

Understanding PQRS Guidelines - 2011

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2011 Physician Quality Reporting System

- Compliance
 - How To understand Quality CPT codes
 - How To use appropriate ICD codes in PQRS
 - How To use modifiers in PQRS coding
 - How To lay out CMS 1500 claims forms for PQRS
 - How To increase revenues by capturing incentive bonus payments
 - How to use PQRS coding for electronic health records
 - How To use E-Prescribing practices and collect incentive bonus payments

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Technology Integrated Practices

- National priority to digitize healthcare by 2010
 - National Health Information Network (NHIN)
 - AOA Health Information Technology (HIT) Study Group
- Software, hardware and instrument technologies have intersected with economics and national political priorities to support a national interdisciplinary EMR system
- Implementation is possible with off-the-shelf technology

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Technology Integrated Practices

- The question is no longer “IF” but “WHEN”
 - Regulators and insurers are already beginning to enforce TIPS
 - Only electronic claims will be accepted
 - End of paper claims
 - Penalties for slow conversion
- HIPAA compliance is built in
- HHS awarded \$3.3 million contract to ANSI to harmonize data standards
 - Poor interoperability at this time
 - 200 EHR products available on market

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New Level II CPT Codes

- New CPT codes developed as supplemental tracking codes for certain medical conditions
 - Used in future to determine quality of care a provider gives to patients with certain disease states
- July 1, 2007 was the start date for voluntary use
- CMS Physician Quality Reporting Initiative (PQRI)
 - If at least 3 of these measures are used at least 80% of the time
 - Bonus payment of 2% on all Medicare claims
 - Reporting periods of Jan 1-Dec 31, 2011 or July 1-Dec 31, 2011
 - Additional bonus for e-prescribing in 2011 of 1%

PQRS Facts

- PQRS reporting is voluntary...for now
- View all measures at <http://www.cms.hhs.gov/PQRI/>
- Can report any measure believed to apply to you including those from other specialties
- Bonus paid out as lump sum in 4th Q of following year
- Bonus paid to each tax identification number, but it is based on, as well as reported by using, the individual NPI
- No need to sign up, just begin reporting
- Some systems won't accept a zero charge, so post \$0.01
- If a patient encounter qualifies for more than one measure, report all that qualify

New Level II CPT Codes

- Definition of terms
 - Numerator – CPT category II codes
 - Denominator – Diagnosis codes that pertain to each category II code
 - Modifiers – new set of HCPCS modifiers developed for PQRI
- E/M code or Eye code for office visit reported first
- Next line will be Level II CPT code (s)
 - linked to the ICD code in question
 - zero dollar amounts not processed!!
- Supplemental testing is reported after quality codes

Performance Measurement Exclusion Modifiers

- Use only when measure could not be performed
- -1P excluded for medical reasons
 - Not indicated: absence of organ/limb, already performed/received, other
 - Contraindicated: allergic history, potential adverse interaction
- -2P excluded due to patient reasons
 - Patient declined, economic, social, religious
- -3P exclusion due to system reasons
 - Resources to perform not available, insurance/payor limitations
- -8P not performed

Measure 12: POAG Optic N. Evaluation

- CPT category II Code: 2027F
- Diagnosis codes
 - 365.10 Open angle glaucoma
 - 365.11 Open angle glaucoma
 - 365.12 Low tension glaucoma
 - 365.15 Residual stage of open angle glaucoma
- Documentation tips – ON can be documented with a drawing, description, photograph or scan
- Modifiers -1P, -8P

Measure 141: POAG Reduction of IOP by 15% or Documentation of Plan of Care

- IOP reduced by 15% from pre-intervention
 - CPT category II Code: 3284F
- IOP reduced less than 15% from pre-intervention
 - CPT category II Code: 3285F plus
 - CPT category II Code: 0517F to document plan of care
 - Recheck IOP, Rx change, additional testing, referral, plan to recheck
- Once per reporting period
- CPT Codes: 92002, 92004, 92014, 92012, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Measure 141: POAG Reduction of IOP by 15% or Documentation of Plan of Care

