PQRS Guidelines

I. Introduction
   A. The reporting of these additional codes are used to determine the quality of care a provider gives to patients with certain diseases.
   B. All PQRS codes including the E-Prescribing code must be linked to an “encounter” or office visit code. These codes are the following: 99201-99205, 99211-99215, 92002, 92004, 92012, or 92014.
   C. The PQRS codes are used for Medicare and Railroad Medicare patients right now but some of the secondary insurances are paying in addition to what you receive from Medicare.
   D. Until this year you had to file at least three different PQRS measures but in 2014 that requirement changes to nine measures.
   E. Must file a PQRS measure on at least 50% of the claims when the exam code and diagnosis code indicates the need. Successful PQRS reporters will earn 0.5% in 2014.
   F. Not participating in PQRS in 2013 will result in a penalty of a reduction in your Medicare payments in by 1.5% in 2015 and not participating in 2014 will increase reduction to 2% in 2016.
   G. In addition, not participating in EHR/MU in 2014 will reduce your Medicare payments by an additional 2%.
   H. If the doctor is Board Certified and participating at the required level of PQRS they can receive an additional 0.5%.
   I. File PQRS codes on EVERY CLAIM (with modifiers if needed) with the diagnosis code and the examination codes for that measure even if you did not perform the measure on that visit. Every encounter with a patient that has a diagnosis code that should be reported has to have the PQRS codes attached or it will be counted against you. If you do not perform the measure on the visit use the appropriate modifier with the PQRS code.
   J. Three Diagnosis we currently Report:
      a. Age Related Macular Degeneration
      b. Primary Open Angle Glaucoma
      c. Diabetes: Insulin and Non-Insulin Dependent
   K. Terms used:
-Numerator-CPT category II codes
- Denominator-appropriate diagnosis codes that go with the category II codes
- Modifiers-new set of HCPCS modifiers developed for these category II codes

II. Measure Selection
   A. Must report 9+ measures covered in at least 3 of the NQS(National Quality Strategy) domains below
      – Patient Safety
      – Person and Caregiver-Centered Experience & Outcomes
      – Communication and Care Coordination
      – Effective Clinical Care
      – Community/Population Health
      – Efficiency and Cost Reduction
   B. All measures for AMD and Diabetic are Effective Clinical Care. The Glaucoma measures are also Clinical Care with the exception of the documentation of a Plan of Care which falls under Communication/Care Coordination.
   C. We have to choose one more NQS domain to report in.

III. Additional Reporting Measures for 2014
   We need to do 2 additional measures and 1 domain to successfully report
   Can be Used with 920XX codes
   A. Measure #317-Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up documentation (Community/Population Health)
   B. Measure #226-Patient screening for tobacco use and received cessation counseling if identified as a user (Community/Population Health)
   C. Measure #130-Documentation of Current Medications in the Medical Record (Patient Safety)
      Cannot be Used with 920XX
   D. Measure #128-Preventive care & Screening: BMI
   E. Measure #111-Preventative care & Screening: Pneumococcal vaccination in >65 yr
   F. Measure #173- Preventative care & Screening: Unhealthy alcohol
   G. Measure #110-Preventative care & Screening: Influenza immunization
   H. Choose from the top three which two you want to do since the last four and not allowed with 92XXX codes.
IV. To whom and when is incentive money paid
   A. Incentive money is paid to each tax identification number, but is based on, as well as reported on each individual NPI number of the doctor performing the services.
   B. Your incentive payment will be paid as a lump sum payment in the fourth quarter of the following year. Example: 2011 incentive bonus paid to you in the third quarter of 2012.
   C. You do not have to sign up just start reporting the PQRS codes on your CMS claim forms.

V. How to report on CMS claim form
   A. E/M code or Eye exam code for office visit listed first.
   B. Next line on the CMS form will be Level II CPT codes linked to the appropriate ICD diagnosis code to be reported.
   C. Must have a dollar amount attached to the PQRS code when filing claim. Enter a $.01 so it will not be rejected.
   D. If any supplemental testing is done it has to be billed after the PQRS codes.

VI. Modifiers
   A. Use only one modifier when a measure could not be performed.
   B. The modifiers describe the reason the measure was not performed and you can still get credit for the measure.
   C. Modifiers and definitions:
      - 1P-excluded for medical reason (potential adverse interaction, etc)
      - 2P-excluded due to patient reasons (patient declined for whatever reason)
      - 8P-not performed other reason

VII. PQRS Measures
   A. Glaucoma- Diagnosis Codes: 365.10, 365.11, 365.12, 365.15, 365.70-365.74
      1) Measure 12: Primary Open Angle Glaucoma Optic Nerve Evaluation
         - CPT Level II Code: 2027F
         - Deleted Code: 365.01 (eliminated 2010)
         - Document viewed optic nerve (drawing, description, photo, or scan)
         - Modifiers 1P, 8P if not done
2) Measure 141: Primary Open Angle Glaucoma Reduction of IOP by 15% or Documentation of Plan of Care

**Controlled IOP**
- 2027F above code
- 3284F-IOP reduced 15% or more from pre-intervention levels
- This is to be performed in a 12 month period or reporting period.
- Modifier 8P

**Uncontrolled IOP**
- 2027F above code
- 3285F-IOP reduced less than 15% from pre-intervention

- 0517F-Plan of care to get IOP reduced (Examples: recheck IOP at specified time, change in therapy, referral to specialist, etc)
- Modifier 3285F none 0517F-8P

