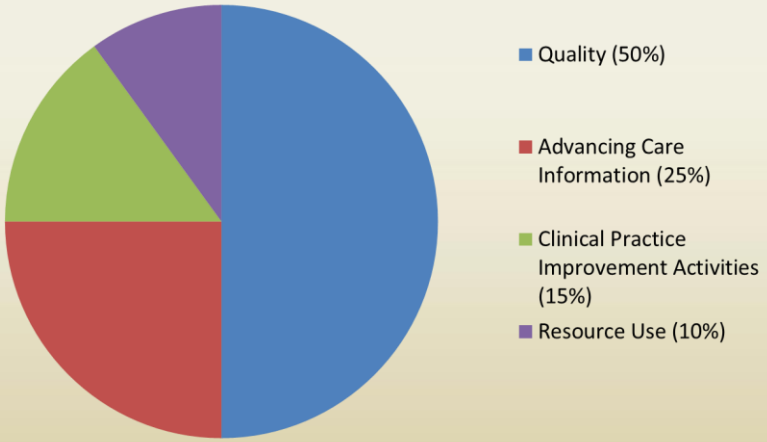
Module 6 – Tips for 2016 and Beyond

MIPS: Four Categories



MIPS will be comprised of 4 categories: Quality, Advancing Care Information (currently Meaningful Use); Resource Use (currently Value-Based Modifier), and Clinical Practice Improvement Activities.

Quality reporting will account for half of the MIPS program.

It is important that providers know how to do it right—to hopefully earn an incentive and prevent a penalty.

Therefore, make sure you are doing PQRS right to get a jump on MIPS reporting.

Module 6 – Tips for 2016 and Beyond

AUA has PQRS resources to help you succeed now.

Helpful tools for PQRS

- PQRS General Resources on AUA Web site: **http://www.auanet.org/resources/physician-quality-reporting-system.cfm**
- PQRS Toolkit on AUA Web site: **www.AUAnet.org/PQRStoolkit**
  - Specifications and AUA flow charts for urology-appropriate measures
  - Quick reference guides
  - Sample orders and questionnaires
  - Web links and phone numbers for assistance
- Dedicated AUA email address for your questions: **PQRS@AUAnet.org**
- AUA Webinars and Conference Calls
- AUA Coding Today Web site: **http://www.auanet.org/resources/aua-coding-today.cfm**
- AUA Quality Registry (AQUA): **http://www.auanet.org/resources/aqua.cfm**

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Module 6 – Tips for Annual Improvement

Take advantage of other resources as well.

- American College of Surgeons Resources
  - Overview
- CMS Resources
  - Overview
  - QualityNet help desk – 866-288-8912 or QNetSupport@hcqis.org

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Mastering the Basics of PQRS

Good luck!

You have completed our training on PQRS reporting.

Remember, don't hesitate to contact the AUA for help at pqrs@auanet.org.

Thanks for taking this course! Watch our website at www.auanet.org for additional information on training and publications that may help in the future.

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