Physician Quality Reporting System
2016
Rules and Guidance for 2016

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2016 PQRS

Physician Quality Reporting System

This webinar will be recorded and the presentation materials made available on the PQRS page available on http://www.aoa.org/pqrs

Please allow 3-5 business days for the recording
Physician Quality Reporting System
PQRS 2016

History Overview:
• Pay for Reporting – Voluntary for 2007-2014
• Tax Relief and Health Care Act of 2006 (TRHCA)
  – Authorized financial incentive for reporting quality data in 2007
• Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)
  – Continued authorization for PQRI through 2009
• Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)
  – Expanded bonus payments through 2010
Physician Quality Reporting System
PQRS 2016

History Overview (Cont’d):

• The Affordable Care Act (ACA) of 2010
  – Extended bonus through 2014
  – Initiated annual penalties beginning in 2015
  – For those who did not report in 2013, Medicare payments will be reduced by 1.5% in 2015
  – For those who **do not report in 2015**, reduces Medicare payments by 2.0% in 2017

• Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)
  – Extends PQRS from 2015 through 2018
  – Authorizes end of PQRS in 2018
  – Begins new program in 2019, Merit-based Incentive Payment System (MIPS)
  – MIPS incorporates some aspects of PQRS
Physician Quality Reporting System
PQRS 2016

• If you are not successful in reporting in 2016 you will be penalized in 2018

• Your Medicare reimbursement will drop by 2.0% for not being successful in PQRS

• 2018 penalties are based on 2016 reporting performance
• **REMEMBER**: YOUR PARTICIPATION IN PQRS ALSO IMPACTS YOUR VALUE BASED MODIFIER (VBM) PERFORMANCE

• Fail in PQRS and you will have an even larger impact on reimbursement in 2018

• More on VBM later
PQRS Form and Manner of Reporting

- **Claims based reporting**—discussed today
- Qualified registry reporting
- Measures group reporting—discussed today
- Certified Electronic Health Records Reporting (CEHRT)
  - Direct product submission
  - Data submission
- Qualified Clinical Data Registry (QCDR)
  - (AOA MORE)
- Group practice reporting (25+ and must register)
  - Web interface
  - CMS-certified survey vendor reporting
  - EHR—direct or data submission
Satisfactory PQRS Reporting
Claims-Based for 2016 PQRS Bonus

For satisfactory reporting:
Must report *at least 9* measures from 3 different NQS domains, 50% of time for each measure and 1 cross cut measure

Report only on Standard Medicare or Railroad Medicare claims
Do NOT report PQRS on Medicare Advantage claims

- This does **NOT** mean 9 measures on every claim at least 50% of time

Possible measures for optometry include at least 1 cross-cutting measure if have at least 1 Medicare patient face-to-face encounter (discuss cross cutting measures later)
Satisfactory PQRS Reporting Claims-Based for 2016 PQRS Bonus

AOA recommendations:
- Report 9-10 of measures discussed in this presentation
  - AOA and CMS have identified these are reportable by Optometry
- Submit PQRS measures for all *reportable* cases
- Consistent reporting will aid in meeting the 50% goal
- No penalty for more frequent reporting

Recommended measures cover all necessary domains including the broadly applicable cross-measure(s) required for successful reporting
PQRS Claims Reporting

- Paper-based CMS 1500 claims
- Must be reported on the same claim as CPT I
  - Sample CMS 1500 form will be reviewed
- No registration is required to participate
- Still strictly “voluntary” for 2016
Reporting Quality Data

- PQRS codes—Quality Data Code (QDC) charged at $0.00 or nominal, such as $0.01 but different denial codes
- Must file with CPT I and other requirements
- **Billing $0.00 ► N620**
  - This procedure code is for quality reporting/informational purposes only
- **Billing $0.01 ► CO 246 or PR 246 AND N620**
  - This non-payable code is for required reporting only
  - This procedure is not payable unless non-payable reporting codes and appropriate modifiers are submitted.