- Diagnosis codes
 - 365.10 Open angle glaucoma
 - 365.11 Open angle glaucoma
 - 365.12 Low tension glaucoma
 - 365.15 Residual stage of open angle glaucoma
- Modifiers -8P

Measure 14: AMD Dilated Exam

- CPT category II Code: 2019F
- Pts 50yrs+ with diagnosis AMD having DFE with documentation of presence or absence of macular thickening or hemorrhage AND level of severity (mild, moderate, severe) of AMD during one or more office visits w/in 12 mos, minimum of once per reporting period
- Diagnosis codes
 - 362.50 Macular degeneration, unspecified
 - 362.51 Non exudative senile macular degeneration (dry)
 - 362.52 Exudative senile macular degeneration (wet)
- Modifiers -1P, -2P, -8P

Measure 140: AMD Counseling on Antioxidant Supplement

- Patients aged 50 and older with a diagnosis of AMD and/or their caregiver(s) who were counseled within 12 months on the benefits and/or risks of the AREDS formulation for preventing progression of AMD
- CPT category II Code: 4177F
- Diagnosis codes
 - 362.50 Macular degeneration, unspecified
 - 362.51 Non exudative senile macular degeneration (dry)
 - 362.52 Exudative senile macular degeneration (wet)
- Modifiers -8P
- Note: If already receiving AREDS supplements, assumption is counseling has already been performed

Measure 140: AMD Counseling on Antioxidant Supplement

- CPT Codes: 92002, 92004, 92014, 92012, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99307, 99308, 99309, 99310, 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337

Measure 117: Diabetes Mellitus Dilated Exam

- CPT category II Code:
 - 2022F: dilated retinal exam by OD/OMD with interpretation documented and reviewed
 - 2024F: 7 standard field stereophotos with interpretation documented and reviewed
 - 2026F: eye imaging validated to match diagnosis from 7 standard field stereophotos with results documented and reviewed
 - 3072F: low risk for retinopathy (no evidence of retinopathy in prior year)
- Modifiers -8P

Measure 117: Diabetes Mellitus Dilated Exam

- Diagnosis Codes
 - 250.00 DM w/o ophthal manif, type II, not uncontrolled
 - 250.01 DM w/o complication, type I, not uncontrolled
 - 250.02 DM w ophthal complications, type II, uncontrolled
 - 250.03 DM w/o complication, type I, uncontrolled
 - 250.10 DM w ketoacidosis, type II not uncontrolled
 - 250.11 DM w ketoacidosis, type I, not uncontrolled
 - 250.12 DM w ketoacidosis, type II, uncontrolled
 - 250.13 DM w ketoacidosis, type I, uncontrolled

Measure 117: Diabetes Mellitus Dilated Exam

- Diagnosis Codes
 - 250.20 DM w hyperosmolarity, type II, not uncontrolled
 - 250.21 DM w hyperosmolarity, type I, not uncontrolled
 - 250.22 DM w hyperosmolarity, type II, uncontrolled
 - 250.23 DM w hyperosmolarity, type I, uncontrolled
 - 250.30 DM w coma, type II, not uncontrolled
 - 250.31 DM w coma, type I, not uncontrolled
 - 250.32 DM w coma, type II, uncontrolled
 - 250.33 DM w coma, type I, uncontrolled

Measure 117: Diabetes Mellitus Dilated Exam

■ **Diagnosis Codes**

- 250.40 DM w renal complic, type II, not uncontrolled
- 250.41 DM w renal complic, type I, not uncontrolled
- 250.42 DM w renal complic, type II, uncontrolled
- 250.43 DM w renal complic, type I, uncontrolled
- 250.50 DM w ophthal manif, type II, not uncontrolled
- 250.51 DM w ophthal manif, type I, not uncontrolled
- 250.52 DM w ophthal manif, type II, uncontrolled
- 250.53 DM w ophthal manif, type I, uncontrolled

Measure 117: Diabetes Mellitus Dilated Exam

■ **Diagnosis Codes**

- 250.60 DM w neurol manif, type II, not uncontrolled
- 250.61 DM w neurol manif, type I, not uncontrolled
- 250.62 DM w neurol manif, type II, uncontrolled
- 250.63 DM w neurol manif, type I, uncontrolled
- 250.70 DM w periph circ disord, type II, not incontrolled
- 250.71 DM w periph circ disord, type I, not uncontrolled
- 250.72 DM w periph circ disord, type II, uncontrolled
- 250.73 DM w periph circ disord, type I, uncontrolled

