Radiologists' Tool Kit: How to Succeed in PQRS and VBPM

written by Dave Halpert | August 19, 2015

When it comes to PQRS reporting, it's not easy being a radiologist. How can you fulfill PQRS reporting requirements and avoid jeopardizing future value-based payments? Many radiologists have found themselves backed into a PQRS corner—not enough measures to report, and those measures that can be reported have some tricky requirements.

Similar to anesthesiologists, radiologists practice in a variety of settings and perform different types of procedures, according to sub-specialty. Depending on the procedures you perform, the vast majority of PQRS measures may not be applicable to you—not only are they clinically irrelevant, but you couldn't report them even if you wanted to—your patients simply won't fall into the denominator.

Up to six percent of your 2017 Medicare Part B revenue is at risk, based on what you report and how you perform in 2015. To ensure that you are not reimbursed only 94 percent for the same services as your colleagues, take the following steps before the end of the measurement year:

Step 1: Recognize That Having Fewer Than Nine Measures Does NOT Exclude You from PQRS

Those who do not see patients in a face-to-face setting have a substantially reduced number of available measures, and some may qualify for fewer measures than normal to fulfill CMS's reporting requirements. For individual measure reporting (whether in a group practice or as an individual provider), these requirements are:

> At least nine measures must be completed for 50 percent of eligible instances.
> Those measures must cover three National Quality Strategy (NQS) Domains.

If patients are seen in a face-to-face encounter, at least one crosscutting measure must be included.
The measure must have performance requirements fulfilled in at least one of the reported instances.

Diagnostic Radiologists often trigger only eight measures. Nevertheless, these providers are not excluded from PQRS—CMS will audit those who do not fulfill nine measures to see if there were other measures that could have been reported. *So, a radiologist won't necessarily be penalized for reporting eight measures, but may be penalized if reporting only a portion of available measures.*

Step 2: Pass CMS's Measure Applicability Validation (MAV) Audit to Avoid Penalties

To ensure that you've fulfilled requirements to the extent possible (protecting you from PQRS and VBPM penalties), use a two-pronged approach:

1) Partner with a Registry that has a proven track record and the ability to report all measures AND one that can show you, preemptively, which measures your patients have triggered. A clear view of the measures your patients have triggered (and in which NQS Domains those measures reside) is critical to passing a MAV audit.

2) Verify with the QualityNet Help Desk. Once you have an idea of the measures in which you have eligible patients, you should speak with the Help Desk to confirm that their assessment matches yours to prevent surprises down the road. They will provide you with confirmation and email documentation, should you need to request an Informal Review with CMS. Of course, your measure pool may change—*a November confirmation may not protect you if a measure is triggered in December, so don't forget Part 1!*

Step 3: Remember That High Performance Is Relative (or, Be Careful with Measure #146)

When Medicare calculates a group's Value-Based Payment Modifier (remember, you'll have a VBPM assigned whether you are reporting as individuals or as a group), after confirming that you should not be penalized under PQRS (CMS refers to this successful group as "Category 1"), CMS will review the performance on the measures you've reported, *compared to others*.

The comparison to others is what makes this tricky, particularly for radiologists. Medicare will calculate a measure's mean and standard deviation from providers across the country. Those who perform better than one standard deviation from the mean are on a course to earn a positive VBPM, depending on how they've performed on other measures in the same NQS

Domain, and then overall. Those who score outside of the standard deviation through inferior performance are at risk of penalties. As you can see, once the 50 percent completion has been met, the next hurdle is to perform well, and *every measure has a different performance threshold.*

This risk is compounded for radiology—in order to pass the MAV audit, you are likely locked into Measure #146: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms. To remain within one standard deviation of the performance mean, a provider must be nearly perfect. Since the measure focuses on avoiding the use of the "Probably Benign" designation, the measure's performance is inversely calculated by CMS, meaning that lower performance is actually better. This measure's mean performance in 2013 (the most recently released CMS benchmark) was a miniscule 0.32 percent, with a standard deviation of 1.11 percent.