- **HOWEVER,** information is sent to National Claims History (NCH) file for PQRS analysis
PQRS Reporting Hints

• Track all claims submitted with PQRS
• Look for PQRS line item denial codes
• Ensure Provider NPI attached to each line item including PQRS line items
• If need to submit corrected claims-include PQRS codes
  – BUT cannot re-file only to add PQRS codes
• More details later BUT Use 8P modifier judiciously – do not use this modifier just to avoid performing the measure requirements!
PQRS Reporting Hints

- Current CMS 1500 form has 12 diagnosis places

- Current electronic claim has 12 diagnosis places

- Report one diagnosis per PQRS code even if more Dx apply

- PQRS analyzes claims data using ALL diagnoses from the base claim and service codes for each individual claim and provider (if multiple providers on one claim)
21. Review applicable PQRS measures related to ANY diagnosis (Dx) listed in Item 21. Up to 12 Dx may be entered electronically.

24D. Procedures, Services, or Supplies - CPT/HCPCS Modifier(s) as needed.

33a. The NPI of the billing provider is entered here. If a solo practitioner, then enter the individual NPI; if a Group is billing, enter the NPI of the Group here. This is a required field.

35a. For group billing, the rendering NPI number of the individual eligible professional who performed the service will be used from each line-item in the PQRS calculations.

The beneficiary is not liable for this nominal $0.01 amount.

QD codes must be submitted with a line-item charge of $0.01 in 2014. Charge field cannot be blank.
Satisfactory PQRS Reporting
Avoiding 2018 penalty in claims based reporting

• Report at least 9 measures covering 3 National Quality Strategy domain to avoid 2018 penalty

• If report 1-8 measures, provider will be subject to Measure Applicability Validation (MAV) to determine whether all applicable measures were reported

• MAV is not a factor if 9-10 measures discussed in this presentation are reported
PQRS Bonus Payment 2016

• No bonus payment for 2016 participation in PQRS
• However could earn VBM Bonus
• Only penalty for NOT reporting
• Reporting period: January 1, 2016 - December 31, 2016
• AGAIN - Failure to comply in 2016 will result in
  - 2% reduction of all Medicare payments in 2018
  - PLUS 2% for VBM reduction

No way to avoid 2018 penalty except to be successful in PQRS for 2016
PQRS Bonus Payment 2016

• Do nothing in 2016 –
  – Get paid 2% less in 2018
  – PLUS at least 2% loss VBM

• Report the 9-10 codes recommended by AOA for 50% of applicable Medicare/RR Medicare patients
  – Get paid standard Medicare rates for 2018 and
  – MAY earn VBM bonus
PQRS  Bonus Payment 2016

• Claims bases reporting analysis is by individual NPI under each Tax Identification Number
  – Must have and correctly use individual NPIs
  – Requires individual providers identified
  – Separate analysis for each TIN

• Must reach the 9 measure-3 domain-50% threshold to avoid 2018 penalty
2016 PQRS Measure Selection

Must Report 9+ measures covering at least 3 NQS domains

NQS domains:

– Patient Safety
– Person and Caregiver-Centered Experience & Outcomes
– Communication and Care Coordination
– Effective Clinical Care
– Community/Population Health
– Efficiency and Cost Reduction

CMS is requesting the reporting of cross cutting measures to collect more data across specialties.
2016 PQRS
6 eye care measures for 2016 Claims Reporting

• **Measure 12 (NQF 0086)** – Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation (Effective Clinical Care)

• **Measure 14 (NQF 0087)** – Age-Related Macular Degeneration (AMD): Dilated Macular Examination (Effective Clinical Care)

• **DELETED Measure 18 XXXX (also true last year!)**

• **Measure 19 (NQF 0089)** – Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care (Effective Clinical Care)

• **Measure 117 (NQF 0055)** – Diabetes mellitus: Dilated Eye Exam in Diabetic Patient (Effective Clinical Care)

• **Measure 140 (NQF 0566)** – Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement (Effective Clinical Care)

• **Measure 141 (NQF 0563)** – Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care (Communication and Care Coordination)
2016 PQRS Measure Lost for Claims Reporting

