



A Guidebook to the 2015 Physician Quality Reporting System

What is PQRS?

The Physician Quality Reporting System (PQRS), formally known as the Physician Quality Reporting Initiative (PQRI), is a reporting program which requires eligible professionals (EPs) enrolled in Medicare, as a Participating or Non-Participating providers, to submit data to the Centers for Medicare and Medicaid Services (CMS) on the satisfactory reporting of specified quality measures. According to CMS, "Under Physician Quality Reporting System (PQRS), covered professional services are those paid under or based on the Medicare Physician Fee Schedule (PFS). To the extent that eligible professionals are providing services [that] get paid under or based on the Physician Fee Schedule, those services are eligible for PQRS incentive payments and/or payment adjustments." Based on that definition, doctors of chiropractic do qualify for PQRS participation.

Since inception in 2007, the PQRS was a pay-for-reporting program. EPs were eligible to receive incentive payments if they successfully and satisfactorily reported on quality measures. However, in 2013 the program began its transition from an incentive program to one in which penalties will be assessed to eligible professionals who did not meet the reporting requirements. To comply with PQRS and thus avoid the payment adjustment, doctors of chiropractic must report on a certain number of measures for a designated percentage of eligible Medicare beneficiaries. Through this initiative, CMS hopes to improve the collection and reporting of evidence-based performance measure at the time of service, rather than from labor intensive retrospective chart reviews. Proper use of these codes can help to establish standards and promote evidence-based best practices, which in turn can reduce claim fraud and streamline the reimbursement process.

PQRS Incentives & Payment Adjustments

Incentive Payments:

The 2014 reporting period (Jan. 1 – Dec. 31, 2014) was the last opportunity providers had to earn an incentive payment, equal to 0.5% of their total estimated Medicare Part B Physician Fee Schedule (PFS) allowed charges, for participating in the PQRS program.

Payment Adjustments:

CMS finalized Calendar Year 2013 as the performance period for the 2015 PQRS penalties. Therefore, if CMS determined that an EP did not successfully and satisfactorily report data on quality measures for covered professional services during the 2013 PQRS reporting period (Jan. 1 – Dec. 31, 2013), those providers will see their Medicare reimbursement **decreased by 1.5%** (98.5% of the fee schedule amount that would otherwise apply to such services) beginning on January 1, 2015.

- For more information, please review the "Quick Reference Guide for Understanding the 2015 Physician Quality Reporting System (PQRS) Negative Payment Adjustment" available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/Quick-Reference-Guide_2015PQRSPaymentAdjustment_F101414.pdf

Further, Calendar Year 2014 was the performance period that affected a provider's 2016 Medicare reimbursement. If CMS determined that an EP did not successfully perform and satisfactorily report on quality measures during the 2014 reporting period (Jan. 1 – Dec. 31, 2014), the provider did not qualify for the 0.5% payment incentive and they will see a **payment decrease of 2%** (98.0% of the fee schedule amount that would otherwise apply to such services) applied to their 2016 Medicare reimbursement.

And finally, **Calendar Year 2015 is the performance period that will affect a provider's 2017 Medicare reimbursement.** If an EP does not successfully perform and satisfactorily report on quality measures during this year's reporting period (Jan. 1 – Dec. 31, 2015), the provider will face a **payment decrease of 2%** (98.0% of the fee schedule amount that would otherwise apply to such services) which will be applied to their 2017 Medicare reimbursement.

Getting Started With PQRS

If you have never participated in PQRS, the ACA encourages you to begin immediately.

For those doctors of chiropractic who are continuing their participation in PQRS, please be advised that **significant updates have been made for 2015** that affect the number of PQRS measures applicable to chiropractic practices as well as the specific quality-data codes (G-codes) used to report these measures. To get started, follow the steps laid out below:

- 1) First, you should know that no registration is required to begin participating in PQRS.
- 2) It is best to start by familiarizing yourself with the two (2) quality measures doctors of chiropractic need to report in 2015. These measures are:
 - **Measure #131:** Pain Assessment and Follow-Up
 - **Measure #182:** Functional Outcome Assessment

DELETED for 2015

 - **Measure #317:** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
 - *For 2015, the CMT codes were removed from the denominator of the Blood Pressure Screening measure and DCs are no longer required to report on this quality measure.*
- 3) To avoid the 2017 payment adjustment, you must report satisfactorily on **both** measures applicable to DCs during the 12-month reporting period in 2015. You must also successfully perform these measures at least once – measures with a zero percent performance rate will not be counted.

