TIPS FROM OUR CONSULTANT

By: Joy Newby, LPN, CPC, PCS
Newby Consulting

2014 MEDICARE FEE SCHEDULE

In December President Obama signed the Pathway to SGR Reform Act of 2011. This law prevented the 20.1 percent reduction in the Medicare Physician Fee Schedule and replaced the reduction with a 0.5 percent positive update to the conversion factor. This change is only for services rendered January 1, 2014 through March 31, 2014.

If Congress does not act on the pending bills to replace the Sustainable Growth Rate (SGR) with a new mechanism to determine the Medicare Physician Fee Schedule, the original 20.1 percent reduction in the fee schedule will become effective April 1, 2014. The following fees show what will happen to the fees-for-services rendered on or after April 2, 2014.

***CPT* Code**	**Description**	**1st Qtr 2014**	**Effective 4/1/2014**
99213	Office visit, established patient	$69.32	$51.84
17000	Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion	$70.18	$52.79
20610	Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)	$57.15	$42.75
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	$15.78	$11.84

Continue to monitor the activities in Washington, D.C. It will be interesting to see what happens over the next couple of months!

PHYSICIAN QUALITY REPORTING SYSTEM

Although the Physician Quality Reporting System (PQRS) continued to be a "voluntary" program, in 2013, if you did not participate in PQRS, your 2015 Medicare fee-for-service payment schedule will be reduced by 1.5 percent. To prevent this penalty, at a minimum, you must have reported at least one PQRS measure on at least one patient. This "gift" was only applicable for one (1) year. There are significant changes in PQRS reporting options for 2014.

Your practice must decide whether you will report PQRS using the Group Practice Reporting Option (GPRO) or if you will report individual measures. Next you need to decide whether your goal is to "successfully" report to qualify for the 0.5 percent incentive payment (lump sum payment in the fall of 2015) which will also prevent the 2016 payment penalty of 2 percent. You can choose to participate in PQRS to simply prevent the 2 percent payment penalty OR you can choose not to report PQRS and simply accept the 2 percent penalty in 2016 for all Medicare fee-for-service payments for services paid on the Medicare Physician Fee Schedule.

This article simply explains the different options and the choices of whether or not to participate. Which reporting option is best is up to you and your practice. Remember, this is a "voluntary" program!

Information about the GPRO reporting option can be found on the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Group_Practice_Reporting_Option.html

As it appears that most physicians continue to report as individuals as opposed to reporting as a group practice, we will focus on the options available to individual physicians and non-physician providers. So let's review the basics of PQRS.

Eligible and Able to Participate

The following professionals are eligible to participate in PQRS:

1. Medicare Physicians
   - Doctor of Medicine
   - Doctor of Osteopathy
   - Doctor of Podiatric Medicine
   - Doctor of Optometry
   - Doctor of Oral Surgery
   - Doctor of Dental Medicine
   - Doctor of Chiropractic

2. Practitioners
   - 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

   *Includes Advanced Practice Registered Nurse (APRN)

3. Therapists
   - Physical Therapist
   - Occupational Therapist
   - Qualified Speech-Language Therapist

Note: Beginning in 2014, professionals who reassign benefits to a Critical Access Hospital (CAH) that bills professional services at a facility level, such as CAH Method II billing, can now participate (in all reporting methods except for claims-based). To do so, the CAH must include the individual provider NPI on their Institutional (FI) claims.

Eligible But Not Able to Participate

Some professionals may be eligible to participate per their specialty, but due to billing method may not be able to participate:

- Professionals who do not bill Medicare at an individual National Provider Identifier (NPI) level, where the rendering provider's individual NPI is entered on CMS-1500 type paper or electronic claims billing, associated with specific line-item services.

Services payable under fee schedules or methodologies other than the PFS are not included in PQRS (for example, services provided in federally qualified health centers, independent diagnostic testing facilities, independent laboratories, hospitals including method I critical access hospitals, rural health clinics, ambulance providers, and ambulatory surgery center facilities).

2014 PQRS Options

- 2 Measure Options
  - Individual Measures
  - Measures Group

- 4 Reporting Options
  - Claims Based
  - Registry
    - Qualified Registry
    - Qualified Clinical Data Registry
  - Direct EHR Vendor
  - EHR Data Submission Vendor

    - Not all measures can be submitted with the four different reporting options. For example, there are some measures that can be reported using claims-based reporting, but cannot be reported using the direct EHR data submission vendor option.