• **DELETED Measure 18** — Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy (Effective Clinical Care) 2021F

• **2021 F DO NOT REPORT** in 2016 unless EHR reporting or DR Measure Group
2016 PQRS

- 6 measures for cataract surgery are registry only codes
- 2 measures for retinal detachment repair are registry only codes
- Cataract Measure Group for cataract surgeons only
- Optometrists would not report these measures
- Modifier -55 is not acceptable with these measures
2016 Cross Cutting Measures

• Of 12 cross cutting measures, these are the 4 measures reported by claims-based reporting and applicable to optometry
  – **Measure 130 (NQF 0419)** Documentation of Current Medications in the Medical Record (Patient Safety)
  – **Measure 131 (NQF 0420)** Pain Assessment and Follow up (Community/population health)
  – **Measure 226 (NQF 0028)** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention (Community/population health)
  – **Measure 317 (No NQF)** Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (Community/population health)

• These 4 measures will be discussed in detail today!!
PQRS 2016

Other possibilities but do NOT allow use with 92000

- **Measure110** Preventive Care and Screening: Influenza Immunization (Community/Population Health)
- **Measure111** Pneumonia Vaccination Status for Older Adults (Community/Population Health)
- **Measure128** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up (Community/Population Health)

**NOW only registry reporting so not for claims reporting**

- **Measure173** Preventive Care and Screening: Unhealthy Alcohol Use – Screening (Community/Population Health)

We have four measures where 92000 codes allowed so we will NOT discuss these other measures today

PQRS Reporting

Reported with Quality Data Codes (QDCs)

- CPT II codes
  - Performance codes developed by CPT
  - If implemented before published in CPT book – posted on line
  - Not all published CPT II codes utilized for PQRS
    (2022F, 4177F, 2019F, 2027F, 5010F, 0517F etc)

- HCPCS G codes used when:
  - Measures without published CPT II codes
  - Measures required to share CPT II codes
    (G8397, G8398, etc)

QDC = PQRS codes for our discussion purposes
PQRS Basics

- Numerator
  - Appropriate QDC(s)
    - CPT II codes
    - HCPCS G codes
- Denominator
  - CPT I codes (E&M; General Ophthalmic codes)
  - Any appropriate diagnosis indicated
  - Additional factors such as age and frequency
Exceptions Modifiers

What if measure cannot be completed?

• When you file one of the appropriate diagnoses along with one of the appropriate evaluation and management codes, you must still report to be counted or it will count against you.

• Use modifiers
  – 1P: medical reason
  – 2P: patient reason
  – 8P: other reason

• Important to use these exception modifiers judiciously and not just to avoid performing measure, especially 8P.
When to Use

• If you report an evaluation & management code
  – 99201-99205 or 99212-99215

OR

• If you report a general ophthalmic service code
  – 92004, 92014, 92002, 92012

ANY OF THESE CODES - THINK PQRS

No other procedure codes are considered

Nursing Home/Rest Home and other E&M codes eligible as well but will not discuss today.
PQRS 2016

• Only Three Conditions To Think About:
  – Age Related Macular Degeneration
  – Primary Open Angle Glaucoma
  – Diabetes: Insulin and Non-insulin Dependent

• ANY OF THESE … THINK PQRS

• Eye care measures have no changes for 2016!!
If you have the **diagnosis** and **examination code**:

The only step left is to add the PQRS code
Must add the PQRS code to every Medicare claim where the diagnosis and examination code is appropriate for the measure

Except, of course, for the 3-4 additional measures now required

If you do this consistently, you will not be penalized!
Rule of thumb:

• USE PQRS EVERY TIME YOU HAVE DIAGNOSIS AND ENCOUNTER CODE (with modifiers if needed) OR WILL COUNT AGAINST YOU!