Please Note: DCs can only report on 2 PQRS measures and the minimum reporting requirement of “9 measures, covering at least 3 NQS domains” to avoid the 2017 PQRS payment adjustment does not apply to doctors of chiropractic. Please see additional information on page 10 regarding the Measure Application Validity (MAV) process.
- 4) To report in PQRS, you will need to place G-codes on your claim. The G-codes will correlate to an action that was taken (or not taken) by the provider.
- 5) You should report Measures #131 and #182 on **every visit**, for every Medicare patient who is at least 18 years old **and** where you have reported a spinal CMT code (CPT® code 98940, 98941, or 98942). In 2015, you must satisfactorily report on **both** of these measures at least 50% of the eligible visits, and successfully perform each measure at least once, to avoid the 2017 payment adjustment.

Information is provided on the following pages to assist you in reporting the appropriate G-code for each measure.

Measure #131: Pain Assessment and Follow-Up

- The purpose of this measure is for CMS to collect data on when a pain assessment is conducted using a standardized tool, **and** a follow-up plan that includes a reassessment of pain is planned/documented when pain is present.
- A standardized tool is defined as an assessment tool that has been appropriately normalized and validated for the population in which it is used.
- Examples of standardized pain assessment tools include, but are not limited to: Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).

Important: The name of the standardized tool used to assess the patient's pain **must** be documented in the medical record (*Exception: A provider may use a fraction such as 5/10 for the Numeric Rating Scale without documenting this actual tool name when assessing pain for intensity*).

- Providers are asked to report, for **each visit**, whether they provided a standardized pain assessment to the patient, if pain was present or absent, **and**, in cases where pain was present, whether they documented a follow-up plan which includes a reassessment of the pain (when pain is present). A multi-dimensional clinical assessment of pain using a standardized tool may include characteristics of pain such as: location, intensity, description, and onset/duration.
- A documented follow-up plan must be related to the presence of pain (a positive pain assessment), and **must** include a planned follow-up appointment to reassess the patient for pain, referrals, or notification of other care providers, as applicable, OR indicate the initial treatment plan is still in effect. The plan may also include educational interventions.
- On **each visit**, the provider should report one (1) of the six (6) quality data codes (G-codes) below on line 24 D of a paper claim or on service line 24 of an electronic claim.

The following chart depicts the situations in which each G-code should be reported for Measure #131:

Provider Action	G-Code Reported
<p><u>Performance Met:</u> Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented.</p> <p>The provider assessed the patient for pain using a standardized tool, documented a positive assessment (pain was present), and also documented a follow-up plan that specifically stated a planned reassessment of pain, a referral, or that the initial plan is still in effect.</p>	G8730
<p><u>Performance Met:</u> Pain assessment using a standardized tool is documented as negative, no follow-up plan required.</p> <p>The provider assessed the patient for pain, documented a negative assessment (absence of pain), so no additional documentation was <u>required</u>.</p>	G8731
<p><u>Other Performance Exclusion:</u> Pain assessment NOT documented as being performed, documentation the patient is not eligible for a pain assessment using a standardized tool.</p> <p>The provider documented that the patient was not eligible for a pain assessment. Patients are not eligible only if one or more of the following reason(s) are documented:</p> <ul style="list-style-type: none"> • Severe mental and/or physical incapacity where the patient is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools; • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. 	G8442

<p><u>Other Performance Exclusion:</u> Pain assessment documented as positive, follow-up plan not documented, documentation the patient is not eligible.</p> <p>The provider assessed the patient for pain using a standardized tool, documented a positive assessment (pain was present), did not document a follow-up plan because the patient was deemed ineligible. Patients are not eligible only if one or more of the following reason(s) are documented:</p> <ul style="list-style-type: none"> • Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others. For example, cases where pain cannot be accurately assessed through use of nationally recognized standardized pain assessment tools; • Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status. 	G8939
<p><u>Performance Not Met:</u> No documentation of pain assessment, reason not given.</p> <p>The provider did not assess the patient for pain and there is no documentation the patient was not eligible (see G8442 or G8939 for non-eligibility reasons).</p>	G8732
<p><u>Performance Not Met:</u> Pain assessment documented as positive using a standardized tool, follow-up plan <u>not</u> documented, reason not given.</p> <p>The provider assessed the patient for pain, documented a positive assessment (pain was present), but did not document a follow-up plan or a reason the patient was not eligible (see G8442 or G8939 for non-eligibility reasons).</p>	G8509