Measure 117: Diabetes Mellitus Dilated Exam

■ **Diagnosis Codes**

- 250.80 DM w other manif, type II, not uncontrolled
- 250.81 DM w other manif, type I, not uncontrolled
- 250.82 DM w other manif, type II, uncontrolled
- 250.83 DM w other manif, type I, uncontrolled
- 250.90 DM w unspec complic, type II, not uncontrolled
- 250.91 DM w unspec complic, type I, not uncontrolled
- 250.92 DM w unspec complic, type II, uncontrolled
- 250.93 DM w unspec complic, type I, uncontrolled

Measure 117: Diabetes Mellitus Dilated Exam

- **Diagnosis Codes**
 - 357.2 polyneuropathy in DM
 - 362.01 background diabetic retinopathy
 - 362.02 proliferative diabetic retinopathy
 - 362.03 nonproliferative diabetic retinopathy
 - 362.04 mild nonproliferative retinopathy
 - 362.05 moderate nonproliferative retinopathy
 - 362.06 severe nonproliferative diabetic retinopathy
 - 362.07 diabetic macular edema
 - 566.41 diabetic cataract

Measure 117: Diabetes Mellitus Dilated Exam

- **Diagnosis Codes**
 - 648.00 DM unspecified as to episode or care or not applicable
 - 648.01 DM delivered, w or w/o mention of antipartum condition
 - 648.02 DM antepartum condition or complication
 - 648.04 DM postpartum condition or complication

Measure 18: DM Documentation of Presence of ME & Level of Severity of Retinopathy

- CPT category II Code: 2021F
- Pts 18yrs+ with diagnosis of Diabetic Retinopathy with DFE
- Documentation must include
 - Level of severity of retinopathy (background, non-proliferative (mild, moderate, severe etc), proliferative)
 - If macular edema is present or absent
- Diagnosis codes
 - 362.01 Background diabetic retinopathy
 - 362.02 Proliferative diabetic retinopathy
 - 362.03 Nonproliferative retinopathy, NOS
 - 362.04 Mild nonproliferative diabetic retinopathy
 - 362.05 Moderate nonproliferative diabetic retinopathy
 - 362.06 Severe nonproliferative diabetic retinopathy
- Modifiers -1P, -2P, -8P

Measure 19: Diabetic Retinopathy
Communication with Physician Managing Diabetes Care

- CPT category II Code: 5010F (Findings of exam communicated) & G8397 (DFE performed documenting presence or absence of macular edema & level of severity of retinopathy) both required
 - G8398 dilated macular exam not performed
- Patients 18 years+ diagnosed w DR and DFE, at least once per reporting period, documented verbally or by letter
- Diagnosis codes
 - 362.01 Background diabetic retinopathy
 - 362.02 Proliferative diabetic retinopathy
 - 362.03 Nonproliferative retinopathy, NOS
 - 362.04 Mild nonproliferative diabetic retinopathy
 - 362.05 Moderate nonproliferative diabetic retinopathy
 - 362.06 Severe nonproliferative diabetic retinopathy
- Modifiers - -1P added for 2011, all others fine

HITECH Incentive Program

- Implementation of American Recovery & Reinvestment Act (ARRA) certified EHR systems
- Office of National Coordinator for Health Information Technology's new temporary certification plan
 - Established three new Authorized Certification & Testing Bodies (ACTBs)
 - to certify software systems
 - FEW systems will pass this certification process
- Medicare payments to EPs not qualified as Meaningful Users of EHRs will be reduced by 1% in 2015, 2% in 2016, 3% in 2017, 4% in 2018 and no more than 95% in subsequent years!!!!!!!!!!!!