AND

• ADD 3-4 OF THE ADDITIONAL MEASURES AT EVERY VISIT FOR A STANDARD MEDICARE OR RR MEDICARE PATIENT

Pay close attention to the diagnosis, procedure codes and age for each measure since diagnosis code and age were two major areas for error in previous years
Discussion of the details!!
Age Related Macular Degeneration

• Any of these three diagnosis codes
  – H35.30 Macular Degeneration, NOS
  – H35.31 Macular Degeneration, non-exudative
  – H35.32 Macular Degeneration, exudative

• Patient age 50 and older
• Two PQRS measures to use
  • #14 (NQF 0087) – USE 2019F
  • #140 (NQF 0566) – USE 4177F

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ARMD

• 2019F:
  – **Dilated** view of macula
  – **Document** +/- macular thickening and +/- hemorrhages **and** level of severity-mild moderate severe

  You must dilate and record finding
  Report at least once per reporting period

AOA Advice:

REPORT EVERY TIME USE ARMD DIAGNOSIS CODES AND EXAMINATION CODE
ARMD Exceptions

• 2019F
  – 1P medical reason for no dilated macula view
  – 2P patient reason for no dilated macula view
  – 8P other reason for no dilated macula view
4177F:

- Discussed pros and cons of AREDS
- Made proper recommendations for individual
- Documented discussion

Discuss and record your recommendation at least once per reporting period for each unique patient …

AOA ADVICE:

REPORT EVERY TIME you use ARMD diagnosis and examination code

If already on AREDS, assumption is you have already discussed
ARMD Exceptions

- 4177F
  - 8P no reason for not discussing AREDS
Glaucoma – Primary Open Angle

- Two PQRS measures to be used
  - #12 (NQF 0086) Use 2027F
  - #141 (NQF 0563) Use 3284F or 0517F+3285F
- Will discuss these two measures together (subcategories)
  - H40.10__ Unspecified open angle glaucoma
  - H40.11__ Primary open angle glaucoma
  - H40.12__ Low tension glaucoma
  - H40.15__ Residual stage open angle glaucoma
- Patient age 18 years and older
Two different reporting options

– Controlled IOP
  • 2027F and 3284F

– Uncontrolled IOP
  • 2027F and 0517F & 3285F
Glaucoma
Primary Open Angle Controlled

• 2027F - Viewed optic nerve (With or without dilation)

• 3284F - IOP reduced 15% or more from pre-intervention

Report at least one every reporting period

AOA Advice:
Report every time you use diagnosis and exam code
Glaucoma
Primary Open Angle Angle Controlled

Exceptions

2027F
• 1P medical reason for not viewing optic nerve
• 8P no reason for not viewing optic nerve

3284F
• 8P IOP not documented, no reason given
Glaucoma
Primary Open Angle Uncontrolled

- 2027F- Viewed optic nerve
PLUS
- 3285F- IOP NOT reduced 15% from pre-intervention levels,
AND
- 0517F- Plan of care to get IOP reduced

Report at least once per reporting period

AOA Advice:
Report every time you use diagnosis & exam code
Glaucoma – Primary Open Angle Uncontrolled

- **0517F Plan of care examples**
  - recheck of IOP at specified time
  - change in therapy
  - perform additional diagnostic evaluations
  - monitoring per patient decisions
  - unable to achieve due to health system reasons
  - referral to a specialist

American Optometric Association
Glaucoma – Primary Open Angle
Uncontrolled Exceptions

2027F
• 1P medical reason for not viewing optic nerve
• 8P no reason for not viewing optic nerve

3285F
• No exceptions – use 3284F 8P if No IOP measure

0517F
• 8P no plan of care to reduce IOP documented
Diabetes

Two different PQRS measures

#19 NQF 0089  5010F+G8397 or G8398  (Ages 18 up)
#117 NQF 0055  2022F (etc)  (Ages 18-75)

• Age 18 +: Communication of macular edema and retinopathy to physician responsible for DM care
  (ONLY WITH RETINOPATHY
  5010F & G8397 Or G8398 alone

• Age 18-75: Diabetes with or without retinopathy –
  2022F or 3072F

Report at least once per reporting period

AOA Advice:

Report every time you use diagnosis and exam code
Diabetes

• Measure #117 Issue!!!
• Dilated Eye Exam for Diabetes  2022F

• CMS guidance left out 92000 codes for this measure
• AOA thinks this is an oversite
• STAY TUNED FOR CLARIFICATION
• 12-15-15 CMS confirms error in guidance and Measure #117 DOES include the 92000 code series
Diabetes with or without retinopathy
2022F or 3072F

• Any of these diabetes diagnoses

• Patients age 18-75 years old
Diabetes with or without retinopathy

2022F  Dilated eye exam in diabetic patient

OR

3072F  Low risk of DR (normal exam last year)

(two other codes for imaging views of the retina exist for this measure, 2024F and 2026F, but we are making it simple and dilation is the recommended clinical care guidelines - few OD’s would use only images)
Diabetes with or without retinopathy

Exceptions

- 2022F
  - 8P no reason for not performing dilated eye exam

- 3072F
  - No exceptions for this measure
Diabetes with retinopathy

- 18+ years of age
- Diagnosis:
  - E08.311, E08.319, E08.321, E08.329, E08.331, E08.339, E08.341, E08.349, E08.351, E08.359,
Diabetes with retinopathy

• **5010F** - Communicated presence or absence of macular edema and the level of DR to physician responsible for the diabetic care ages 18 and up

• Exceptions
  – **1P** medical reason for not communicating
  – **2P** patient reason for not communicating
  – **8P** no reason for not communicating
Diabetes with retinopathy

G8397 Dilated macular exam performed

OR

G8398 Dilated macular exam not performed

► Has to be coded along with the 5010F QDC for this measure to be complete ◄
Diabetes Examples

1. DM – no DR, age 18-75: **2022F**

2. DM + DR, age 18-75: **2022F, 5010F, G8397**

3. DM – no DR, over age 75: **no PQRS codes**

4. DM + DR, over age 75: **5010F, G8397**
Combined Examples

1. ARMD + DM, age 52: 2019F, 4177F, 2022F

2. ARMD + G (controlled), age 35: 2027F, 3284F

3. ARMD + G (uncontrolled) + DM age 72:
   2019F, 4177F, 2027F, 0517F, 3285F, 2022F

4. G (uncontrolled) + DM with DR, age 72:
   2027F, 0517F, 3285F, 2022F, 5010F, G8397

5. ARMD + G (controlled) + DM, age 78:
   2019F, 4177F, 2027F, 3284F
Other Measures Required to File

- Need *at least* three measure beyond the 6 eye care specific measures (all listed below are cross cutting measures)
- 92000 series codes allowed + 99000 series
  1. #130 Documentation of Current Medications in the Medical Record
  2. #131 Pain Assessment and Follow up
  3. #226 Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
  4. #317 Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

Again, measures that do not include 92000 series codes are not being discussed today and are not being recommended for reporting.
#130 (NQF 0419) Documentation of Current Medications in the Medical Record

- Not related to any specific diagnosis codes
- Report on **EACH visit** in a 12 month period
- Will use on Medicare and Railroad Medicare patients
- Age 18+
- Use if you report an evaluation & management code
  - 99201-99205 or 99212-99215
- If you report a general ophthalmic service code
  - 92004, 92014, 92002, 92012

Nursing Home/Rest Home and other E&M codes eligible as well but will not discuss today

Again, no other procedure codes or “testing” codes apply
#130 (NQF 0419) Documentation of Current Medications in the Medical Record

**MUST** include name, dosage, frequency and route of administration for

1. All prescription medications
2. All over-the-counters medications
3. All herbals
4. All vitamin/mineral/dietary (nutritional) supplements

- **Route** - Documentation of the way the medication enters the body (some examples include but are not limited to: oral, sublingual, subcutaneous injections, and/or topical)

- **Not Eligible** - A patient is not eligible if the following reason is documented:
  - Urgent or emergent medical situation where time is of the essence and to delay treatment would jeopardize the patient’s health status
#130 (NQF0419) Documentation of Current Medications in the Medical Record

