ZIRMED®
INNOVATING CONNECTED HEALTHCARE

Maximizing Medicare Reimbursements with ZirMed's PQRS Solutions

As healthcare expenditures continue to rise, politicians and employers have sought ways to slow the growth of healthcare expenses and the budgetary shortfalls that accompany these increases. While most solutions proposed to fix America's health care crisis have been met with intense debate and criticism, virtually all parties can agree that efforts to improve prevention and quality of care are crucial for the success of any reform.

If a provider fails to include the necessary PQRS quality code on a claim before submitting it, then realizes the omission and submits a duplicate claim with the PQRS data, the claim will still not count as a successful submission.

Although America spends more money on healthcare per capita than any other nation, high rates of obesity, chronic disease, and preventable deaths place the US well behind other industrialized nations in terms of health outcomes. As such, programs designed to assess and enhance the quality of care delivered continue to grow in popularity.

In 2007, CMS took its first step toward "pay for performance" reimbursements by launching the Physician Quality Reporting Initiative (PQRI). Since its introduction, CMS has paid more than $100 million in bonus payments to the hundreds of thousands of providers who have begun reporting information used to evaluate patient outcomes and approximate the quality of care delivered.

THE PHYSICIAN'S QUALITY REPORTING SYSTEM (PQRS)

Working with national standard setting organizations, CMS has developed a list of quality measures that address various aspects of patient care, including prevention, chronic disease management, acute episode care management, procedure, related care, resource utilization, and care coordination. Each PQRS measure is used to estimate the quality of care delivered by the provider.

These measures are intended to determine the proportion of patients who actually received the care that they should have received, based on CMS' guidelines. For instance, CMS expects that when following established protocols, diabetes patients aged 18-75 should have a hemoglobin A1c Level of less than 9.0%.

Using information included on the claim form combined with specially designed quality reporting codes, CMS determines the percentage of applicable patients who achieved the desired outcome, and uses this as a metric of the quality of care delivered by the provider.

Every original Medicare Part B claim accepted by a Medicare intermediary during the reporting period is transferred to the National Claims History (NCH) file. **Note that only original—and not duplicate—claims are entered in the NCH file.**

If a provider fails to include the necessary PQRS quality code on a claim before submitting it, then realizes the omission and submits a duplicate claim with the PQRS data, the claim will still not count as a successful submission. Therefore, it is extremely important for providers to employ screens and validations for potential errors and omissions before the claim is sent to Medicare.

At the end of the reporting period, an outside firm hired by CMS analyzes the data contained in the NCH to calculate the reporting and performance rates for each provider. Providers who successfully meet the reporting requirements in 2016 will avoid the 2% negative payment adjustment in 2018.

PQRS REPORTING REQUIREMENTS[1]

CMS has acknowledged that, in some cases, there may not be 9 applicable measures for an eligible provider to report on—but it has also made clear that it believes those cases are extremely rare, stating that "CMS fully expects individual eligible professionals to report a full complement of 9 measures covering 3 NQS [National Quality Strategy] domains."

To enforce this expectation, CMS has outlined three classifications that will lead to an eligible provider's reporting being subject to Measure-Applicability Validation (MAV):

1. Providers who report quality data for **only 1 to 8 PQRS** measures for at least 50% of their patients or encounters that are eligible for each measure.

2. Providers who submit data for **9 or more** PQRS measures across **less than 3 domains** for at least 50% of their patients or encounters eligible for each measure.

3. Providers who see 1 Medicare patient (face-to-face encounter), but do not report on 1 cross-cutting measure.

Currently, the PQRS penalties are based exclusively on participation and successful reporting rather than on the performance indicated by the PQRS measures.

Even if a provider reports a negative outcome for each qualifying patient, he or she will still avoid the penalty if quality data has been submitted on at least 50% of the qualifying claims. Therefore, it is the act of reporting itself, and not the quality of care indicated by the reporting, that determines whether a provider will meet the requirements.