B. Macular Degeneration-Diagnosis Codes: 362.50, 362.51, 362.52
1) Measure 14: Age Related Macular Degeneration Dilated Exam
- CPT Level II Code: 2019F
- Patient 50+ yrs old with diagnosis AMD
- Dilated view of macula
- Recorded +/- macular thickening and +/- hemorrhages
- Must dilate and record finding once per 12 month period or reporting period.
- Modifiers 1P, 2P, 8P

1) Measure 140: AMD Counseling on Antioxidant Supplement
- CPT Level II Code: 4177F
- Discussed with patient or caregiver one the benefits and risks of the supplements formulated for the preventing progression of AMD
- Modifier 8P

C. Diabetes-Diagnosis Codes: 250.00-250.03, 250.10-250.13, 250.20-250.23, 250.30-250.33, 250.40-250.43, 250.50-250.53, 250.60-250.63, 250.70-250.73, 250.80-250.83, 250.90-250.93, 357.2, 362.01-362.07, 566.41, 648.01-648.04
1) Measure 117: Diabetes Mellitus Dilated Exam

**Diabetes with or without retinopathy**
- CPT Level II Code: 2022F
- Dilated eye exam on diabetic patient
- Modifiers 8P
OR

- CPT Level II Code: 3072F
- Low risk of Diabetic Retinopathy (no evidence of retinopathy in exam last year)
- Modifiers none

2) Measure 18: Diabetic Documentation of Presence of Macula Edema & Level of Severity of Retinopathy
- CPT Level II Code: 2021F
- Diagnosis Codes: 362.01-362.06
- Patient age 18 yrs or older
- Documentation +/- macular edema and level of diabetic retinopathy
- Modifiers 1P, 2P, 8P

3) Measure 19: Diabetic Retinopathy Communication with Physician Managing Diabetes Care
- CPT Level II Code: 5010F
- Communicated presence or absence of macular edema and the level of diabetic retinopathy to physician responsible for the diabetic care.
- Reported with either G8397 Dilated macular exam performed or G8398 Dilated macular exam not performed
- Modifiers 1P, 2P, 8P

D. Preventive Care and Screening: Screening for High Blood Pressure and FU Documented

1) Measure #317 High Blood Pressure Screening

2) BP Classifications:

<table>
<thead>
<tr>
<th>BP Classification</th>
<th>Systolic BP mmHG</th>
<th>Diastolic BP mmHG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal Blood Pressure Reading</td>
<td>&lt;120</td>
<td>and &lt;80</td>
</tr>
<tr>
<td>Pre-Hypertensive BP Reading</td>
<td>≥120 and ≤139</td>
<td>or ≥80 and &lt;89</td>
</tr>
<tr>
<td>First Hypertensive BP Reading</td>
<td>≥140</td>
<td>or ≥90</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>Second Hypertensive BP Reading</td>
<td>≥140</td>
<td>or ≥90</td>
</tr>
</tbody>
</table>

3) Current Blood Pressure Measurement
   - CPT Level II Code: G8783
     - Normal Blood Pressure documented, follow-up not required
       OR
   - CPT Level II Code: G8950
     - Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up documented
       OR
   - CPT Level II Code: G8784
     - Blood pressure reading not documented, documentation the patient is not eligible
       OR
   - CPT Level II Code: G8951
     - Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, documentation the patient is not eligible
       OR
   - CPT Level II Code: G8785
     - Blood pressure reading not documented, reason not given
       OR
   - CPT Level II Code: G8952
     - Pre-Hypertensive or Hypertensive blood pressure reading documented, indicted follow-up not documented, reason not given

Reasons for patient not being eligible:
   - Patient has an active diagnosis of hypertension.
   - Patient refuses to participate either in measurement or follow-up
– Patient is in an urgent or emergency situation where time is of the essence and to delay treatment would jeopardize the patient’s health. This may include severe elevated blood pressure when immediate medical attention is indicated.

E. Patient screened for tobacco use and received cessation counseling if identified as user
   – Measure #226 Document as tobacco user or non-tobacco user and if they are a user counsel them and put documentation in record
   – CPT Level II Code: 4004F
   – We already record tobacco use add documentation of counseling
   – Cessation Counseling is defined as brief counseling, 3 minutes or less with or without pharmacotherapy.
     OR
   – CPT Level II Code: 1036F
   – Not a current tobacco user

F. Current medications with name, dose, frequency, and route documented
   – Measure #130 Documenting all Meds(prescription meds, over-the-counter meds, herbals, and vitamins/mineral/dietary supplements) within the patients record and must include dose, frequency, and route (the ways the medication enters the body such as oral, sublingual, subcutaneous injections, or topical)
   – CPT Level II Code: G8427
   – Current Medications with Name, Dosage, Frequency and Route Documented
     OR
   – CPT Level II Code: G8430
   – Current Medications with Dosage not documented, Patient not Eligible (Emergency Situations Only where patient’s health will be jeopardized by delaying treatment because time is of the essence.)
     OR
   – CPT Level II Code: G8428
   – Current Medications with Name, Dosage, Frequency and Route not Documented, Reason not Specified
     – Go over Meds(We are doing this now) but add the dose, frequency and route

G. The last three measures are to be done on all Medicare and Railroad Medicare patients not related to any specific diagnosis codes.

VIII. Summary
These reporting measures started with incentive money from the government to doctors to start reporting the level of care you are providing. It has now become a penalty for not reporting rather than an incentive. The sooner you start using these Level II codes the faster you become proficient with them and start qualifying for incentive money and more importantly avoid the penalties to come starting in 2015 and carrying forward.