“Meaningful Use” of “Certified” EHR

- Published in Federal Register July 28, 2010
- Eligible to receive a bonus incentive payment of up to \$44,000 over 5 years, per physician...more in health shortage areas
 - \$18,000 – 2011
 - \$12,000 – 2012
 - \$ 8,000 – 2013
 - \$ 4,000 – 2014
 - \$ 2,000 – 2015
- Medicare incentive based on 75% of your allowed charges (not the 80% you are paid)
- Requires \$24,000 in allowed charges to get maximum 1st year payment, but still receive partial payment on less Medicare volume

Meaningful Use of Certified EHR

- Must start in 2011 or 2012 to achieve highest payment
 - Utilization requirements easier to meet in 1st two years
 - Only need to demonstrate compliance w MU criteria over 90 day reporting period during 2011 vs full year 2012
 - MU Stage 1 applied in 2011 and 2012, MU Stage II in 2013
 - Notified if achieved w/in 2 mos after reporting period
 - If failure, have chance to try again in another 90 D period same yr
- A benefit of waiting to implement EHR until 2012
 - Can still collect e-prescribing 1% bonus in 2011 & still qualify for max EHR incentives (\$44K)
 - An EP cannot collect both MIPPA (eRx) & ARRA (EHR incentives) during same reporting periods

Meaningful Use of Certified EHR

- To receive Medicaid incentives practices must document that a majority of their patients are low income individuals or receive care under Medicaid program
 - No reporting periods requirements in year one
 - Attest to MU and apply for funds the next day
 - 90 days consecutive reporting period in year 2
 - Full year reporting in subsequent years
 - More items to be defined
 - ODs not yet specifically included as EPs yet in Medicaid MU rules

Measure 124: HIT Adoption of EHR

- To qualify, EMR must be certified by Authorized Testing & Certification Body (ACTB), PQRS qualified* in compliance with standards set by HHHS or must be capable of all the following:
 - Manage a medication list, manage a problem list, meet privacy/security standards
 - Enter, store, display lab tests as discrete searchable data elements
- **Report at each visit / no modifiers / no diagnosis codes**
- **G8447** encounter was documented using ATCB certified EHR
- **G8448** encounter documented using PQRS qualified HER, or other acceptable system
- *list of qualified EHR vendors of 2011 PQRS will be available in Alternative Reporting Mechanism Section, from navigation bar on left side of CMS PQR website at <http://cms.gov/pqri>

PQRI Name Change to PQRS

- CMS continues incentive payments in 2011
 - www.cms.gov/PQRI/15_MeasuresCodes.asp
- Successful PQRS reporters earn 1.0% in 2011
- Must report on at least 3 measures 50% of the time
 - Decrease from 80% in 2010
- Can report for full year (Jan1-Dec31) or half year (July1-Dec31)
- Incentive payments for years 2012-2014 will be extended and provide payment of 0.5%
- In 2015 a -1.5% PQRS payment penalty will be applied, in 2016 this increases to -2.0%

E-Prescribing

- CMS continues incentive payments in 2011, and eligible professionals, even those (group practices) with fewer than 200 employees can also participate
 - www.cms.gov/ERXIncentive/
- Successful electronic prescribers earn 1.0% in 2011 and 2012
- Beginning 2012, EPs who are not successful e-prescribers may be subject to a payment penalty
 - -1% in 2012, -1.5% In 2013, -2% 2014 +
- CMS will determine success by analyzing claims data from Jan1-June30, 2011
- Must submit at least 10 e-prescriptions during the first 6 months of 2011 to avoid penalty in 2012

E-Prescribing Facts

- Reporting period begins Jan 1, 2011 through Dec 31, 2011 All claims received by Feb 28, 2012
- Separate from, but similar to PQRS
- Not necessary to have EHR to participate, but need qualified system to participate
 - \$650-\$2500/yr fees are typical
- The individual who generates at least 10 eRx associated with patient visits during the Jan1-June30, 2011 reporting period will be eligible for incentive payment, and avoid payment penalty adjustment in 2012

E-Prescribing

- CPT codes: 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 92002, 92004, 92012, 92014
- G8553 – at least 1 Rx created during the encounter was generated and transmitted electronically using qualified e-Rx system (capable of all of the following)
 - Generate a complete active medication list incorporating data received from pharmacies and Pharmacy Benefits Managers
 - Select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts
 - Provide information related to lower costs, appropriate alternatives
 - Provide information on formulary medications, eligibility and authorization requirements received from patient's drug plan