To calculate whether a provider has successfully met the reporting requirements, CMS computes a "denominator" and "numerator" for each measure. As shown below, the "denominator" is the number of patients that the physician has seen whose age, diagnoses, and/or procedures meet the requirements for one of the PQRS measures. For example, in *Measure #109 – Patients with Osteoarthritis who have an Assessment of their Pain and Function,* all patients aged 21 or older who have an office visit and a diagnosis of Osteoarthritis are included in the denominator for the measure. Providers wishing to report on this measure must include a special CPT-II code to indicate whether or not an assessment of the patient's Osteoarthritis symptoms and functional status was completed. Each claim containing the

1 The reporting requirements discussed within this section are applicable only to the claims-based method of PQRS reporting. In addition to claims-based reporting, providers have the option to submit PQRS information as measure groups, through qualified registries, and through selected electronic medical record systems. For more information on these alternative reporting options, please visit www.cms.hhs.gov/pqri.

quality data is then added to the numerator for this particular measure. So long as the numerator divided by the denominator is greater than 50%, the provider will meet the reporting requirements.

However, some PQRS measures are calculated on a per-patient rather than a per-instance basis. In *Measure #1,* for example, providers must report the necessary PQRS data only one time per year for each patient aged 18 to 75 who presents with diabetes mellitus. Once a provider has submitted the necessary quality information on a patient during the reporting period, he or she no longer has to submit PQRS data for that particular patient. Therefore, if a patient meeting the above criteria has an office visit in January and the data is successfully reported for that visit, the provider no longer has to worry about submitting this PQRS data on the patient's subsequent visits.

HOW TO PARTICIPATE IN PQRS

With PQRS, there is no sign-up, registration, or enrollment necessary for participation. Those wishing to participate simply begin reporting the PQRS quality data on their applicable claims. Although the program is easy to begin, it certainly pays to do a little homework up front to ensure successful participation. The following guidelines will help ensure that your PQRS reporting experience is a success.

Determine which measures are most applicable for your practice

The first and most important step toward successfully participating in PQRS is to identify those measures that are most relevant for your practice. Choose the measures that fit your standard courses of care, since it is far more likely that you and your staff will remember to include PQRS codes on each claim when PQRS reporting becomes part of your normal workflow.

As a proxy for this, many industry experts suggest that providers report on the measures that occur most frequently in their practice. Choosing the most frequently occurring measures has the added benefit of increasing your reporting margin of safety—i.e., the maximum number of claims you can submit without PQRS quality data while still meeting the 50% reporting requirement.

Along these same lines, many providers participating in PQRS in the past have realized the benefit of reporting more than the minimum of nine measures. Although there is no additional incentive for reporting on more than nine measures, reporting on one extra measure provides some leeway and allows providers to avoid the 2% penalty even if they underreport on one of their measures.

Despite growing participation in PQRS, 40% of eligible professionals were subject to a 1.5 percent penalty in 2015. (Source: CMS)

Discuss PQRS with providers and staff members

Successful participation hinges on cooperation and communication between providers and their staff members. PQRS will entail changes in workflow, and it is important to ensure that everyone on staff is aware of and prepared for these changes.

After selecting which measures to report, providers should read through the applicable documentation for each of their selected measures to ensure that they know for which patients and in which instances PQRS quality data must be reported. Indeed, the best way to ensure that PQRS data is reported in all applicable instances is to put processes and tools in place to help providers remember to include the necessary PQRS codes on the initial chart.

Put upfront checks and procedures in place to ensure that PQRS data is included on all claims that require it

In both 2007 and 2008, approximately half the providers who participated did not qualify for the PQRS bonus because they did not meet reporting requirements. Remember: failure to include PQRS data does not elicit an error or rejection from the payer. As such, claims missing PQRS data can easily slip out of the door unnoticed.