Measure #182: Functional Outcome Assessment

- The purpose of this measure is for CMS to collect data on when functional outcome assessments are conducted, using a standardized tool, along with the creation of a treatment plan based on the functional deficiencies found.
- Functional outcome assessments are designed to measure a patient's physical limitations/deficiencies in performing the usual human tasks of living and to directly quantify functional and behavioral symptoms. Functional outcome deficiencies which result in impairment or loss of physical function, related to musculoskeletal/neuromusculoskeletal capacity, may include but are not limited to: restricted flexion, extension and rotation, back pain, neck pain, pain in the joints of the arms or legs, and headaches.
- Examples of standardized functional outcome assessment tools include Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), Physical Mobility Scale (PMS), Patient-Reported Outcomes Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).
 - **Important:** Documentation of a **current** functional outcome assessment must include identification (the name) of the standardized tool used.
 - **Please Note:** A functional outcome assessment is multi-dimensional and quantifies pain and musculoskeletal/neuromusculoskeletal capacity; therefore the use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does **not** meet the criteria of a functional outcome assessment standardized tool.
- Providers are asked to report, for **each visit**, whether they conducted a functional outcome assessment of the patient and whether they documented a care plan when functional outcome deficiencies were identified. A care plan describes expected/planned activities based on identified deficiencies (e.g., goals, services, appointments and procedures).
- The intent of the measure is for the functional outcome assessment tool to be **utilized** at a minimum of every 30 days, but **reporting** is required each visit due to coding limitations. Therefore, for visits occurring within 30 days of a previously documented functional outcome assessment, the code G8942 should be used for reporting purposes.
- On **each visit**, the provider should report one (1) of the seven (7) quality-data codes (G-codes) below on line 24 D of a paper claim or on service line 24 of an electronic claim.

The following chart depicts the situations in which each G-code should be reported for Measure #182:

Provider Action	G-Code Reported
<p><u>Performance Met:</u> Functional outcome assessment documented as positive using a standardized tool AND a care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented.</p> <p>The provider performed a functional outcome assessment, using a standardized tool, and documented a care plan which included goals based on the deficiencies found.</p>	G8539
<p><u>Performance Met:</u> Functional outcome assessment using a standardized tool is documented; no functional deficiencies identified, care plan not required.</p> <p>The provider performed a functional outcome assessment, using a standardized tool, but a care plan is not required because no functional deficiencies were identified.</p>	G8542

<p><u>Performance Met:</u> Functional outcome assessment using a standardized tool is documented within the previous 30 days and care plan, based on identified deficiencies on the date of the functional outcome assessment, is documented.</p> <p>The provider has documented a functional outcome assessment, using a standardized tool, and a care plan which included goals based on the deficiencies found, within the last 30 days.</p>	G8942
<p><u>Other Performance Exclusion:</u> Functional Outcome Assessment NOT documented as being performed, documentation the patient is not eligible for a functional outcome assessment using a standardized tool.</p> <p>The provider documented the patient was not eligible for a functional outcome assessment. Patients are not eligible only if one or more of the following reason(s) are documented:</p> <ul style="list-style-type: none"> • The patient refuses to participate • The patient is unable to complete the questionnaire • Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status 	G8540
<p><u>Other Performance Exclusion:</u> Functional outcome assessment documented, care plan not documented, documentation the patient is not eligible for a care plan.</p> <p>The provider performed a functional outcome assessment, using a standardized tool, and found functional deficiencies, did not document a follow-up plan because the patient was deemed ineligible. Patients are not eligible only if one or more of the following reason(s) are documented:</p> <ul style="list-style-type: none"> • Patient refuses to participate • Patient unable to complete questionnaire • Patient is in an urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient's health status 	G9227
<p><u>Performance Not Met:</u> Functional outcome assessment using a standardized tool not documented, reason not given.</p> <p>The provider did not perform a functional outcome assessment and there is no documentation the patient was not eligible (see G8540 or G9227 for non-eligibility reasons).</p>	G8541
<p><u>Performance Not Met:</u> Documentation of a positive functional outcome assessment using a standardized tool; care plan <u>not</u> documented, reason not given.</p> <p>The provider performed a functional outcome assessment, using a standardized tool, and found functional deficiencies, but did not document a care plan. In addition, there is no documentation the patient was not eligible (see G8540 or G9227 for non-eligibility reasons).</p>	G8543

