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Physician Quality Reporting System What Neurosurgeons Need to Know for 2015

Prepared by the:

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Physician Quality Reporting System

What Neurosurgeons Need to Know for 2015

Since 2007, the Physician Quality Reporting System (PQRS) has been a *voluntary* federal program, offering Medicare incentive payments to physicians who reported quality measure data to the Centers for Medicare and Medicaid Services (CMS). However, the Affordable Care Act (ACA) requires that CMS phase out incentive payments. Physicians and other eligible professionals (EPs) will now be subject to increasing penalties for failure to satisfy PQRS reporting requirements. As such, **2014 was the LAST year to qualify for a PQRS incentive payment. Beginning in 2015, the program transitions to penalties only.** Neurosurgeons who do not satisfy the program's requirements in 2015 will be paid two percent less than the Medicare Physician Fee Schedule (MPFS) amount for services rendered from Jan.1, 2017 to Dec. 31, 2017.

CMS also will use the 2015 reporting year to determine a separate Value-Based Payment Modifier (VM), which will affect payments to **all physicians**, regardless of group practice size, in 2017. The VM is tied to satisfactory PQRS participation, and CMS uses PQRS quality measures to calculate additional, and increasingly larger, performance-based payment adjustments under the VM. [Click here](#) for more information about the VM.

As a result of these and other penalty-driven programs — including the *separate* Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs (known as meaningful use) — nearly 10 percent of neurosurgeons' Medicare payments will be at risk over the coming years.¹

Increasing Significance of PQRS Participation		
	2014	2015
Physician Quality Reporting System		
Bonus for Traditional PQRS	+0.5% payment in 2015	~No Incentives~
Bonus for PQRS MOC*	+0.5% in 2015	
Penalty for Failure to Satisfy PQRS	-2.0% in 2016	-2.0% in 2017
Physician Value-Based Payment Modifier		
Additional Penalty for Failure to Satisfy PQRS	-2% in 2016	Up to -4.0% in 2017
Total Potential Penalties	-4.0% in 2016	Up to -6.0% in 2017

*The PQRS MOC supplemental bonus ends after 2014.

In addition to payment penalties, CMS plans to make 2015 physician quality **performance data available to the public as early as 2016**. To date, CMS has only publicly reported on a physician's participation status in federal quality reporting programs, such as the PQRS, but not on individual-level physician performance rates for specific measures.

¹ With the passage of H.R. 2, the [Medicare Access and CHIP Reauthorization Act of 2015](#), Medicare's quality programs will transition to a new system called the Merit-based Incentive Payment System. Beginning in 2019, MIPS will replace the PQRS, EHR and VM programs and their existing penalty-only structure. Under MIPS, physicians will be eligible for bonuses as well as being subject to penalties, although only the outlier physicians will be subject to the steepest penalties, which will be no more than 9 percent in the later years of implementation of this new program. More details about MIPS will be provided in a separate publication.

Given the increasing significance of successful PQRS participation, it is critical that neurosurgeons understand recent changes that will affect their participation options in 2015.

PQRS Reporting Options for 2015

Eligible professionals (EPs) can choose from multiple reporting options to satisfy PQRS reporting requirements, including:

- Reporting as an individual physician or as a group practice under the Group Practice Reporting Option (GPRO);
- Reporting individual measures or measures groups, which are sets of clinically relevant measures that must be reported together (*note: for 2015, there are no measures groups entirely relevant to neurosurgeons*);
- Reporting measures data via claims, a qualified registry, an electronic health record (EHR), or a qualified clinical data registry (QCDR).

How to Get Started

1. Determine your eligibility

[Click here](#) for more information on which professionals are considered eligible for purposes of the PQRS. Note that PQRS participation is not limited to physicians. Other non-physicians in your practice, such as nurse practitioners and physician assistants, may also be subject to payment penalties for non-compliance.

For purposes of group practice reporting, CMS defines “group practice” as those with two or more EPs, identified by individual National Provider Identifiers (NPIs), who reassign their billing rights to a single Tax Identification Number (TIN).

An EP must decide whether to participate in the PQRS as an individual or as a group practice, but cannot receive credit for both. In fact, once a group practice elects to participate in the GPRO, individuals tied to that group are no longer eligible to participate in the PQRS as individuals. Therefore, if you are a part of a larger group, it is important to determine whether your group plans to participate as a group.

