**What is PQRS?** The Physician Quality Reporting System (PQRS) is a program through the Centers for Medicare and Medicaid Services (CMS) designed to improve the quality of care to Medicare beneficiaries by tracking practice patterns.

**Who should participate?** Audiologists who bill outpatient Medicare Part B beneficiaries (does not apply to Part B hospital and skilled nursing facilities) must participate in the Medicare Physician Quality Reporting System (PQRS) to avoid deductions to claims in 2016. This applies to audiologists in independent practices as well as those providing services in otolaryngology offices or university clinics, billing with their individual NPI or TIN on the claim form as the rendering provider of the service.

**When should we start?** Audiologists should start immediately in order to avoid the 2% penalty to be retained in 2016 for failure to report on 2014 eligible measures. In order to avoid the payment penalty, audiologists are required to report on the following:

<table>
<thead>
<tr>
<th>Measure</th>
<th>2014 Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>#261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness</td>
<td>One time per calendar year for 50% of the eligible Medicare patients</td>
</tr>
<tr>
<td>#130: Documentation of Current Medications in the Medical Record</td>
<td>50% of every eligible Medicare patient visit</td>
</tr>
</tbody>
</table>

CMS retired measure #188, Referral for Otologic Evaluation for Patients with Congenital or Traumatic Deformity of the Ear, effective on January 1, 2014.

Measure #134, (Preventative Care and Screening - Screening for Clinical Depression and Follow-Up Plan) is an option for reporting but not required to avoid the 2016 payment reduction. Measure #134 should only be reported if you routinely utilize a depression screening tool and is within your state scope of practice. You will not be penalized for not reporting on Measure #134. If used, this measure should be reported once per reporting period.

**How does the penalty apply?**

If benchmarks are not met in 2014 penalties apply as payment reductions taken onto 2016 claims submitted for services provided by the individual provider who did not meet the requirements. PQRS is tracked by the Taxpayer Identification Number (TIN) of the clinic/practice which submitted the claim with the National Provider Identifier (NPI) of the audiologist listed on the claim as the “rendering provider.” If an audiologist in a practice does not meet the 2014 requirements, all services submitted from the practice with the audiologist as the rendering provider will be reduced by 2% in 2016.

CMS uses a Measures Applicability Validation (MAV) process to determine if providers met minimum requirements. All claims from audiologists will be subject to this process because there are less than 9 measures to report, a new PQRS requirement for 2014. The claims are analyzed to determine if the audiologist reported all applicable measures. Measure #261 and Measure #130 are linked, so that if one is reported, the claims will be analyzed for the other. For instance, if Measure #130 is reported by an audiologist, and Measure #261 is not, the claims will be analyzed to determine if the ICD-9/ICD-10
codes for dizziness required by the measure (780.4 and 386.11) and the corresponding CPT codes required by dizziness Measure #261 were on claims. If so, Measure #261 should have been reported, the audiologist fails the MAV, and penalties will be applied in 2016. If the audiologist does not provide services for patients with these dizziness ICD-9/ICD-10 codes, the MAV will recognize that Measure #261 was not applicable and the MAV is passed. In this case, no penalty will be assessed.

Additionally, all measures have options for a “positive” action (performed what the measure indicates), exclusion (patient/service did not qualify), or non-action (did not perform this measure). In order to be considered participatory, audiologists cannot report the non-action 100% of the time.

**How does the incentive work?**

2014 is the final year to obtain the 0.5% bonus. When individuals meet benchmark requirements, an incentive payment equal to 0.5% of the audiologists estimated total allowed charges for covered Medicare Part B Physician Fee Schedule (PFS) services provided in 2014 will be paid to the TIN of the clinic/practice submitting the claims for reimbursement.

**What do we do?** Reporting is easy! Any time you perform a CPT code in the tables below, you must determine if there is a corresponding G code and report it on the claim form. Satisfactory reporting is based on the number of patients for whom you provide a service represented by one of the CPT codes, or one of the combinations of CPT code and ICD-9/10 code when an ICD-9/10 is indicated, as in the case for Measure #261 (referral for otologic evaluation for patients with acute or chronic dizziness). The ICD-9 coding system will transition to the ICD-10 coding system on October 1, 2014. If the CPT code is reported with the ICD-9/10 code, the appropriate G code must also be reported, and placed in box 24 D on the CMS 1500 claim form like a billable service. If the ICD-9/10 code chosen is not listed in the measure requirements, you do not report on that measure and you will not be penalized for not reporting.

**Example:**

A patient presents with referral from internal medicine with a diagnosis of 780.4 (dizziness and giddiness). The audiologist performs, among other tests, a comprehensive audiology evaluation (92557). The following measures are eligible to report, if allowed by your state licensure law:

First Step: Review Patient Eligibility and Codes for Each Measure

- CPT code 92557 is included in these 3 measures:

<table>
<thead>
<tr>
<th>Measure: #261</th>
<th>Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Measure: #130</td>
<td>Documentation and Verification of Current Medications in the Medical Record</td>
</tr>
<tr>
<td>Measure: #134</td>
<td>Screening for Clinical Depression and Follow-Up Plan</td>
</tr>
</tbody>
</table>

- Because 780.4 is included in Measure #261, you report the code that best matches the action you took on that date of service:
  - G8856, referral to a physician for otologic evaluation performed, if you are referring this patient to an otorhinolaryngologist
  - OR
G8857, patient is not eligible for referral for otologic evaluation measure (e.g., patients who are already under the care of a physician for acute or chronic dizziness), if you are referring this patient to their referring primary care physician

OR

G8858, referral to a physician for an otologic evaluation not performed, reason not specified

It is the combination of the CPT code and the ICD-9/10 code that triggers the patient eligibility for reporting, not the measure description.

