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Health Information Compliance Alert

ED PQRS Reporting: Prepare for Quality And Cost of Care to Impact Your Reimbursement

Size matters when it comes to data collection.

The recent final rule makes changes to quality reporting initiatives associated with the Physician Quality Reporting System (PQRS). Read on to find out how your practice or facility will report on quality measures and which ones have been removed.

The rule also continues the phased-in implementation of the physician value-based payment modifier (Value Modifier), created by the Affordable Care Act, that will affect payments to certain physician groups based on the quality and cost of care they furnish to beneficiaries enrolled in the traditional Medicare fee-for-service program, says Michael A. Granovsky, MD, FACEP, CPC, President of LogixHealth, an ED coding and billing company in Bedford, MA.

Size does matter on payment for data collection: Chief among the changes is a proposed expansion in 2014 of PQRS' quality measures and collection of data from all practices regardless of size and ACOs that are in the Medicare Shared Savings Program. Also, for data reported in 2014, the agency proposes adding patient-derived data collected via the Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey to the site. The measures designed around the survey focus on providers' performance based on patient responses. While CMS wants to encourage all practices to report the provider performance measures, it will pay only for the collection of such data from PQRS GPRO practices with 100 or more eligible providers. You would have to have at least 20 participating patients to report the seven measures, warns Granovsky.

Check Out These Changes To CMS's Quality Reporting Programs

1. **CMS: Hospital Outpatient Quality Reporting (OQR) Program.**

The rule finalizes several new measures for the OQR program affecting the CY 2016 payment determination and subsequent years, with data collection beginning in CY 2014. One new measure in particular will impact EDs and their healthcare staff, says Granovsky.

New measure finalized: Influenza Vaccination Coverage among Healthcare Personnel (OP-27) (NQF #0431). This measure was adopted previously for the Hospital Inpatient Quality Reporting (IQR) Program for the FY 2015 payment determination and subsequent years.

Each year, the **Centers for Medicare & Medicaid Services (CMS)** reevaluates its list of outpatient quality measures, and for 2014 elected to remove one particular ED-relevant measure due to a concern regarding the ability to technically implement the measures within the parameters raised by stake holders. Additionally, the measure was thought to be potentially overly burdensome, Granovsky adds.

Measure removed: Transition record: Transition Record with Specified Elements Received by Discharged ED Patients (OP-19) (NQF# 0649), because this measure cannot be implemented with the degree of specificity needed to fully address stakeholders' concerns without being overly burdensome to both hospitals and CMS.

2. **CMS: Hospital Value-Based Purchasing (VBP) Program**.

The rule sets performance and baseline periods for the catheter-associated urinary tract infection (CAUTI), central line-associated bloodstream infection (CLABSI), and surgical site infection (SSI) measures for the FY 2016 Hospital VBP Program.

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The final performance period is Jan. 1, 2014 through Dec. 31, 2014, and the final baseline period is Jan. 1, 2012 through Dec. 31, 2012. The rule also creates a second level independent CMS review process for hospitals that are dissatisfied with the result of their existing administrative appeal, Granovsky explains.

CMS Announces Meaningful Use Revised Timeline

The agency recently announced a revised timeline for Meaningful Use Stage 2 and 3.

Under the revised timeline, Stage 2 will be extended through 2016, and Stage 3 will begin in 2017 for those providers that have completed at least two years in Stage 2. The stated goal of this change is two-fold: (1) to allow CMS and the Office of the National Coordinator for Health Information Technology (ONC) to focus efforts on the successful implementation of the enhanced patient engagement, interoperability and health information exchange requirements in Stage 2; and (2) to utilize data from Stage 2 participation to inform policy decisions for Stage 3.

Benefit: The phased approach to program participation should help providers move from creating information in Stage 1, to exchanging health information in Stage 2, to focusing on improved outcomes in Stage 3.

Eligible providers who have already completed at least two years of Stage 2 would now begin Stage 3 in 2017, says Granovsky.

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