2015 Criteria for Qualifying for the Incentive Bonus AND Avoiding the 2017 Payment Adjustment

Reporting Mechanism	Reporting Criteria	Reporting Period
Claims-based reporting <i>(NOTE: Claims-based reporting is the only reporting mechanism currently available to DCs.)</i>	Report both measures correctly for at least 50% of the eligible Medicare Part B FFS claims. Measures with a 0% performance rate will not be counted.	January 1, 2015 – December 31, 2015

How to Find Out if You Successfully Participated in PQRS

Each year, a Physician Quality Reporting System (PQRS) Final Feedback Report is issued for each provider based on their participation the previous year.

Interim feedback reports will be available quarterly for every Taxpayer Identification Number (TIN) under which at least one eligible professional (identified by his/her NPI) submitting Medicare Part B FFS claims reported at least one valid PQRS measure during the reporting period. This will be done through an "Interim Report Dashboard".

The Dashboard allows eligible professionals to log-in to a web-based tool and access interim PQRS data on a quarterly basis in order to monitor the status of claims-based individual measures. Please note the Dashboard does **not** provide final data analysis for full-year reporting or indicate PQRS incentive eligibility. The Dashboard will only provide claims-based data for interim feedback. Please take the time to download and read the "2014 Dashboard User Guide" once it is available (spring 2014).

How to Access your Final Feedback Report

If a PQRS feedback report is available for your National Provider Identifier (NPI), there are two (2) ways to access it.

1. A provider can simply call their A/B MAC to request the PQRS feedback report, which will contain information based on their individual NPI (if the provider is part of a group practice, each provider in the group practice must submit individually). To obtain a list of MAC Provider Contact Centers, visit the ACA website at:

http://www.acatoday.org/pdf/AB_MACs_ByState.pdf

In addition to PQRS information, these reports will provide individual providers with information on their Medicare Part B Physician Fee Schedule allowed charges upon which the incentive payment will be based, if applicable.

2. Providers can logon to the secure PQRS Portal on QualityNet at: <https://www.qualitynet.org/portal> to access their feedback report.
3. Users who have questions or need assistance should contact the Quality Net Help Desk at: 1-866-288-8912 (Monday-Friday 7:00 a.m.-7:00 p.m. CST) or email Onetsupport@hcqis.org

Timeline of Incentives/Payment Adjustments

- 2013 – 0.5% incentive bonus available*
- 2014 – 0.5% incentive bonus available*
- 2015 – 1.5% payment decrease (based on non-participation or unsuccessful performance in 2013) *
- 2016 – 2.0% payment decrease (based on non-participation or unsuccessful performance in 2014) *
- 2017 – 2.0% payment decrease (based on non-participation or unsuccessful performance in 2015) *

* Starting on January 1, 2015, negative payment adjustments will be applied to the Medicare reimbursement for each year based on a provider's non-participation or unsuccessful/unsatisfactory performance in PQRS two (2) years prior.

New Fee Schedule Format & Negative Payment Adjustments

The negative payment adjustments apply to all providers that did not satisfactorily participate PQRS during the 2013 reporting period and/or who were not meaningful Electronic Health Record (EHR) users in 2014, regardless of whether they have elected to be "participating" (Par) or "non-participating" (Non-Par) for purposes of Medicare payments. In preparation for the implementation of the negative payment adjustments beginning on January 1, 2015, all Medicare Administrative Contractors (MACs) were directed by CMS to revise the format of their fee schedules to display the limiting charge amount after applying the EHR and PQRS negative adjustment(s). Specifically, the MACs are required to add the following line items:

- EHR Limiting Charge;
- PQRS Limiting Charge;
- EHR/2014 eRx* Limiting Charge;
- EHR + PQRS Limiting Charge; and
- EHR/2014 eRx* + PQRS Limiting Charge.

*Note: DCs are not affected by the Electronic Prescribing (eRx) penalty.