The specifications of the measures are available on the Audiology Quality Consortium (AQC) website under the "Quality Measures" section. Further detailed specifications with applicable codes are available on the CMS website.

Step One: Review the Codes for Each Measure


- ICD-9-CM codes (and effective 10/1/14, the ICD-10 codes)
  - Indicate the diagnosis of the patient.
  - Represent the measures' denominator (the eligible patients for a measure) in conjunction with CPT codes.

- CPT Codes
  - Indicate the procedure performed on the patient.
  - Represents the measures' denominator (the eligible patients for a measure) in conjunction with the ICD-9-CM codes.

- G Codes
  - Represents the measures' numerator (action required by the measure for reporting and performance) as well as when the action does not occur because the patient fits into the denominator exclusion (patient that fits into the denominator but is not eligible for the measure).

Eligible PQRS Measures for Audiologists:

- Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness
- Documentation of Current Medications in the Medical Record
- Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan

Measure Requirements in detail:

Measure: #261: Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness

Reporting Criteria: Patients of any age with the following procedure codes and associated diagnosis codes Should be reported once per year per patient.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92540, 92541, 92542, 92543, 92544, 92545,</td>
<td>780.4, 386.11</td>
<td>G8856: Referral to a physician for otologic evaluation performed</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G8857: Patient is not eligible for the referral for otologic evaluation measure (e.g.,</td>
</tr>
</tbody>
</table>
patients who are already under the care of a physician for acute or chronic dizziness)

**G8858**: Referral to a physician for an otologic evaluation not performed, reason not specified

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**Measure: #130: Documentation of Current Medications in the Medical Record**

**Reporting Criteria**: Patients ≥ 18 years with the following procedure codes

Should be reported for every patient visit.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92541, 92542,</td>
<td>No specific</td>
<td><strong>G8427</strong>: List of current medications (includes prescription, over-the-counter,</td>
</tr>
<tr>
<td>92543, 92544,</td>
<td>ICD-9 codes</td>
<td></td>
</tr>
<tr>
<td>92545, 92547,</td>
<td>are included</td>
<td><strong>G8430</strong>: Provider documentation that patient is not eligible for medication</td>
</tr>
<tr>
<td>92548, 92557,</td>
<td>for this</td>
<td></td>
</tr>
<tr>
<td>92567, 92568,</td>
<td>measure</td>
<td></td>
</tr>
<tr>
<td>92570, 92585,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>92588, 92626</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Measure: #134: Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan**

**Reporting Criteria**: Patients ≥ 12 years with the following procedure codes

Should be reported once per year per patient.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>ICD-9 Codes</th>
<th>G Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>92557, 92567,</td>
<td>No specific</td>
<td><strong>G8431</strong>: Positive screen for clinical depression using an age appropriate</td>
</tr>
<tr>
<td>92568, 92625,</td>
<td>ICD-9 codes</td>
<td></td>
</tr>
<tr>
<td>92626</td>
<td>are included</td>
<td></td>
</tr>
<tr>
<td></td>
<td>for this</td>
<td></td>
</tr>
</tbody>
</table>

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**Step Two: Fill Out the CMS-1500 Claim Form**

A [sample 1500 claim form](file) [PDF] is available on the Centers for Medicare & Medicaid Services (CMS) website. CMS also has a sample claim form filled out for PQRS in Appendix D of its [2014 Physician Quality Reporting Initiative Implementation Guide](file) [ZIP].

- ICD-9/10 codes are placed in box 21
- CPT codes are placed in box 24D
- G-codes are placed in box 24D
Step Three: Make Sure You Meet CMS' Minimum Reporting Requirements

To obtain the 0.5% PQRS incentive payment, Medicare requires that eligible professionals report on at least 9 quality measures in 2014 for at least 50% of eligible patient visits (a professional’s Part B patients for whom the measure applies according to the measure frequency specification). If less than 9 measures are available for reporting, such as is the case for audiologists, CMS will permit a professional to report on fewer than 9 measures for at least 50% of eligible patient visits. This is when the Measures Applicability Validation (MAV) process applies.

In the MAV process, the claims are analyzed to determine if the audiologist reported all applicable measures. Measure #261 and Measure #130 are linked, so that if one is reported, the claims will be analyzed for the other. Additionally, in order to be considered participatory, audiologists cannot report the “non-action” option of the measures 100% of the time.

It is important to remember that in order to avoid the payment penalty, audiologists are required to report on Measure #261 (Referral for Otologic Evaluation for Patients with Acute or Chronic Dizziness) for at least 50% of eligible Medicare patient visits AND to report on Measure #130 (Documentation of Current Medications) for at least 50% of eligible Medicare patient visits. Audiologists have the opportunity to qualify for the payment incentive for its last year by meeting the same requirements for 2014. For more information about the MAV process that applies to audiologists, see the CMS PQRS Analysis and Payment page.

Measure specific information, including reporting toolkits, flow charts, clinical scenarios and corresponding CMS 1500 claim forms can be found here.

FOR QUESTIONS, CONTACT:

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