Also note, if a group practice self-nominates to participate in the GPRO and satisfies PQRS requirements *as a group*, all individual EPs who have reassigned their billing rights to that group’s TIN will be considered satisfactory PQRS reporters. This is true even if the group qualified based on measures that are irrelevant to some individuals in the group. Therefore, a neurosurgeon in a larger multi-specialty group practice could potentially avoid a PQRS penalty without taking any action if others in the group (e.g., primary care physicians) report on a sufficient number of measures. This would allow other physicians essentially to carry the weight of the group in regards to satisfying reporting requirements.

2. Review each method’s specific reporting criteria to determine which reporting option is best for you.

After determining whether you will participate in the PQRS as an individual or group practice, you will need to select the most relevant and least burdensome reporting mechanism to feed your quality data to CMS. Slightly different options are available depending on whether you participate individually or as a group practice. [Click here](#) for more detailed information about *individual* reporting and [here](#) for group practice reporting. Additional resources are listed below:

- [Click here](#) for more detailed instructions on how to report quality measures data via **claims**.
- [Click here](#) for additional information about reporting via a **qualified PQRS registry**. Neurosurgery is not sponsoring a qualified registry for 2015. However, there are multiple third party vendors that can, for a fee, collect data on any PQRS measure via an online portal on behalf of an EP and submit it to CMS. A list of qualified vendors for 2015 will be available on the CMS website by spring 2015.
- [Click here](#) for additional information about reporting via a **Qualified Clinical Data Registry (QCDR)**. The QCDR reporting mechanism is relatively new and allows physicians to satisfy PQRS requirements by reporting on measures not included in the traditional PQRS measure set via a specialty society-sponsored clinical data registry. Neurosurgery, through the [National Neurosurgery Quality and Outcomes Database \(N²QOD\)](#), has applied to become a QCDR for 2015. This should offer many neurosurgeons a platform that both minimizes the reporting burden and provides a more relevant set of measures. For 2015, this tool will focus only on spine care. In the future, the N²QOD hopes to have additional practice modules to allow more neurosurgeons to satisfy Medicare's quality reporting requirements. Additional information about the availability of this tool and the final set of CMS-approved neurosurgical-focused measures will be posted sometime in April.
- [Click here](#) for additional information about the **EHR reporting option**, including a guide titled, "2015 PQRS EHR Reporting Made Simple." Note that EPs and group practices using this reporting option may be able to satisfy both PQRS and the electronic clinical quality measure (eCQM) component of the Medicare EHR Incentive Program.
- [Click here](#) for additional information about the **GPRO**, including instructions for larger group practices wishing to report measures via the GPRO Web Interface.

3. Select your measures

For 2015, CMS removed many measures relevant to neurosurgeons, including the Perioperative Care measures group and the Back Pain measures group. At the same time, CMS raised the bar on the number of measures that must be reported to avoid a penalty. Most reporting options now require that the individual or group practice report on nine measures, including one "cross-cutting" measure, for 50 percent of all applicable Medicare Part B patients over the reporting year. PQRS measures are categorized into National Quality Strategy (NQS) domains, and the nine measures selected must cover at least three of these domains.²

Given these changes, neurosurgeons have a fairly limited number of traditional PQRS measures to choose from for 2015. The [table below](#) lists individual 2015 PQRS measures that *may* be relevant to a neurosurgical practice. However, neurosurgeons are encouraged to review the entire list of [2015 PQRS individual measures](#) and [2015 PQRS measures groups](#) to determine if other measures apply. Once you have identified potentially relevant measures, you will want to review their detailed specifications. The specifications list reporting mechanisms available for that measure; the domain under which the measure falls; and, most importantly, the measure's numerator, denominator and any applicable exclusions. The numerator details the clinical quality action that is the focus of the measure. The denominator — defined by a set of ICD-9, CPT, HCPCS codes, and other demographic and/or place of service data — identifies the patients eligible for each measure. It is critical to review the denominator of each potentially relevant measure to determine whether and/or to what extent it applies to your patient population.

² Domains include: Patient and Family Engagement, Patient Safety, Care Coordination, Population and Public Health, Efficient Use of Healthcare Resources, Clinical Processes/Effectiveness.