The MACs are only required to post how the negative payment adjustments will specifically affect Non-Par providers because they have the ability to choose either to accept or not accept assignment on Medicare claims on a case-by-case/claim-by-claim basis. In 2015, for cases/claims when a Non-Par provider chooses not to accept assignment, they are required to abide by the limiting charge restrictions when collecting payment from the patient and the limiting charge amounts vary depending upon whether the provider successfully participated in PQRS (in 2013) and/or EHR (in 2014).

Please Note: It is very important that Non-Par providers select the correct limiting charge amount that applies to them when billing Medicare for claims in which they do not accept assignment. CMS states: "*Submission of a non-par, non-assigned Medicare Physician Fee Schedule (MPFS) service with a charge in excess of the Medicare limiting charge amount constitutes a violation of the limiting charge. A physician or supplier who violates the limiting charge is subject to a civil monetary penalty of not more than \$10,000, an assessment of not more than 3 times the amount claimed for each item or service, and possible exclusion from the Medicare program. Therefore, it is crucial that EPs are provided with the correct limiting charge they may bill for a MPFS service.*"

Participating (Par) providers that did not successfully/satisfactorily report data on quality measures for covered professional services during the 2013 PQRS reporting period (Jan. 1 – Dec. 31, 2013) and/or were not meaningful EHR users in 2014 will also receive negative payment adjustments beginning on January 1, 2015. CMS will take the penalty directly out of the allowed amount for services billed. Because it will apply the penalty to the entire allowed charge, then pay 80 percent of that amount, the beneficiary's 20 percent coinsurance would be slightly reduced as well.

For more information on this topic, please refer to MLN Matters® Number MM8667 "Posting the Limiting Charge after Applying the Electronic Health Record (EHR) and Physician Quality Reporting System (PQRS) Negative Adjustments" available at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8667.pdf>

What is the Measures Applicability Validation (MAV) Process?

The following criterion for individual eligible professionals reporting via claims and registry was finalized in the 2015 Medicare Physician Fee Schedule Final Rule:

For the 12-month reporting period for the 2017 PQRS payment adjustment, report at least 9 measures, covering at least 3 of the NQS domains AND report each measure for at least 50 percent of the eligible professional's Medicare Part B FFS patients seen during the reporting period to which the measure applies. Of the measures reported, if the eligible professional sees at least 1 Medicare patient in a face-to-face encounter, the eligible professional will report on at least 1 measure contained in the proposed cross-cutting measure set... If less than 9 measures apply to the eligible professional, the eligible professional would report up to 8 measure(s), AND report each measure for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. Measures with a 0 percent performance rate would not be counted.

We understand that there may be instances where an eligible professional may not have at least 9 measures applicable to an eligible professional's practice. In this instance, an eligible professional reporting on less than 9 measures would still be able to meet the satisfactory reporting criterion via claims and registry if the eligible professional reports on 1–8 measures, as applicable, to the eligible professional's practice. If an eligible professional reports on 1–8 measures, the eligible professional would be subject to the MAV process, which would allow us to determine whether an eligible professional should have reported quality data codes for additional measures.

That being said, please note that doctors of chiropractic **can** meet the satisfactory reporting criterion by only reporting on the applicable two (2) measures. DCs should report on Measures #131 and #182 for at least 50 percent of the Medicare Part B FFS patients seen during the reporting period and will then be subject to the Measures Applicability Validation, or MAV, process. The MAV determines whether an eligible professional should have reported quality data codes for additional measures based on "clinically related clusters." Since no other measures are applicable to chiropractic practice, DCs are able to avoid future payment penalties. It is also very important to note that under no circumstance can you resubmit a claim for services that have already been billed for the sole purpose of adding PQRS data.

For more information about the MAV process and negative payment adjustments, please visit the CMS PQRS Analysis and Payment webpage at: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html>

Frequently Asked Questions

Q. What is the Physician Quality Reporting System?

A. The Physician Quality Reporting System (PQRS) represents CMS' effort to implement a quality measure reporting program for Medicare providers.

Q. Is participation in PQRS mandatory?

A. PQRS is technically not mandatory; however, the Patient Protection and Affordable Care Act (PPACA) mandated that beginning on January 1, 2015, Medicare is required to adjust payments for providers who did not successfully/satisfactorily participate in PQRS. Therefore, in 2015 –providers that did not successfully participating in PQRS during the 2013 reporting period (Jan.1 – Dec. 31, 2013), will have their reimbursement will be decreased by 1.5%. In 2016 and beyond, reimbursement will be decreased by 2% and will be based on performance two years prior.