• **G8427**: List of current medications documented by the provider, including drug name, dosage, frequency and route

OR

• **G8430**: Provider documentation that patient is not eligible for medication assessment

OR

• **G8428**: Current medications (includes prescription, over-the-counter, herbals, vitamin/mineral/dietary [nutritional] supplements) with drug name, dosage, frequency and route **not** documented by the provider, reason not specified
#131 (NQF 0420) Pain Assessment & Follow up

- Not related to any specific diagnosis codes
- Report on EACH visit in a 12 month period
- Use on Standard Medicare and Railroad Medicare patients
- Age 18+
- Use if you report an evaluation & management code
  - 99201-99205 or 99212-99215
- If you report a general ophthalmic service code
  - 92004, 92014, 92002, 92012

Nursing Home/Rest Home and other E&M codes eligible as well but will not discuss today

Again, no other procedure codes or “testing” codes apply
#131 (NQF 0420) Pain Assessment & Follow up

- Must use standardized Pain Assessment Tool
- Documentation of pain assessment using standardized tool(s) on each visit

AND

- Documentation of follow-up plan when pain is present
  - Follow-up plan must be related to presence of pain:
    - “Patient referred to pain management specialist for back pain”
    - or “Return in two weeks for re-assessment of pain”
  - may include pharmacologic and/or educational interventions
Standardized Tool - appropriately normalized and validated for population in which it is used (Reference AOA website)

1. Brief Pain Inventory (BPI)
2. Faces Pain Scale (FPS)
3. McGill Pain Questionnaire (MPQ)
4. Multidimensional Pain Inventory (MPI)
5. Neuropathic Pain Scale (NPS)
6. Numeric Rating Scale (NRS)
7. Oswestry Disability Index (ODI)
8. Roland Morris Disability Questionnaire (RMDQ)
9. Verbal Descriptor Scale (VDS)
10. Verbal Numeric Rating Scale (VNRS)
11. Visual Analog Scale (VAS)
Not Eligible – A patient is not eligible if one or more of the following reason(s) is documented:

1. Severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others

2. Patient in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status
#131(NQF 0420) Pain Assessment & Follow up

- **G8730**: Pain assessment documented as positive using a standardized tool AND a follow-up plan is documented

  OR

- **G8731**: Pain Assessment Documented as Negative, No Follow-Up Plan Required

  OR

- **G8442**: Pain assessment NOT documented, documentation patient not eligible for pain assessment using a standardized tool

  OR

- **G8939**: Pain assessment documented as positive, follow-up plan not documented, documentation patient is not eligible

  OR

- **G8732**: No documentation of pain assessment, reason not given

  OR

- **G8509**: Pain assessment documented as positive using a standardized tool, follow-up plan not documented, reason not given
#226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

- Screened for tobacco use and cessation counseling intervention
- 1+ times within 24 months

**AND**
- Received cessation counseling intervention if tobacco user
- Age 18 years and older
- **Reported once per reporting period**

**Definitions:**
- Tobacco Use – Includes use of any type of tobacco.
- Cessation Counseling Intervention – Includes brief counseling (3 minutes or less), and/or pharmacotherapy.

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#226 (NQF 0028): Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

4004F:
Patient screened for tobacco use AND received tobacco cessation intervention (counseling, pharmacotherapy, or both), if identified as a tobacco user

OR

1036F:
Current tobacco non-user
4004F

1P: Documentation of medical reason(s) for not screening for tobacco use (eg, limited life expectancy, other medical reasons)

8P: Tobacco screening OR tobacco cessation intervention not performed, reason not otherwise specified
#317: (No NQF) Preventive Care and Screening: Screening for High Blood Pressure & FU Documented

- Screened for high blood pressure AND recommended follow-up plan is documented based on current blood pressure (BP) reading as indicated
  - Age 18 years and older
  - Once per reporting period
- Must **perform the blood pressure screening** at qualifying visit
- *May not* obtain measurements from external sources
- Recommended follow-up plan documented, as indicated if the blood pressure is pre-hypertensive or hypertensive
- Documented follow up plan must be related to the current BP reading as indicated, example:
  