2015 Individual PQRS Measures Potentially Relevant to Neurosurgeons³

PQRS #	Measure Title	Measure Description	National Quality Strategy Domain	Reporting Mechanisms
21	Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin	Percentage of surgical patients aged 18 years and older undergoing procedures with the indications for a first OR second generation cephalosporin prophylactic antibiotic, who had an order for a first OR second generation cephalosporin for antimicrobial prophylaxis.	Patient Safety	Claims, Registry
22	Perioperative Care: Discontinuation of Prophylactic Parenteral Antibiotics (Non-Cardiac Procedures)	Percentage of non-cardiac surgical patients aged 18 years and older undergoing procedures with the indications for prophylactic parenteral antibiotics AND who received a prophylactic parenteral antibiotic, who have an order for discontinuation of prophylactic parenteral antibiotics within 24 hours of surgical end time.	Patient Safety	Claims, Registry
23	Perioperative Care: VTE Prophylaxis (When Indicated in ALL Patients)	Percentage of surgical patients aged 18 years and older undergoing procedures for which VTE prophylaxis is indicated in all patients, who had an order for Low Molecular Weight Heparin (LMWH), Low-Dose Unfractionated Heparin (LDUH), adjusted-dose warfarin, fondaparinux or mechanical prophylaxis to be given within 24 hours prior to incision time or within 24 hours after surgery end time.	Patient Safety	Claims, Registry
32	Stroke and Stroke Rehabilitation: Discharged on Antithrombotic Therapy	Percentage of patients aged 18 years and older with a diagnosis of ischemic stroke or transient ischemic attack (TIA) who were prescribed antithrombotic therapy at discharge.	Effective Clinical Care	Claims, Registry
46	Medication Reconciliation <i>*cross-cutting measure</i>	Percentage of patients aged 18 years and older discharged from any inpatient facility (e.g., hospital, skilled nursing facility, or rehabilitation facility) and seen within 30 days following discharge in the office by the physician, prescribing practitioner, registered nurse, or clinical pharmacist providing on-going care who had a reconciliation of the discharge medications with the current medication list in the outpatient medical record documented.	Communication and Care Coordination	Claims, Registry

³ The AANS and CNS recognize the current paucity of quality measures with sufficient granularity to capture the subtleties of neurosurgical care. We continue to work to develop more appropriate and meaningful measures for inclusion in the PQRS and other federal reporting programs, including through the QCDR mechanism mentioned above.

PQRS #	Measure Title	Measure Description	National Quality Strategy Domain	Reporting Mechanisms
47	Advance Care Plan <i>*cross-cutting measure</i>	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan.	Communication and Care Coordination	Claims, Registry
130	Documentation of Current Medications in the Medical Record <i>*cross-cutting measure</i>	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 <i>must</i> include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND <i>must</i> contain the medications' name, dosage, frequency and route of administration.	Patient Safety	Claims, Registry, EHR, GPRO Web Interface
131	Pain Assessment and Follow-Up <i>*cross-cutting measure</i>	Percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit AND documentation of a follow-up plan when pain is present.	Community/ Population Health	Claims, Registry
154	Falls: Risk Assessment	Percentage of patients aged 65 years and older with a history of falls who had a risk assessment for falls completed within 12 months. Note: If the risk assessment indicates patient has documentation of two or more falls in the past year or any fall with injury in the past year, #155 <i>should</i> also be reported.	Patient Safety	Claims, Registry
155	Falls: Plan of Care	Percentage of patients aged 65 years and older with a history of falls who had a plan of care for falls documented within 12 months.	Communication and Care Coordination	Claims, Registry
226	Tobacco Use: Screening and Cessation Intervention <i>*cross-cutting measure</i>	Percentage of patients aged 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.	Community/ Population Health	Claims, Registry

[Click here](#) for a list of “cross-cutting” measures available for 2015.

4. Start Reporting or Register

Individual physicians do not have to register with CMS to participate in the 2015 PQRS. If using the claims-based reporting option, simply start reporting the Quality-Data Codes (QDCs) listed in the specifications of the measures you have selected on applicable Medicare Part B claims. If using a third party entity to submit your measure data to CMS, such as a qualified registry, please check with the entity to determine whether it has its own set of registration and reporting deadlines.