Q. To which Medicare providers does PQRS apply?

A. The program applies to:

- Doctor of Medicine
- Doctor of Osteopathy
- Doctor of Podiatric Medicine
- Doctor of Optometry
- Doctor of Oral Surgery
- Doctor of Dental Medicine
- **Doctor of Chiropractic**
- Physician Assistant
- Nurse Practitioner
- Clinical Nurse Specialist
- Certified Registered Nurse Anesthetist (and Anesthesiologist Assistant)
- Certified Nurse Midwife
- Clinical Social Worker
- Clinical Psychologist
- Registered Dietician
- Nutrition Professional
- Audiologists (as of 1/1/2009)
- Physical Therapist
- Occupational Therapist
- Qualified Speech-Language Therapist (as of 7/1/2009)

Q. When does the 2015 PQRS reporting period begin and end?

A. For 2015, the program begins on January 1, 2015 and concludes December 31, 2015.

Q. What are the requirements for participating in the PQRS program?

A. It is not necessary to register to participate in the PQRS program, but participants must have a National Provider Identifier (NPI) number in order to participate and must treat Part B beneficiaries.

Q. What is meant by the 50 percent threshold for satisfactory PQRS Reporting?

A. This means that, during the 12-month reporting period, you have satisfactorily reported the measure for at least 50 percent of the Medicare Part B eligible visits (i.e., where the patient is at least 18 years old and a spinal CMT code was billed). That said, the ACA strongly recommends that you report PQRS measures on every visit to increase the chances of meeting the satisfactory reporting requirements for the incentive and to avoid the payment adjustment.

Q. What are considered appropriate assessment tools for Measure #131, the pain assessment measure?

- A. An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for pain assessment include, but are not limited to, Brief Pain Inventory (BPI), Faces Pain Scale (FPS), McGill Pain Questionnaire (MPQ), Multidimensional Pain Inventory (MPI), Neuropathic Pain Scale (NPS), Numeric Rating Scale (NRS), Oswestry Disability Index (ODI), Roland Morris Disability Questionnaire (RMDQ), Verbal Descriptor Scale (VDS), Verbal Numeric Rating Scale (VNRS), and Visual Analog Scale (VAS).

Q. What are considered appropriate assessment tools for Measure #182, the functional assessment measure?

- A. An assessment tool that has been appropriately normalized and validated for the population in which it is used. Examples of tools for the functional outcome assessment measure include, but are not limited to, Oswestry Disability Index (ODI), Roland Morris Disability/Activity Questionnaire (RM), Neck Disability Index (NDI), Physical Mobility Scale (PMS), Patient-Reported Outcomes Measurement Information System (PROMIS), Disabilities of the Arm, Shoulder and Hand (DASH), and Knee Outcome Survey Activities of Daily Living Scale (KOS-ADL).

*Please Note: The use of a standardized tool assessing pain alone, such as the visual analog scale (VAS), does **not** meet the criteria of a functional outcome assessment standardized tool.*

Q. Is there a charge amount associated with reporting PQRS quality data codes (G-codes)?

- A. In an effort to streamline reporting of Quality Data Codes across multiple CMS quality reporting programs, CMS strongly encourages all eligible professional to submit quality data codes (PQRS G-codes) with a line item charge of one cent (\$0.01). Please note that the beneficiary is **not** liable for this nominal amount. When the claim 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.

Q. What is the Remittance Advice Remark Code (RARC N620)? * ^

- A. The new RARC code N620 is your indication that the PQRS codes were received into the CMS National Claims History (NCH) database. The accompanying message is "Alert: This procedure code is for quality reporting/informational purposes only." RARC N620 is used for processing claims with a \$0.00 QDC line-item charge, and will not show a group code or CARC.
- EPs that bill with \$0.00 charge on a QDC line item will see N620 (instead of N365 which was deactivated as of 7/1/14). EPs began receiving code N620 on the claim EOB form beginning 4/1/2014.

Q. What is the Claim Adjustment Reason Code (CARC) 246 with CO/PR and RARC N572? * ^

- A. Eligible professionals who bill PQRS G-codes with a \$0.01 line item will receive CO 246 N572. CARC 246 indicates that "This non-payable code is required for reporting only." CARC 246 must also be used with Group code CO or PR and with RARC N572 and indicates that "This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted."