  “Patient referred to primary care provider for BP management.”
#317: Preventive Care and Screening: Screening for High Blood Pressure & FU Documented

Definitions:

- **BP Classification** - BP is defined by four BP reading classifications
- **Recommended BP Follow-Up** - *BP screening intervals, lifestyle modifications and interventions based on the current BP reading*
- **Lifestyle Modifications** - Weight Reduction, Dietary Approaches to Stop Hypertension (DASH) Eating Plan, Dietary Sodium Restriction, Increased Physical Activity, or Moderation in Alcohol (ETOH) Consumption.
- **Second Hypertensive Reading** - Requires a BP reading of Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg during the current encounter AND a most recent BP reading within the last 12 months Systolic BP ≥ 140 mmHg OR Diastolic BP ≥ 90 mmHg.
- **Second Hypertensive Reading Interventions** - Anti-Hypertensive Pharmacologic Therapy, Laboratory Tests, or Electrocardiogram (ECG).
<table>
<thead>
<tr>
<th>BP Classification</th>
<th>Systolic BP mmHg</th>
<th>Diastolic BP mmHg</th>
<th>Recommended Follow-Up</th>
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<tbody>
<tr>
<td>Normal BP Reading</td>
<td>&lt; 120</td>
<td>AND &lt; 80</td>
<td>• No Follow-Up required</td>
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<tr>
<td>Pre-Hypertensive BP Reading</td>
<td>≥ 120 AND ≤ 139</td>
<td>OR ≥ 80 AND ≤ 89</td>
<td>• Rescreen BP within a minimum of 1 year AND Lifestyle Modifications OR</td>
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<td>• Referral to Alternative/Primary Care Provider</td>
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<tr>
<td>First Hypertensive BP Reading</td>
<td>≥ 140</td>
<td>OR ≥ 90</td>
<td>• Rescreen BP within a minimum of ≥ 1 day and ≤ 4 weeks AND Lifestyle Modifications OR</td>
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<td></td>
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<td></td>
<td>• Referral to Alternative/Primary Care Provider</td>
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<tr>
<td>Second Hypertensive BP Reading</td>
<td>≥ 140</td>
<td>OR ≥ 90</td>
<td>• Lifestyle Modifications AND 1 or more of the Second Hypertensive Reading Interventions</td>
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<td>(see definitions)</td>
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<td>• Referral to Alternative/Primary Care Provider</td>
</tr>
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#317: Preventive Care and Screening: Screening for High Blood Pressure & FU Documented

- **Not Eligible** – A patient is not eligible if one or more of the following reason(s) are documented:

1. Patient has an active diagnosis of hypertension
2. Patient refuses to participate (either BP measurement or follow-up)
3. Patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient’s health status. This may include but is not limited to severely elevated BP when immediate medical treatment is indicated
#317: Preventive Care and Screening: Screening for High Blood Pressure & FU Documented

- **G8783**: Normal blood pressure documented, follow-up not required

- **G8950**: Pre-Hypertensive or Hypertensive blood pressure reading documented, AND the indicated follow-up is documented

- **G8784**: Blood pressure reading not documented, documentation the patient is not eligible

- **G8785**: Blood pressure reading not documented, reason not given

- **G8952**: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, reason not given

- **NOTE: DELETED OPTION**

- **XXG8951**: Pre-Hypertensive or Hypertensive blood pressure reading documented, indicated follow-up not documented, documentation the patient is not eligible
PQRS “Rules to live by”

1. Must file at least nine different PQRS measures with 3 different domains with one measure being cross cutting

2. Must file a PQRS measure on at least 50% of the claims whenever the examination code and diagnosis code indicates the need for a measure (two-three other measures will be filed on every claim)

3. 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 (two-three other measures will be filed on every claim)

4. Track all claims with PQRS codes to ensure proper denial of N620 so measures will go to National Claims History file and be counted