Registration is required for those wishing to participate in the PQRS via the GPRO in 2015. Authorized representatives of group practices will be able to register via the web **between April 1, 2015 and June 30, 2015** (note: this deadline is earlier than last year). Additional information will be posted [here](#). Once a group registers for the GPRO, it cannot withdraw its registration, and individual members of the group cannot participate in the PQRS as individuals.

Measures Applicability Validation (MAV) Process

EPs who report fewer than nine measures and/or report across fewer than three domains will trigger the Measures Applicability Validation (MAV) process. CMS uses the MAV to analyze whether an EP should be subject to the PQRS penalty for failure to report on additional measures. The process relies on two steps:

1. Evaluating whether any of the measures reported by the EP are found in a CMS-defined cluster of measures related to a particular clinical topic or service (if so, then CMS assumes other closely-related measures in that same cluster may also apply to the EP’s patient population); and
2. A minimum threshold test that evaluates whether any potentially relevant, but non-reported measures, apply to more than 15 Medicare patients (if so, CMS concludes the EP should be subject to a PQRS penalty for not satisfactorily reporting on as many measures as he/she could have).

CMS recognizes that certain EPs simply will not have nine measures that apply to their patient population. If CMS does not identify any other relevant measures through the MAV process, it may conclude that the EP sufficiently satisfied PQRS reporting requirements and should not be subject to a penalty. The MAV is only triggered in cases where less than nine measures or fewer than three domains are reported. CMS will not use the MAV to evaluate the *appropriateness* of the nine measures selected by an EP. Additional information about the MAV process is available [here](#).

PQRS Maintenance of Certification (MOC) Incentive Program

CMS has retired this program. Per law, EPs may no longer earn an additional PQRS bonus payments for enhanced participation in a Maintenance of Certification (MOC) Program.

Additional Resources

The [2015 PQRS Implementation Guide](#) provides a comprehensive overview of the PQRS program. It includes information on how to select measures, how to read and understand measure specifications, and how to submit quality measure data codes on claims forms. You are also encouraged to visit the [CMS website](#) for regular updates.

2015 PQRS Reporting Options to Avoid a Penalty if Participating as an Individual

Reporting Period	Measure Type	Reporting Mechanism	Satisfactory Reporting Criteria
12-month (Jan 1-Dec 31, 2015)	Individual Measures	Claims	Report at least 9 measures covering at least 3 National Quality Strategy (NQS) domains, ⁴ including 1 cross-cutting measure, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. If less than 9 measures apply, report 1-8 measures covering 1-3 NQS domains, but subject to Measures Applicability Validation (MAV) process. ⁵ Measures with a 0 performance rate will not be counted.
12-month (Jan 1-Dec 31, 2015)	Individual Measures	Qualified Registry	Report at least 9 measures covering at least 3 NQS domains, OR, if less than 9 measures covering at least 3 NQS domains apply, report 1-8 measures covering 1-3 NQS domains, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. If less than 9 measures apply, report 1-8 measures covering 1-3 NQS domains, but subject to the MAV process. ⁵ Measures with a 0 performance rate will not be counted.
12-month (Jan 1-Dec 31, 2015)	Individual Measures	Direct EHR product or EHR data submission vendor	Report 9 measures covering at least 3 of the NQS domains. If an EP's EHR product/vendor does not contain patient data for at least 9 measures covering at least 3 domains, then the EP would be required to report all of the measures for which there is Medicare patient data. EPs are required to report on at least 1 measure for which there is Medicare patient data.
12-month (Jan 1-Dec 31, 2015)	Measures Groups	Qualified Registry	Report at least 1 measures group, AND report each measures group for at least 20 patients, the majority (11 patients) of which must be Medicare Part B FFS patients. Measures groups containing a measure with a 0 percent performance rate will not be counted.
12-month (Jan 1-Dec 31, 2015)	Individual PQRS and/or non-PQRS measures reported by a QCDR	Qualified Clinical Data Registry (QCDR)	Report at least 9 measures available for reporting under a QCDR covering at least 3 of the NQS domains, AND report each measure for at least 50% of all applicable patients (both Medicare and non-Medicare). Of these measures, at least 2 must be outcome measures, OR, if 2 outcomes measures are not available, at least 1 outcome measures and at least 1 resource use, patient experience of care, efficiency/appropriate use, or patient safety measure.

