ICD-10-CM FAQs

Background: ICD-10-CM received revisions in October 2016. At that time, PQRS program stakeholders provided questions regarding measure reporting concerns. CMS analyzed the potential impact of the ICD-10-CM revisions on the quality measures within the PQRS program and provided a response within a Listserv message in early December. Stakeholders then provided further questions as represented within the list of FAQs in this document.

The purpose of the following FAQs regarding ICD-10-CM updates is for CMS to provide responses to questions that may arise from 2016 PQRS stakeholders."

Question 1: Where can I find information about the ICD-10-CM code updates that impact PQRS quality reporting on the CMS Website?
Answer 1: Please refer to the "ICD-10 Code Updates (12-15-2016)" message on the PQRS Spotlight webpage for full information, or view the PQRS ICD-10 Section webpage for frequently asked questions (FAQs) related to these code updates.

Question 2: Which 2016 PQRS measures were impacted by changes to ICD-10-CM codes in the 4th Quarter of 2016?
Answer 2: The majority of ICD-10-CM coding changes that impacted 2016 PQRS measures were related to diabetes, pregnancy, cardiovascular, oncology, mental health and eye disease diagnosis. The impacted PQRS measures may be different depending on the reporting mechanism. CMS expects the current ICD-10-CM coding as defined in the 2016 measure specification to be utilized for submissions through all reporting mechanisms.

Question 3: Do we still need to report 2016 PQRS measures if we believe we are unable to satisfactorily report the measures due to potential changes to ICD-10-CM codes?
Answer 3: CMS expects individual eligible professionals (EPs) and group practices to still report quality measures for 2016 PQRS measures regardless of whether they believe they are affected or are not impacted by the ICD-10-CM updated code changes. CMS will determine, based on measures that were reported for 2016 PQRS, whether they were impacted by the ICD-10-CM code updates.

Question 4: What is the process for determining which group practices or eligible professionals (EPs) are negatively impacted by the ICD-10-CM coding changes for all reporting mechanisms?
Answer 4: CMS will perform an analysis after the close of the 2016 PQRS reporting period and CMS will review the submissions to determine which group practices and EPs were negatively impacted by the ICD-10-CM coding changes. The group practices and EPs affected by the impact of the ICD-10-CM code updates will be removed from the PQRS payment adjustment prior to the release of feedback reports. Registries, Qualified Clinical Data Registry (QCDR) and Electronic Health Record (EHR) vendors should calculate the measures as defined in the 2016 measure specifications and utilize the calculated measures data in their submission on your behalf. CMS determined that there has been minimal impact to the Group Practice Reporting Option (GPRO) Web Interface measures due to the assignment and sampling process. Therefore, those PQRS group practices and Accountable Care Organizations (ACOs) reporting via the GPRO Web Interface will not be impacted by the ICD-10-CM code updates. If you receive a

payment adjustment and believe it is due to ICD-10-CM code updates, you have the option to submit a request for an informal review of the payment adjustment.

Question 5: For 2016 Measures Group reporting, if an eligible professional (EP) has less than a 20 patient sample due to the ICD-10-CM code update, should they submit on the Measures Group even if the denominator is less than 20 patients?
Answer 5: Yes, you should submit your Measures Group even if there are less than 20 eligible instances. CMS is anticipating that the following Measures Groups may be affected by the ICD-10-CM code updates:

- Diabetes Measures Group
- Cataracts Measures Group
- Oncology Measures Group
- Cardiovascular Prevention Measures Group
- Diabetic Retinopathy Measures Group

For EPs that submit less than 20 patients for one of the Measure Groups listed above, CMS reserves the option to validate if the EP had less than 20 denominator eligible instances. Upon confirmation of less than 20 denominator eligible instances, CMS will not apply the 2018 PQRS payment adjustment to those EPs.

Question 6: For 2016 PQRS, what happens if the eligible professional (EP) chooses a different reporting mechanism because they believe they will be unsuccessful in submitting a measures group via registry due to the ICD-10-CM update, but still fail? Would they avoid the payment adjustment in this scenario?
Answer 6: EPs reporting via registry are allowed to change their reporting method for 2016 PQRS reporting if they believe they will be unable to satisfactorily report. CMS recommends EPs collaborate with their registry in order to determine how best to satisfactorily report.