** The ACA recommends that you keep track of all cases reported so that you can verify QDCs reported against the RAVEOB sent by your Medicare Administrative Contractor (MAC). Each QDC line item should be listed with the N365 denial remark code. Additionally, you should regularly review the RAVEOB you receive from your MAC to ensure the N365 code appears.*

*^ If you believe your G-codes were submitted correctly, but you are not receiving the appropriate remittance advice on your EOBs, you have several options. You can contact your MAC and request that they provide you with the full version of your RAs/EOBs or that they provide you with your PQRS reporting success rate. Another option is to visit the PQRS Dashboard. This is a web-based tool that allows providers to log-in and access interim PQRS data on a quarterly basis and monitor the status of claims-based reporting. The Dashboard is available at: <https://www.qualitynet.org/portal>. Please Note: The Dashboard should **not** be used to determine final data analysis for full-year program reporting, or final determination of PQRS incentive eligibility.*

Q. I have read that there are five methods available for providers to report PQRS quality measures. Which method(s) can I use?

- A. The claims-based reporting method (on your Medicare Part B claims) is the **only** available method to the chiropractic profession. DCs do not qualify to report PQRS using the other four methods [registry-based, qualified Electronic Health Record (EHR), Qualified Clinical Data Registry (QCDR) or the Group Practice Reporting Option (GPRO)].

Additional Resources

ACA webpage dedicated to PQRS: www.acatoday.org/PQRS

CMS webpage dedicated to PQRS: www.cms.gov/PQRS

ACA's Government Relations Department: Phone 703-812-0242 | Email: Medicare@acatoday.org

CMS PQRS Helpdesk: Phone: 1-866-288-8912 | Email: Qnetsupport@hcqis.org

In addition, CMS regularly holds calls dedicated to PQRS and allows for open question and answer sessions. Look for announcements of these calls on the www.cms.gov/PQRS website under "CMS Sponsored Calls" and in ACA publications.

Glossary of Terms

Centers for Medicare and Medicaid Services (CMS): The nation's federal agency which administers Medicare, Medicaid, and the State Children's Health Insurance Program.

Denominator: The denominator is associated with a given patient population that may be counted as eligible to meet a measure's inclusion requirements. PQRS measure denominators are identified by ICD, CPT, and HCPCS codes (e.g., 98940, 98941, 98942), as well as patient demographics (e.g., 18 years of age or older) and place of service (if applicable).

Eligible Professional (EP): Under PQRS, covered professional services are those paid under or based on the Medicare Physician Fee Schedule (MPFS). To the extent that eligible professionals are providing services which get paid under or based on the MPFS, those services are eligible for physician quality reporting. Providers not defined as EPs in the Tax Relief and Health Care Act of 2006 or the Medicare Improvements for Patients and Providers Act of 2008 are not eligible to participate in PQRS and do not qualify for incentives. Refer to www.cms.gov/PQRS for a list EPs eligible to participate in PQRS.

Measure:

- **Outcome Measure** – A measure that provides information on how health care affects patients.
- **Performance Measure** – A measure used to assess the performance of a process or function.
- **Process Measure** – A measure associated with the practice of health care or the furnishing of a service that is known to be effective.
- **Structure Measure** – A measure that assesses whether organizational resources and arrangements are in place to deliver healthcare, such as number, type, and distribution of medical personnel, equipment, and facilities.

Numerator: A clinical action to be counted as meeting a measure's requirements (i.e., patients who were assessed for the presence or absence of pain or functional deficiency). PQRS measure numerators are identified by G-codes.

Pay-for-Performance (PFP): A model based on rewarding quality health care by setting different payment levels for health care providers based on how well they meet benchmarks of quality and efficiency (e.g., PQRS).

Physician Quality Reporting System (PQRS): Mandated by Congress through the Tax Relief and Health Care Act of 2006 (TRHCA), CMS developed the Physician Quality Reporting Initiative (PQRI). PQRI establishes a financial incentive for eligible professionals to participate in a voluntary quality reporting program. To recognize that the PQRI was no longer an initiative and the program was made permanent; in 2011 CMS renamed the program the Physician Quality Reporting System (PQRS).

Reporting Period: The period during which PQRS measures are to be reported for covered professional services. Satisfactory reporting of PQRS measures are for dates of service that fall within the calendar year – January 1 through December 31.