What does that mean in plain English? It means that, if you report this measure on 100 patients, but use the "Probably Benign" designation in only one instance, your performance is inferior to the mean. If you use it twice, you're a standard deviation outside of the mean, and at risk of penalties. Those with sharp eyes may think they've seen a typo, as it appears that you would have to have mathematically impossible performance to score better than one standard deviation than the mean. Unfortunately, that's not a typo—those are the numbers that CMS has released. Exercise extreme caution when documenting this measure.

Step 4: Find a "Common Denominator" by Reporting Clustered Measures

Similar to orthopedists, radiologists have measures that can be reported together, because the measures include the same groups of patients. By collecting the appropriate documentation, you can document on two or three measures for the price of one. Better still, there are clusters within different radiology sub-specialties.

For Radiation Oncology, there are two measures related to pain, and they are tied together. The first measure, for eligible patients, is whether pain intensity was quantified (Measure #143). If so, and pain was present, proceed to Measure #144, which tracks whether there is a plan of care for pain documented in the record (including medications, etc.). This seems intuitive, but make sure that your plan contains the required elements listed in the Measure Specification, and that it is documented in a manner consistent with any data interfaces you have developed with your technology partners.

Diagnostic Radiologists have three measures in a cluster focused on overuse of cardiac stress imaging for low risk patients. These are Measures #322-324. Note that these measures are relatively new, so previous performance results will not be released until later this year.

Reporting them will keep you from incurring automatic penalties from VBPM for not fulfilling PQRS requirements (Medicare refers to this unfortunate group as “Category 2,” which is easy to remember because they will be penalized twice), but their effect on your VBPM once you’ve earned Category 1 status is yet to be determined.

Interventional Radiology has its own cluster, focused on carotid artery stenting (CAS) procedures (Measures #344 and #345). Like Measures #322-324, these are newer and do not have documented performance thresholds. They are also outcome measures, meaning that, for example, if a patient is not “discharged to home” within two days following the procedure (Measure #344), your performance will suffer.

Step 5: Report the Appropriate Measures for Your Practice (or, Don’t Assume a Colleague’s Strategy Is Right for You)

Earlier, we noted that Diagnostic Radiologists often trigger less than nine measures. Since there may be no patient contact, these providers would also not trigger a crosscutting measure.

Interventional Radiologists and Radiation Oncologists do not follow the same pattern. It’s likely that these groups will qualify for nine measures, and the options are not always intuitive (see Step 2). These sub-specialties could also report measures such as those related to radiation dose limits (#156) and overuse of certain scans for low-risk patients (#102), in addition to the clusters described above.

Additionally, these sub-specialties will be required to report at least one crosscutting measure, triggered by face-to-face encounters. Among others, crosscutting measures include:

> #130: Documentation of Current Medications in the Medical Record
> #131: Pain Assessment and Follow-Up
> #226: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

Although the measures are not necessarily complicated, documenting them may be a challenge, particularly for those who have not done so throughout the year. Many specialists fall into this category, believing that these measures are more appropriately reported in the primary care setting. Unfortunately for these providers, the crosscutting requirement only accounts for the codes on the claim, and not the specialty of the billing provider. Failure to report one of these measures may put you at risk in a MAV Audit, and for being penalized for both PQRS and VBPM.

Yes, it may be difficult to retrospectively document this information now, as there is no diagnosis required for these measures—everyone seen face-to-face is eligible. Nevertheless, there is still time to compile this information so that your Registry may report it during the submission period, and it's certainly better to start now, rather than at the end of the year.

Radiologists, like other specialists, may find that you have a MAV Audit in your future—but, maybe not. Whether you have the opportunity to pick and choose the measures that work for you or are locked into a smaller set, the first step to avoiding a VBPM penalty is to ensure you are designated by CMS as "Category 1." Make sure that you have fulfilled your PQRS requirements as they relate to your practice. If you have registered as a Group Practice, make certain that everyone knows who has triggered which measures—*a single face-to-face encounter can leave your group open for penalties if you fail to recognize that a crosscutting measure is required.*

With so many providers attempting to break from the pack, but forced into reporting the same measures, describing the field as "competitive" is a gross understatement. As you work toward Category 1, be extremely cognizant of performance requirements, and consider partnering with a Registry that can help you to compare your scores against previous results, as well as show you all of your applicable measures. Identifying potential issues early, even if they are simple gaps in documentation, can make a big difference when Medicare starts comparing results and calculating VBPMs.

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