2011 E-Prescribing Hardship Codes

- Report at least one time during the payment reporting period, Jan1-June30, 2011
- Exceptions for system hardships
- G8642 – EPs in rural area without high speed internet
- G8643 – EPs in area without available pharmacies for e-prescribing
- G8644 – EP does not have prescribing privileges

CASE 1: Glaucoma, established pt

- CPT / ICD
 - 92012 / Glaucoma (365.11) = \$65.00
 - 2027F / Glaucoma (365.11) = \$0.10
 - Documentation of Optic nerve findings
 - 3284F / Glaucoma (365.11) = \$0.10
 - Documentation of IOP lowering 15%
 - 92133 / Glaucoma (365.11) = \$40.00

CASE 2: Macular degeneration, estab pt

■ CPT / ICD

- 99214 / AMD (362.51) = \$65.00
- 2019F / AMD (362.51) = \$0.10
 - Documentation of Dilated retinal examination
- 4177F / AMD (362.51) = \$0.10
 - Documentation of recommendation of antioxidant vitamin
- 92250 / AMD (362.51) = \$70.00

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CASE 3: Diabetes Mellitus, estab pt

■ CPT / ICD

- 99214 / Cataract/ DM (366.16/362.51) = \$80.00
- 2022F / DM (362.51) = \$0.10
 - Documentation of Dilated retinal examination
- 92015 / Myopia (367.1) = \$20.00

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CASE 4: Diabetes Mellitus, estab pt

■ CPT / ICD

- 99214 / BDR (362.01) = \$80.00
- 2022F / BDR (362.01) = \$0.10
 - Documentation of Dilated retinal examination
- 2021F / BDR (362.01) = \$0.10
 - Documentation of presence & severity of retinopathy
- 5010F / BDR (362.01) = \$0.10
 - Documentation of communication with primary care provider
- G8397 / BDR (362.01) = \$0.10
 - Dilated fundus exam performed, documents presence or absence of ME & severity of retinopathy
- 92015 / Myopia (367.1) = \$20.00

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CASE 5: Dry Eye, estab pt Using EHR

- CPT / ICD
 - 99214 / Dry eye (370.33) = \$80.00
 - G8447 / no diagnosis code needed
 - Documentation of examination findings using certified electronic health record system
 - 92015 / Myopia (367.1) = \$20.00

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CASE 6: POAG, estab pt using EHR & e-prescribing

- CPT / ICD
 - 92012 / Glaucoma (356.11) = \$65.00
 - 2027F / Documentation of Optic Nerve findings
 - 3284F / Documentation of IOP lowering by 15%
 - G8447 / no diagnosis code needed
 - Documentation of examination findings using certified electronic health record system
 - G8553 / no diagnosis code needed/can use 365.11
 - At least one prescription generated using an e-prescribing system

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Billing Errors in PQRS Participants

- Put \$0.01 in charge field of 1500 form
- Report PQRI codes on all qualifying visits
- Submit on same form as regular CPT codes
- Exam or surgery CPT code should be followed by PQRI measure(s); any other tests/procedures should follow PQRI measure
- Corresponding diagnosis code for each measure should be applied to the exam or surgical code as well as the Category II CPT code. Unrelated diagnosis codes should never be attached to the Category II CPT codes

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Billing Errors in PQRS Participants

- Problems with the NPI number
- Diagnosis codes not linked properly to exam or surgical codes
- Human error in neglecting to report Category II or HCPCS codes
- Billing service error resulting in stripping of Category II or HCPCS codes
- If a patient qualifies for more than one measure report all that qualify
- Check EOMBs to assure Category II CPT codes are present and shown as denied charge (CO-96 or N365)

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Resource Information

- Primary Eyecare Network
 - 1.800.444.9230 www.primaryeye.net
 - **Medicare Compliance Kit**
 - Health History Questionnaire, Examination Forms
 - E/M Worksheets, ICD-9 Codes
 - Interpretation/Report form
 - **Medicare A-Z Manual**
 - Superbills / Signature on File stickers / Electronic Claims
 - **HIPAA Compliance Manual**
 - **PQRS Code Card**

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Thank you

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