5. Ensure your insurance clearinghouse is not stripping PQRS codes from claims
Value Based Modifier (VBM)

- What it is **NOT**
  - Not a coding modifier added to claims

- What it **IS**
  - Compilation of quality and efficiency data
  - Impacts **ALL** Medicare Physicians
  - Began in 2015 (YES THIS YEAR) will impact majority of optometrists
  - 2017 reimbursement impact based on 2105 performance
  - 2018 reimbursement impact based on 2016 performance
  - Compiles costs of individual physician's care compared with outcomes
  - All physicians at risk for being paid less than normal Medicare fee-for-service rates
Value Based Modifier (VBM)

• **HOW** VBM impact is determined?
  – CMS analysis for physician's score categorized:

1. **Quality**: Low quality, average quality or high quality.
2. **Cost**: Low cost, average cost, high cost.
   Physicians will receive reimbursement based on score
   a) Increase reimbursement
   b) No change in reimbursement
   c) Reimbursement penalty
VBM & Merit-based Incentive Payment System (MIPS)

• VBM will impact reimbursement in 2017
AND
• Participation in VBM program will help optometrists as MIPS is implemented

• Under MIPS, optometrists will continue to be annually evaluated based on the quality and costs of care provided to patients
VBM 2016

• What to Do in 2016 to Avoid VBM Payment Penalties in 2018??
  - PARTICIPATE and MEET PQRS IN 2016!
    – Where have you heard this over and over again?[][]

• If do not participate in PQRS, then BOTH PQRS penalty and VBM penalty

PQRS penalty = 2%
VBM penalty:
  – Solo and 2 to 9 EPs groups penalty= 2% → total 4%
  – 10 + EPs groups penalty=4% → total 6%
Summary of 2016 Penalties

- **PQRS Failure to Participate**
  - -2% MPFS

- **Value Based Modifier NON-PQRS Participants**
  - Non-PQRS Solo and 2-9 provider groups
    - -2% MPFS
  - Non-PQRS 10+ provider groups
    - -4% MPFS

- **Value Based Modifier PQRS Participants**
  - PQRS Solo and 2-9 provider groups
    - 0% - +2x MPFS
      - (x = quality tiering)
  - PQRS 10+ provider groups
    - -4% - +4x MPFS
      - (x = quality tiering)
  - Groups/solo eligible for extra +1x MPFS IF in top 25% quality tiering

Potential to LOSE 4% or more of your Medicare Reimbursement

Does not even account for Meaningful Use penalties
Additional PQRS Resources

- [www.CMS.gov/PQRS](http://www.CMS.gov/PQRS)
- [AskTheCodingExperts@aoa.org](mailto:AskTheCodingExperts@aoa.org)
- Physician Quality Reporting System – [www.aoa.org/pqrs](http://www.aoa.org/pqrs)
- Medical Records & Coding – [www.aoa.org/coding](http://www.aoa.org/coding)
- Electronic Health Records – [www.aoa.org/EHR](http://www.aoa.org/EHR)
- AOA Codes for Optometry (2 Volumes) 1-800-262-2210
- [www.AOACodingToday.com](http://www.AOACodingToday.com) - **Free** for AOA Members
- Paraoptometric Resource Center - [prc@aoa.org](mailto:prc@aoa.org)
- Paraoptometric Coding Certification - [cpc@aoa.org](mailto:cpc@aoa.org)
Additional AOA PQRS Resources

Exam room “Cheat sheet” for 10 recommended measure
Measure flow charts
Summary article to come

This webinar will be recorded and the presentation materials made available on the PQRS page available on http://www.aoa.org/pqrs

Please allow 3-5 business days for the recording
You will need to be logged on to view the recording
No Office is an Island

• Many resources available but it’s up to you to seek answers
• Don’t be shy about emailing your questions to www.aoa.org/ask-the-coding-experts
• Free service to AOA members and their staff
• Be sure to register for future medical records & coding webinars at http://www.aoa.org/events
Questions?

Thank You!