- 2 Reporting Periods
  - 12 months (1/1/2014 through 12/31/2014
    - Claims must be submitted no later than 2/28/2015
  - 6 months (7/1/2014 through 12/31/2014)
    - Must be submitted no later than 2/28/2015
    - Measures Group - Registry Reporting Only

Significant Changes in 2014

There are new individual measures and new measures groups for 2014. You will also find some previous measures have been revised for 2014. In all probability you will need to revise how you have reported previous PQRS measures.

You will find that the 2014 measures address various aspects of care, such as:

- Prevention
- Chronic- and acute-care management
- Procedure-related care
- Resource utilization
- Care coordination

You will also find that individual measures are assigned to one of six National Quality Strategy (NQS) Domains:

- Patient Safety
- Person and Caregiver-Centered Experience and Outcomes
- Communication and Care Coordination
- Effective Clinical Care
- Community/Population Health
- Efficiency and Cost Reduction

The following examples have been selected to identify how a measure is assigned to a specific domain.

- <u>Patient Safety</u>
  Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter.

  This list must include
  - ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements
  - AND must contain the medications' name, dosage, frequency, and route of administration

- <u>Person and Caregiver-Centered Experience and Outcomes</u>
  Urinary Incontinence: Plan of Care for Urinary Incontinence in Women aged 65 Years and Older: 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

- Communication and Care Coordination
  Closing the referral loop:
  Receipt of specialist report:
  - Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred

- Effective Clinical Care
  Controlling High Blood Pressure: Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mmHg) during the measurement period

- Community/Population Health
  Preventive Care and Screening: Tobacco Use:
  Screening and Cessation Intervention: Percentage of patients 18 years and older who were screened for
  - Tobacco use one or more times within 24 months AND
  - Who received cessation counseling intervention if identified as a tobacco user

- Efficiency and Cost Reduction
  Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use: Percentage of adults 18 through 64 years of age with a diagnosis of acute bronchitis who were not prescribed or dispensed an antibiotic prescription on or 3 days after the episode

Earn the Incentive AND Prevent the 2016 Payment Penalty

If you choose to report individual measures to receive the payment incentive **AND** prevent the 2016 payment penalty, to the extent possible, you need to report:

- at least 9 quality measures (as opposed to 3 measures in 2013)
- that cover at least 3 different domains
- for at least 50 percent of the time the measures are applicable to the patients seen in 2014

Eligible professionals (EP) that report less than 9 measures or less than 3 domains, will be subject to Measure-Applicability Validation (MAV). The MAV process will determine whether the EP should have submitted additional measures or additional measures with additional domains to be considered incentive eligible or avoid the payment adjustment. For more information on the MAV process, see: http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/AnalysisAndPayment.html

You can also choose to report at least one measures group on a 20-patient sample. For more information, see Getting Started with 2014 Reporting of PQRS Measures Groups on the CMS website at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

Report to Only Prevent the 2016 Payment Penalty

If you want to avoid the 2.0 percent penalty applicable to your 2016 Medicare fee-for-service payments for services included on the Medicare Physician fee schedule, you will need to report:

- at least 3 quality measures
- covering 1 NQS domain
- for at least 50 percent of the time the measures are applicable to the patients seen in 2014

EPs that submit quality data for one or two PQRS measures for at least 50 percent of their patients or encounters eligible for each measure will be subject to MAV.

How to Get Started

Sounds overwhelming? CMS has excellent guides on how to begin to report and also explains the differences for reporting in 2014 compared with 2013. The "How To" guides are available on the CMS webiste at http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/How_To_Get_Started.html

Need Help?

If you have questions or need assistance with PQRS reporting, contact the QualityNet Help Desk. The help desk is available Monday–Friday; 7:00 AM–7:00 PM CST

- Phone: 1-866-288-8912
- TTY: 1-877-715-6222
- Email: Qnetsupport@sdps.org

ICD-10: What is Your Action Plan?

The October 1, 2014, ICD-10 compliance date is fast approaching. By now, you should be employing identified preparation strategies. For detailed timelines and checklists for activities that all providers need to carry out to prepare for ICD-10, visit the CMS ICD-10 web page (http://www.cms.gov/Medicare/Coding/ICD10/index.html) now! You can also access an On-line Implementation Guide, (https://implementicd10.noblis.org/start/) designed especially for small and medium practices, large provider practices, small hospitals, and payers.

Please complete a brief survey (http://survey.constantcontact.com/survey/a07e8twefakhqqqm79v/start) to help WPS Medicare determine the readiness of our provider community for the implementation of ICD-10 codes.