Depending on how often the provider sees patients who would qualify for a PQRS measure, sending a single batch of claims without PQRS data could put the provider at risk of being subjected to the 2% penalty in 2018. As there is no way to add PQRS data to a claim once it has made its way to the Medicare intermediary, providers must put processes in place to ensure that PQRS data is included on all claims that require it.

ZIRMED'S PQRS SOLUTIONS

Responding to our customers' concerns about PQRS, ZirMed has developed a comprehensive PQRS Toolkit to help providers successfully participate. For both PQRS veterans and newcomers, ZirMed has the tools that providers need to meet the reporting requirements and avoid the 2% penalty on the total Medicare Part B reimbursements.

PQRS Suggested Measures Report

Instead of wading through the hundreds of pages of documentation produced by CMS to determine which measures are applicable to their practice, providers can instead ask ZirMed to do the heavy lifting. In this report, ZirMed analyzes up to the last 12 months of claim data for each provider and determines which PQRS measures occur most frequently in their typical course of care. Report in hand, providers can then focus only on learning about those measures that are relevant and applicable to their practices. We update the specific diagnosis codes associated with each measure on an annual basis, ensuring that your suggested measures align with the most current PQRS standards.

PQRS Monitoring Service

ZirMed's innovative PQRS Monitoring Service enhances your ability to find and correct claims that lack the necessary PQRS data while simultaneously minimizing workflow disruptions. ZirMed's solution serves as a safety net, screening all outgoing Medicare Part B claims for PQRS errors and omissions. Once activated, ZirMed's PQRS Monitoring Service will reject any claim that is missing the necessary PQRS quality data before it can reach the Medicare intermediary.

To eliminate unnecessary alerts and rejections, ZirMed's unique solution allows accounts to select which measures they intend to report on a per-provider basis. Accounts with multiple providers can select different PQRS measures for their providers, each of whom will only receive rejections when they have failed to meet the requirements for their own selected PQRS measures.

> Providers wishing to avoid Medicare penalties in 2018 need to participate in PQRS in 2016. Depending on the volume of patients who would qualify for a PQRS measure, sending a single batch of claims without PQRS data could create a very real risk of being subjected to the 2% penalty in 2018.

For those measures that only need to be reported once per patient, ZirMed's solution recognizes when a provider has already reported on a particular patient and allows subsequent claims—which do not require PQRS data—to automatically pass through the system.

FAQs

How do I know which measures to report?

For only $49 per report, ZirMed will analyze up to your last 12 months of claims to determine which measures are most applicable to your organization. Order your reports with the confidence of our Money-Back Guarantee: if ZirMed cannot suggest any PQRS measures, we will refund your $49 report fee on your next invoice.

How do I catch claims that are missing PQRS data?

For a monthly fee of only $10 per provider, ZirMed will scrub all of your outgoing Medicare Part B claims and alert you each time a claim that meets the requirements for the PQRS measures you selected does not have the necessary PQRS quality codes.

How do I get started with ZirMed's PQRS Solution?

Simply click on "Access PQRS Information" from the ZirMed landing page. From here, you'll be able to order Suggested Measure reports for your providers and select which measures you want ZirMed to check for each provider. Be sure to click "Checkout" when you finish, which will add these items to your next ZirMed invoice.

CONCLUSION

Providers wishing to avoid Medicare penalties in 2018 need to participate in PQRS in 2016. It's also important to note that aspects of PQRS will be pulled directly into the Merit-Based Incentive Payment System (MIPS) that CMS will implement in 2019.

Interested in ZirMed's PQRS solution? Request a personalized demo at info.zirmed.com/pqrs2016

About ZirMed®

ZirMed empowers healthcare organizations to optimize revenue and population health with the nation's only comprehensive end-to-end platform of cloud-based financial and clinical performance management solutions—including patient access, charge integrity, claims management, AR management, patient responsibility, and population health management. ZirMed's award-winning solutions and breakthrough predictive analytics technology improve the revenue cycle, support effective management of population health, and enhance operating efficiencies. To learn how ZirMed can boost your organization's bottom-line performance,, visit **www.ZirMed.com.**