HOW DOCUMENTATION IMPACTS VBPM, PQRS

By Richard Pinson, MD, FACP

In calendar year 2015, Medicare will begin phasing in a physician payment adjustment, the Value-Based Payment Modifier (VBPM), which will apply to all physicians by calendar year 2017. The VBPM awards or penalizes physicians in group or solo practices for quality and cost of care. A group is defined as 2 or more “eligible” clinicians (not just physicians) who have individual National Provider Identifier (NPI) numbers that bill under a single taxpayer identification number (TIN).

To be eligible for the VBPM, physicians must participate in Medicare’s Physician Quality Reporting System (PQRS), which has provided incentive payments since 2007 to practices that report certain quality performance data to CMS. Only 36% of all physicians participated in the PQRS program during 2012, according to CMS. However, non-participation during 2014 will result in an automatic 4% reduction in 2016 physician fees; the penalty for non-participation in 2015 will be 6% of fees paid in 2017.

For successful participation in PQRS, hospitalists must report on at least 9 measures in at least 3 quality categories (domains) defined by CMS. Unfortunately, very few PQRS measures are consistent with hospitalist practices (Table 1); most are specialty-specific or focused on outpatient care. The Society of Hospital Medicine is currently working with CMS to define more appropriate hospitalist-specific measures.

In 2016, VBPM will reward or penalize participating physicians by as much as 2% of their fee schedule (see Table 2) based on quality and cost performance in 2014. In 2017, the VBPM adjustment range will be +4% to -4% based on 2015 performance. The reward incentive (but not the penalty) may be adjusted slightly based on Medicare cost projections for the applicable year. The best-performing clinicians may also be eligible for an additional 1% reward if their average patient risk/severity score ranks in the top 25th percentile, to help ensure that those who care for sicker patients aren’t unfairly penalized. Expected distributions of VBPM in 2016 and 2017 are shown in Table 3. About 25% of clinicians will likely see some reward, 25% some penalty, and 50% no reward or penalty.

For the VBPM, quality of care is assessed using the reported PQRS performance measures and 3 additional outcome measures: all-cause 30-day readmissions; high admission rates for 3 acute conditions (bacterial pneumonia, urinary tract infection, and dehydration); and high admission rates for 3 chronic conditions (diabetes, chronic obstructive pulmonary disease/asthma, and heart failure). VBPM cost of care is measured by a single composite score combining per capita Medicare costs (including Parts A and B) and Medicare spending per beneficiary, then compared to a national mean of costs.

So how do documentation and coding impact VBPM? The VBPM outcome and cost measures use ICD-9-CM coded data to determine if patients will be included in the measure, as well as to risk-adjust the analysis. The number of diagnoses and the severity of illness reflected by the codes determine the risk adjustment used to measure performance. Therefore, precise documentation is absolutely necessary to assign the correct codes that will accurately demonstrate severity of illness.

For example, in cases of urinary tract infection (UTI) or pneumonia, if sepsis is also diagnosed and present on admission,