Question 7: Does CMS plan to communicate to group practices and eligible professionals (EPs) that were affected by the ICD-10-CM code updates within the PQRS feedback reports next year?
Answer 7: CMS is assessing the ability to include additional communication regarding ICD-10-CM impact within the PQRS feedback reports and will provide further information as it becomes available.

Question 8: When does CMS plan to release the 2017 electronic Clinical Quality Measures (eCQMs) value set addendum?
Answer 8: All changes to the eCQM value sets will be available through the National Library of Medicine's Value Set Authority Center (https://vsac.nlm.nih.gov/) starting in early to mid-January 2017. CMS will provide a follow-up communication announcing the availability of the addendum and educational materials. Please note that these changes will only affect the value sets for the eCQMs. The Health Quality Measure Format (HQMF) specifications, the value set object identifiers (OIDs), and the measure version numbers for 2017 eCQM reporting will not change. The eCQM value set addendum for 2017 will be published to the eCQM Library and the eCQI Resource Center.

Question 9: Why does CMS reference 2017 PQRS payment adjustments when the 2016 reporting period affects 2018 PQRS payment adjustments?
Answer 9: The 2017 payment adjustment reference is included because eligible professionals (EPs) that participated in a Medicare Shared Savings Program ACO that failed to report quality data for 2015 for the 2017 PQRS payment adjustment period, have available a special secondary PQRS reporting period in 2016 that enables the EPs to avoid the 2017 PQRS payment adjustment and the 2017 Value Modifier (VM) automatic downward adjustment.
Affected EPs may submit 2016 PQRS quality data under one of the available reporting options for this special secondary reporting period. This data is submitted outside the ACO by EPs in order to avoid the 2017 PQRS payment adjustment and 2017 VM automatic downward adjustment.

Question 10: For 2016 PQRS, can eligible professionals or group practices report on ICD-9-CM codes?
Answer 10: The coding as defined in the measure specification of the specific reporting mechanism you are reporting should be utilized. The 2016 PQRS Individual Measure Specifications for Claims and Registry do not define ICD-9-CM codes and therefore are not appropriate to utilize to determine the denominator of the measure. For other reporting mechanisms, if the measures coding includes ICD-9-CM coding, it would be appropriate to utilize ICD-9-CM coding as it is defined in the measure.

Question 11: What is the impact to the Value Modifier (VM) payment adjustments? The listserv message we received says that the Value Modifier program will consider solo practitioners and groups, as identified by their taxpayer identification number (TIN), who meet reporting requirements in order to avoid the PQRS payment adjustment (either as a group or by having at least 50% of the individual eligible professionals in the TIN avoid the PQRS adjustment) to be "Category 1," meaning they will not incur the automatic downward adjustment under the Value Modifier program.
Answer 11: The PQRS will make a determination as to whether the individual EPs within the group avoid the PQRS payment adjustment as individuals, or the group avoided the adjustment via a group practice reporting option (GPRO). If the TIN avoided the 2018 PQRS payment adjustment as a group or at least 50% of its individual EPs avoid the 2018 PQRS payment adjustment, then the TIN would also avoid the 2018 Value Modifier automatic downward adjustment. PQRS will consider the impact of the ICD-10-CM coding updates on individual EPs' and groups' ability to avoid the PQRS payment adjustment and consequently, the automatic downward adjustment under the Value Modifier.

Question 12: We were informed of the listserv message related to ICD-10-CM updates. If my individual eligible professional (EP) or practice did not satisfactorily report for 2016 PQRS, will they be subject to the 2018 PQRS payment adjustment?
Answer 12: If it is found that the individual EP or group practice failed to satisfactorily report for 2016 PQRS **solely because of** ICD-10-CM coding updates to the quality measures, then they will not be subject to the 2018 payment adjustment. If it is found that the individual EP or group practice failed to satisfactorily report due to other reasons, they would be subject to the 2018 payment adjustment.

Question 13: Due to the pending administration change, does CMS anticipate an impact to 2016 PQRS reporting requirements?
Answer 13: At this time, CMS does not anticipate changes to the 2016 PQRS reporting requirements due to administration changes. Eligible professionals and group practices should still plan to report to the 2016 PQRS program in order to avoid the 2018 payment adjustment.