2015 PQRS Reporting Options to Avoid a Penalty if Participating as a Group Practice

Reporting Period	Group Practice Size	Reporting Mechanism	Measure Type	Satisfactory Reporting Criteria
12-month (Jan 1-Dec 31, 2015)	25-99 eligible professionals (EPs)	GPRO Web Interface	Individual GPRO measures in GPRO Web Interface	Report on all measures included in the Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100% of assigned beneficiaries. A group practice must report on at least 1 measure for which there is Medicare patient data.

⁴PQRS measures are categorized under the following National Quality Strategy (NQS) domains: Patient and Family Engagement; Patient Safety; Care Coordination; Population and Public Health; Efficient Use of Healthcare Resources; and Clinical Processes/Effectiveness.

⁵ Under the Measures Applicability Validation (MAV) process, CMS verifies whether an EP could have reported on additional clinically relevant measures. It is only triggered when an EP reports on less than 9 measures and/or less than 3 NQS domains. For more information on this process, [click here](#).

Reporting Period	Group Practice Size	Reporting Mechanism	Measure Type	Satisfactory Reporting Criteria
12-month (Jan 1-Dec 31, 2015)	25-99 EPs and 100+ EPs	GPRO Web Interface + CMS Certified CAHPS Survey Vendor	Individual GPRO measures in the GPRO Web Interface + CAHPS for PQRS	<p>The group practice must report on all measures included in the GPRO Web Interface; AND populate data fields for the first 248 consecutively ranked and assigned beneficiaries in the order in which they appear in the group's sample for each module or preventive care measure. If the pool of eligible assigned beneficiaries is less than 248, then the group practice must report on 100% of assigned beneficiaries. A group practice will be required to report on at least 1 measure for which there is Medicare patient data.</p> <p>In addition, the group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor. <i>Note: the CAHPS component is optional for groups with 25-99 EPs, but mandatory for groups with 100+ EPs reporting via the Web Interface.</i></p>
12-month (Jan 1-Dec 31, 2015)	2-99 EPs	Qualified Registry	Individual Measures	Report at least 9 measures covering at least 3 NQS domains, including 1 cross-cutting measure, AND report each measure for at least 50% of the Medicare Part B FFS patients seen during the reporting period to which the measure applies. If less than 9 measures apply, report 1-8 measures covering 1-3 NQS domains, but subject to MAV. Measures with a 0 performance rate will not be counted.
12-month (Jan 1-Dec 31, 2015)	2-99 EPs and 100+ EPs	Qualified Registry + CMS Certified Survey Vendor	Individual Measures + CAHPS for PQRS	<p>The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the qualified registry. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, the group practice must report on at least 1 measure in the cross-cutting measure set.</p> <p><i>Note: the CAHPS component is optional for groups with 2-99 EPs, but mandatory for groups with 100+ EPs reporting via the Web Interface</i></p>
12-month (Jan 1-Dec 31, 2015)	2-99 EPs	Direct EHR Product or EHR Data Submission Vendor Product	Measures	Report 9 measures covering at least 3 of the NQS domains. If the group's EHR product/vendor does not contain patient data for at least 9 measures covering at least 3 domains, then the group would be required to report all of the measures for which there is Medicare patient data. A group must report on at least 1 measure for which there is Medicare patient data.

Reporting Period	Group Practice Size	Reporting Mechanism	Measure Type	Satisfactory Reporting Criteria
12-month (Jan 1-Dec 31, 2015)	2-99 EPs And 100+ EPs	Direct EHR Product or EHR Data Submission Vendor Product + CMS Certified Survey Vendor	Individual Measures + CAHPS for PQRS	<p>The group practice must have all CAHPS for PQRS survey measures reported on its behalf via a CMS-certified survey vendor, and report at least 6 additional measures, outside of CAHPS for PQRS, covering at least 2 of the NQS domains using the direct EHR product or EHR data submission vendor product. If less than 6 measures apply to the group practice, the group practice must report up to 5 measures. Of the additional 6 measures that must be reported in conjunction with reporting the CAHPS for PQRS survey measures, a group practice would be required to report on at least 1 measure for which there is Medicare patient data.</p> <p><i>Note: the CAHPS component is optional for groups with 2-99 EPs, but mandatory for groups with 100+ EPs reporting via the Web Interface</i></p>