WHO:

CMS tells us about the background of PQRS:

“Background. The Physician Quality Reporting System (Physician Quality Reporting or PQRS) is a reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals. The program provides an incentive payment to practices with eligible professionals (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]) who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the program also applies a payment adjustment to eligible professionals who do not satisfactorily report data on quality measures for covered professional services.”

WHY:

Here is what the ACA says:

“The Centers for Medicare and Medicaid Services’ (CMS’) Physician Quality Reporting System (PQRS – formerly referred to as PQRI) will continue in 2013. Beginning January 1, 2013, physicians who report certain quality measures may be eligible for a 0.5% payment incentive, to be paid in the third quarter of 2014. To assist doctors of chiropractic who participate in this program, the ACA has compiled useful information developed by the ACA, the American Medical Association (AMA), as well as CMS, to help familiarize the chiropractic profession with the measures relevant to their practice and facilitate the data collection required to successfully report.

WHEN:

Please Note: Providers who are not satisfactorily reporting during the 2013 reporting period will have their Medicare reimbursement decreased by 1.5% beginning in 2015. Then, in 2016, the payment adjustment will increase to 2%.

Chiropractic participation in the PQRS is critical, as it demonstrates to CMS and the rest of the healthcare community that the chiropractic profession is serious about quality care improvement. It is through the enhancement of quality patient care that the chiropractic profession will enhance its involvement in our nation’s health care delivery system.”
EASY GUIDE TO PQRS

For 2013 chiropractors will report on two measures:

• #131 – Pain Assessment and Follow-Up

• #182 – Functional Outcome Assessment

(#124 – Health Information Technology: Adoption/Use of Electronic Health Records was retired at the end of 2012)

#131 Pain Assessment and Follow-Up

Measure description: Percentage of visits for patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.

What you will report each visit: Whether or not you assessed the patient’s pain using a standardized tool AND documented a follow-up plan by selecting and reporting the most appropriate G Code.

Eligible encounters occur with the following CPT/HCPCS Codes:

90791, 90792, 92507, 92508, 92526, 96116, 96150, 97001, 97003, 97532, 98940, 98941, 98942
99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, G0101, G0402, G0438, G0439

How do you report that you meet these requirements?

Choose the most appropriate G Code on your Medicare eligible encounter.

G-code descriptions:

G8730: Pain assessment documented as positive utilizing a standardized tool AND a follow-up plan is documented.

G8731: Pain assessment documented as negative, no follow-up plan required

G8939: Pain assessment documented, follow-up plan not documented, patient not eligible/appropriate

G8442: Documentation that patient is not eligible for a pain assessment

G8732: No documentation of pain assessment, reason not given

G8509: Documentation of positive pain assessment; no documentation of a follow-up plan, reason not given.
#182 – Functional Outcome Assessment

**Measure description:** Percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter AND documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.

**What you will report each visit:** Whether or not you assessed the patient’s current functional outcome using a standardized tool and documented a care plan, if functional outcome deficiencies have been identified. 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 numerator quality data code G8942 should be used for reporting purposes.

**Eligible encounters occur with the following CPT/HCPCS Codes:**

- 97001, 97002, 98940, 98941, 98942

**How do you report that you meet these requirements?**

Choose the most appropriate G Code on your Medicare eligible encounter.

**G-code descriptions:**

- **G8539:** Documentation of a functional outcome assessment using a standardized tool AND documentation of a care plan based on identified deficiencies on the date of the functional outcome assessment

- **G8542:** Documentation of a functional outcome assessment using a standardized tool; no functional deficiencies identified, care plan not required

- **G8543:** Documentation of a functional outcome assessment using a standardized tool; care plan not documented, reason not given

- **G8942:** Documented functional outcome assessment and care plan within the previous 30 days

- **G8540:** Documentation that the patient is not eligible for a functional outcome assessment using a standardized tool

- **G8541:** Functional outcome assessment using a standardized tool not documented, reason not given
The most commonly used codes are:

Pain Assessment:

G8730 (KEY is to make sure you have a planned reassessment of pain on EACH note)

Functional Outcome Assessment:

G8539 (KEY this is used on the date that the patient filled out the functional outcome assessment tool i.e. Oswestry, Neck Disability Index, Etc.)

G8942 (KEY is to use this code on all subsequent visits in which you have a functional outcome assessment on file and current. CMS defines current as <30 Days old)

Typically on visit one of an active treatment plan for Medicare eligible patients you will use codes:

G8730 & G8539

Subsequent visits you will most likely use codes:

G8730 & G8942

MAKE SURE YOU KNOW THE MEDICARE REQUIREMENTS FOR DOCUMENTATION!